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

PROPOSAL FORM – ROUND 8
(SINGLE COUNTRY APPLICANTS)

Applicant Name	COUNTRY COORDINATING MECHANISM (CCM), NIGERIA
Country	NIGERIA
Income Level *(Refer to list of income levels by economy in Annex 1 to the Round 8 Guidelines)*	LOW INCOME

Applicant Type ✓ ☐ CCM ☐ Sub-CCM ☐ Non-CCM

Round 8 Proposal Element(s):

	Disease	Title	HSS cross-cutting interventions section *(include in one disease only)*
x	HIV[1]	Towards Intensified HIV/AIDS Prevention, Treatment, Care and Support Services In Nigeria	X
x	Tuberculosis[1]	Scaling up priority Tuberculosis control interventions in Nigeria	☐
X	Malaria	Intensifying malaria control interventions towards universal access in Nigeria.	☐

Currency **x** USD or ☐ EURO

Deadline for submission of proposals: **12 noon, Local Geneva Time, Tuesday 1 July 2008**

[1] In contexts where HIV is driving the tuberculosis epidemic, applicants should include relevant HIV/TB collaborative interventions in the HIV and/or tuberculosis proposals. Different HIV and tuberculosis activities are recommended for different epidemiological situations. **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/

INDEX OF SECTIONS and KEY ATTACHMENTS FOR PROPOSALS

'**+**' = A key attachment to the proposal. These documents **must** be submitted with the completed Proposal Form. Other documents may also be attached by an applicant to support their program strategy (*or strategies if more than one disease is applied for*) and funding requests. Applicants identify these in the 'Checklists' **at the end of** s.2 and s.5.

1. Funding Summary and Contact Details

2. Applicant Summary (including eligibility)

+ Attachment C: Membership details of CCMs or Sub-CCMs

Complete the following sections for each disease included in Round 8:

3. Proposal Summary

4. Program Description

4B. HSS cross-cutting interventions strategy **

5. Funding Request

5B. HSS cross-cutting funding details **

** *Only to be included in one disease in Round 8. Refer to the Round 8 Guidelines for detailed information.*

+ Attachment A: '**Performance Framework**' (Indicators and targets)

+ Attachment B: '**Preliminary List of Pharmaceutical and Health Products**'

+ Detailed Work Plan: Quarterly for years 1 – 2, and annual details for years 3, 4 and 5

+ Detailed Budget: Quarterly for years 1 – 2, and annual details for years 3, 4 and 5

IMPORTANT NOTE:

Applicants are strongly encouraged to read the *Round 8 Guidelines* fully before completing a Round 8 proposal. Applicants should continually refer to these Guidelines as they answer each section in the proposal form. All other Round 8 Documents are available here.

A number of recent Global Fund Board decisions have been reflected in the Round 8 Proposal Form. The *Round 8 Guidelines* explain these decisions in the order they apply to this Proposal Form. Information on these decisions is available at:
http://www.theglobalfund.org/en/files/boardmeeting16/GF-BM16-Decisions.pdf.

Since Round 7, efforts have been made to simplify the structure and remove duplication in the Round 8 Proposal Form. The *Round 8 Guidelines* therefore contain the **majority of instructions** and examples that will assist in the completion of the form.

1. FUNDING SUMMARY AND CONTACT DETAILS

1.1. Funding summary

Disease	Total funds requested over proposal term					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
HIV	132,287,960	161,579,617	157,841,304	191,434,362	188,469,398	831,612,641
Tuberculosis	22,291,727	19,765,677	22,905,835	55,031,128	61,228,112	181,222,479
Malaria	294,137,505	40,213,528	134,574,670	80,853,046	50,031,745	599,810,494
HSS cross-cutting interventions within *[insert name of the one disease which includes s.4B. and s.5B. only if relevant]*	45,315,004	29,740,359	35,480,888	38,046,029	29,447,772	178,030,052
					Total Round 8 Funding Request ➔:	1,791,038,042

1.2. Contact details

	Primary contact	Secondary contact
Name	JEROME MAFENI	BELLO FATAI WOLE
Title	Dr.	Dr.
Organization	ENHANSE Project/Constella Futures	COUNTRY COORDINATING MECHANISM (CCM), NIGERIA
Mailing address	50 HAILE SELASSIE STREET, ASOKORO, PMB 533, ABUJA, NIGERIA	N0 2, CASSANDRA STREET, OPPOSITE ZENITH BANK, MAITAMA OFF GANA STREET, ABUJA,NIGERIA.
Telephone	234-803-7001609	234-806-0093229
Fax	234-9-3145574	
E-mail address	jmafeni@gmail.com	fwbello@yahoo.com
Alternate e-mail address	jmafeni@constellagroup.com	fwbello@ccmnigeria.org

1.3. List of Abbreviations and Acronyms used by the Applicant

Acronym/ Abbreviation	Meaning
RMC	Resource Mobilization Committee
OVC	Oversight Committee
EXCO	Executive Committee
	[use "Tab" key to add extra rows if needed]

2. APPLICANT SUMMARY (including eligibility)

CCM applicants: Only complete section 2.1. and 2.2. and DELETE sections 2.3. and 2.4.
Sub-CCM applicants: Complete sections 2.1. and 2.2. and 2.3. and DELETE section 2.4.
Non-CCM applicants: Only complete section 2.4. and DELETE sections 2.1. and 2.2. and 2.3.

IMPORTANT NOTE:
Different from Round 7, 'income level' eligibility is now set out in s.4.5.1 (focus on poor and key affected populations depending on income level), and in s.5.1. (cost sharing).

2.1. Members and operations

2.1.1. Membership summary

	Sector Representation	Number of members
x	Academic/educational sector	2
x	Government	5
x	Non-government organizations (NGOs)/community-based organizations	9
x	People living with the diseases	1
x	People representing key affected populations[2]	1
x	Private sector	2
x	Faith-based organizations	2
x	Multilateral and bilateral development partners in country	4
	Other *(please specify):International NGOs*	3
	Total Number of Members: *(Number must equal number of members in 'Attachment C'[3])*	29

[2] Please use the *Round 8 Guidelines* definition of *key affected populations*.
[3] **Attachment C** is where the CCM (or Sub-CCM) lists the names and other details of all current members. This document is a mandatory attachment to an applicant's proposal. It is available at: http://www.theglobalfund.org/documents/rounds/8/AttachmentC_en.xls

2.1.2. Broad and inclusive membership

Since the last time you applied to the Global Fund (and were determined compliant with the minimum requirements):

(a)	Have non-government sector members (*including any new members since the last application*) continued to be transparently selected by their own sector; and	☐	No	x	Yes
(b)	Is there continuing active membership of people living with and/or affected by the diseases.	☐	No	x	Yes

2.1.3. Member knowledge and experience in cross-cutting issues

Health Systems Strengthening

The Global Fund recognizes that weaknesses in the health system can constrain efforts to respond to the three diseases. We therefore encourage members to involve people (from both the government and non-government) who have a focus on the health system in the work of the CCM or Sub-CCM.

(a) Describe the capacity and experience of the CCM (or Sub-CCM) to consider how health system issues impact programs and outcomes for the three diseases.

The Nigeria CCM has members who have composite experience in Health Systems especially amongst the multilateral and bi-lateral partners (WHO, UNDP.UNAIDS, USG, DFID, CIDA etc) who are willing to bring to bear their wealth of experience to CCM Nigeria. Also the CCM has been bring though as observers many players in the area of health systems not forgetting the appropriate government institution which has the constitutional responsibility.

Gender awareness

The Global Fund recognizes that inequality between males and females, and the situation of sexual minorities are important drivers of epidemics, and that experience in programming requires knowledge and skills in:

- methodologies to assess gender differentials in disease burdens and their consequences (including differences between men and women, boys and girls), and in access to and the utilization of prevention, treatment, care and support programs; and
- the factors that make women and girls and sexual minorities vulnerable.

(b) Describe the capacity and experience of the CCM (or Sub-CCM) in gender issues including the number of members with requisite knowledge and skills.

The Composition of CCM Nigeria is conscious of gender issue and as a result Eight (8) female represent different constituency on the CCM Board. There position in their primary office is at the policy making level which indicates the requisite skill they posses. They are capable and very resourceful and also contribute immensely to the day to day running of CCM. There impact is significant in the decision making.

Multi-sectoral planning

The Global Fund recognizes that multi-sectoral planning is important to expanding country capacity to respond to the three diseases.

(c) Describe the capacity and experience of the CCM (or Sub-CCM) in multi-sectoral program design.

CCM Nigeria is composed of representations from constituencies that come from various sectors. All these are involved in the design of CCM proposals. Additionally, CCM involves the broader public through advertisements for expression of interest to participate in analysis of gaps in the national response to the three diseases, identify priorities and develop interventions around them. The same stakeholders are involved in the elaboration of the national strategies (MDGs, NEEDS, Universal Access targets, and National Strategic Frameworks for HIV/AIDS, Malaria and Tuberculosis) which are multi-sectoral in nature and from which the GFATM Nigeria proposals are derived. The RMC of the CCM Nigeria is Chaired by WHO, and has representation from the 3 disease programs, multi-by organizations, line ministries represented on the CCM, the Civil Society organizations, and co-opted members. The RMC coordinates proposal development activities for CCM Nigeria.

2.2. Eligibility

2.2.1. Application history

'Check' one box in the table below and then follow the further instructions for that box in the right hand column.

x	Applied for funding in Round 6 and/or Round 7 **and** was determined as having met the minimum eligibility requirements.	➔ ***Complete all of sections 2.2.2 to 2.2.8 below.***
☐	Last time applied for funding was before Round 6 **or** was determined non-compliant with the minimum eligibility requirements when last applied.	➔ ***First, go to 'Attachment D' to and complete.*** *(Do not complete sections 2.2.2 to 2.2.4)* ➔ ***Then also complete sections 2.2.5 to 2.2.8 below.***

2.2.2. Transparent proposal development processes

➔ *Refer to the document 'Clarifications on CCM Minimum Requirements' when completing these questions.*

➔ *Documents supporting the information provided below must be submitted with the proposal as clearly named and numbered annexes. Refer to the 'Checklist' after s.2.*

(a) Describe the process(es) used to invite submissions for possible integration into the proposal from a broad range of stakeholders including civil society and the private sector, and at the national, sub-national and community levels. *(If a different process was used for each disease, explain each process.)*	
CCM Nigeria, advertised in three National Daily Newspapers calling for Expression of Interest to participate in the Global Fund Round 8 process. Organizations were asked to submit a page concept paper on areas of proposed interventions and also express interest to be Sub Recipients or Principal Recipients. **(SEE ANNEX 1 copy of advert).** In addition electronic copy of the advertisement was circulated to all CCM Nigeria members. The submitted concept papers were received and processed by the Resource mobilization Committee and the area of focus was identified **(ANNEX 2 list and area of intervention/disease)** .The stakeholders meeting was called inviting all organizations that submitted concept paper. The meeting took place on Friday 11th of April, 2008 with 190 participants 14th full CCM Meeting took place on Saturday 12th of April 2008 and the shortlisted PRs was presented to the board by Resource Mobilisation committee based on the organizations that expressed interest to serve as PRs and SRs **.(SEE ANNEX 3 minutes and attendance list).** At the stakeholders meeting the gaps and priority interventions based on disease areas were identified by all stakeholders and were agreed on by all participants. It was also agreed upon at the meeting to advertised call for full proposals from organizations whose concept papers were identified by the Nigeria CCM to be aligned with the priority intervention areas as agreed by the stakeholders **(SEEANNEX4 identified focus area of intervention for all the three diseases and the advert copy for full proposal)**	
(b) Describe the process(es) used to transparently review the submissions received for possible integration into this proposal. *(If a different process was used for each disease, explain each process.)*	
Following the response to the advert called for full proposals by the CCM Nigeria, Organisations shortlisted responded and submitted full proposals for inclusiveness in the Country Coordinating Proposals. The received proposals by the CCM Nigeria Secretariat was sent to the RMC for reviewed, and the Nigeria CCM invited all the successful potential PRs for Round 8, the existing(PRs, SRs and SSRs) as well as implementing partners to the 16th CCM full meeting on Tuesday 13th of May, 2008 at NACA Conference Hall. Decision was then reached that all should be part of the proposal drafting team and the recommended proposals by the RMC were made available to the different proposal drafting team for integration into the Nigeria CCP.(ANNEX 5 Report of the RMC, minutes of 15th meeting and the list of the Potential PRs for RD8).	
(c) Describe the process(es) used to ensure the input of people and stakeholders other than CCM (or Sub-CCM) members in the proposal development process. *(If a different process was used for each disease, explain each process.)*	
A technical assistance contribution from different international organizations and local organizations is an additional input couple with the stakeholders' contributions. The area of interventions is not limited to the programmatic but includes the budgetary and costing. Again the National program gap analysis committee in collaboration with the Health Strengthening System of the Federal Ministry of Health gives relevant information that indeed tailored the direction for the proposal.	
(d) **Attach** a signed and dated version of the minutes of the meeting(s) at which the members decided on the elements to be included in the proposal for all diseases applied for.	***Annex4 Minutes of the 14th CCM Meeting with stakeholders meetings]***

2.2.3. Processes to oversee program implementation

(a) Describe the process (es) used by the CCM (or Sub-CCM) to oversee program implementation.
The Oversight Committee is responsible for oversight function of the Global Fund grants, and in particular the appropriate and timely use of finances; appropriate and timely completion of procurement; effective programme implementation; effective management of the grants and Sub-Recipients by the Principal Recipients, technical results and impact also include timely submission of the quarterly report. The Oversight Committee have two Task Teams viz: Finance and Procurement Task Team, and the Grant Performance Task Team. This committee also manages the executive dashboard for grant oversight. Committees and Task Teams have no formal decision making powers; their roles are to carry out responsibilities and tasks assigned to them by the CCM Nigeria. They shall formulate and present findings, reports, and recommendations to the CCM Nigeria for final decision. Decisions at CCM Nigeria meetings are reached through consensus whenever possible otherwise by voting, whereby the simple majority rule applies for all matters except constitutional change, where two-third rule applies.
(b) Describe the process(es) used to ensure the input of stakeholders other than CCM (or Sub-CCM) members in the ongoing oversight of program implementation.
Stakeholders are allowed to take part in the Oversight functions of program implementation and also at all CCM Nigeria meetings. They contribute and make their own suggestion and observations which are considered before a final decision is taken. In addition, their finding at the grass root contributes to the national work plan.

2.2.4. Processes to select Principal Recipients

The Global Fund recommends that applicants select both government and non-government sector Principal Recipients to manage program implementation. ➔ *Refer to the Round 8 Guidelines for further explanation of the principles.* .

(a) Describe the process used to make a transparent and documented selection of each of the Principal Recipient(s) nominated in this proposal. *(If a different process was used for each disease, explain each process.)*	
The Nigeria CCM advertised for the PRs and SRs in the same advert that call for one page concept paper SEE ANNEX 1 above. The organisations that expressed interest were all shortlisted and presented at the stakeholders meeting. The RMC reviewed the applications and made recommendation to the Nigeria CCM in its 14th (SEE ANNEX 4) meeting and the CCM finally shortlisted 12 organisations for verification purpose after which 9 of the organisations were chosen at the 15th meeting of CCM Nigeria. (SEE ANNEX 5 Minutes of 15th meeting including name and addresses of the verified and short listed potential PRs for RD 8) .	
(b) **Attach** the signed and dated minutes of the meeting(s) at which the members decided on the Principal Recipient(s) for each disease.	***Annexes 4 & 5***

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2.2.5. Principal Recipient(s)

Name	Disease	Sector**
National Agency for the Control of AIDS	HIV/AIDS	Public
Planned Parenthood Federation of Nigeria	HIV/AIDS	NGO

Civil Societies on HIV/AIDS in Nigeria	HIV/AIDS	CSO
Society for Family Health	MALARIA	NGO
Yakubu Gowon Centre	MALARIA	NGO
Access Bank Nigeria Ltd	MALARIA	Private
Clinton Foundation	TB	Foundation
Chan Medi-Pharm Ltd	TB	FBO
Association for Reproductive and Family Health	TB	NGO

*** Choose a 'sector' from the possible options that are included in the Round 8 Guidelines at s.2.1.1.*

2.2.6. Non-implementation of dual track financing

Provide an explanation below if at least one government sector and one non-government sector Principal Recipient have not been nominated for each disease in this proposal.

Most government Ministries and agencies are going for Sub Recipient and Sub Sub Recipient due to the decision that there primary roles is known to be implementer.

2.2.7. Managing conflicts of interest

(a)	Are the Chair **and**/**or** Vice-Chair of the CCM (or Sub-CCM) from the same entity as any of the nominated Principal Recipient(s) for any of the diseases in this proposal?	Yes ***provide details below*** Yes ➔*go to s.2.2.8.*
(b)	**If yes, attach** the plan for the management of actual and potential conflicts of interest.	☐ ***[Insert Annex Number]***

2.2.8. Proposal endorsement by members

Attachment C – Membership information and Signatures	**Has 'Attachment C'** been completed with the signatures of all members of the CCM (or Sub-CCM)?	Yes

3. PROPOSAL SUMMARY

3.1. Duration of Proposal

	Planned Start Date	To
Month and year: *(up to 5 years)*	January 2009	December 2013

3.2. Consolidation of grants

(a) Does the CCM (or Sub-CCM) wish to consolidate any existing HIV Global Fund grant(s) with the Round 8 HIV proposal?

☐ Yes *(go first to (b) below)*

☐ No *(go to s.3.3. below)*

'Consolidation' *refers to the situation where multiple grants can be combined to form one grant. Under Global Fund policy, this is possible if the same Principal Recipient ('PR') is already managing at least one grant for the same disease. A proposal with more than one nominated PR may seek to consolidate part of the Round 8 proposal.*

➔ *More detailed information on grant consolidation (including analysis of some of the benefits and areas to consider is available at: http://www.theglobalfund.org/documents/rounds/8/R8GC_Factsheet_en.pdf*

(b) If yes, which grants are planned to be consolidated with the Round 8 proposal after Board approval?
(List the relevant grant number(s))

3.3. PROPOSAL SUMMARY

3.3.1. Duration of Proposal

	Planned Start Date	To
Month and year: *(up to 5 years)*	January 2009	December 2013

3.3.2. Consolidation of grants

(b) Does the CCM (or Sub-CCM) wish to consolidate any existing HIV Global Fund grant(s) with the Round 8 HIV proposal?

☐ Yes *(go first to (b) below)*

☐ No *(go to s.3.3. below)*

'Consolidation' *refers to the situation where multiple grants can be combined to form one grant. Under Global Fund policy, this is possible if the same Principal Recipient ('PR') is already managing at least one grant for the same disease. A proposal with more than one nominated PR may seek to consolidate part of the Round 8 proposal.*

➔ *More detailed information on grant consolidation (including analysis of some of the benefits and areas to consider is available at: http://www.theglobalfund.org/documents/rounds/8/R8GC_Factsheet_en.pdf*

(c) If yes, which grants are planned to be consolidated with the Round 8 proposal after Board approval?
(List the relevant grant number(s))

3.4. Alignment of planning and fiscal cycles

Describe how the start date:

(a) contributes to alignment with the national planning, budgeting and fiscal cycle; and/or

(b) in grant consolidation cases, increases alignment of planning, implementation and reporting efforts.

ONE PAGE MAXIMUM

The decision by the Nigeria CCM regarding the proposal cycle above (subject to date of grant signature) takes into account the need to align all Global Fund processes in the country with national planning, budgeting and reporting processes. The Fiscal cycle for the Federal Republic of Nigeria runs from January – December. If the grant is signed in time and implementation commences in January 2009, the project cycle will be fully aligned to national fiscal year and will therefore be aligned to national budgeting, planning and fiscal cycles. This alignment will be in line with one of the requirements of the Paris declaration of aid effectiveness.

As indicated above, this proposal does not provide for grant consolidation with any of the existing Global Fund grants in the country.

3.5. Program-based approach for HIV

3.4.1. Does planning and funding for the country's response to HIV occur through a program-based approach?

☐ Yes. Answer s.3.4.2

☐ No. ➔ *Go to s.3.5.*

3.4.2. If yes, does this proposal plan for some or all of the requested funding to be paid into a common-funding mechanism to support that approach?

☐ Yes ➔ ***Complete s.5.5 as an additional section to explain the financial operations of the common funding mechanism.***

☐ No. Do not complete s.5.5

3.6. Summary of Round 8 HIV Proposal

Provide a summary of the HIV proposal described in detail in section 4.
Prepare after completing s.4.

ONE PAGE MAXIMUM

The Nigeria's Global Fund Country Coordinating Mechanism (CCM) requests US$831,612,641 million from the Global Fund under its Round 8 call for proposals to support the scale-up of priority HIV/AIDS prevention, treatment, care and support services. This proposal will build on the round 5 proposal which supported provision of comprehensive adult ART services in five sites in each of the 36 states of the country and the Federal Capital Territory (FCT). In round 8 the gap in access and coverage of HIV services to rural communties will be bridged by further decentralizing services to the PHC and community levels. It also complements the efforts of the GON and its partners by allowing a shift of resources facilitating harmonization of efforts to enhance the national response.

This proposal will contribute to the national goal to expand HIV/AIDS prevention, treatment, care and support in Nigeria in order to reduce HIV incidence and its associated morbidity and mortality through five main objectives:

1. To scale up gender sensitive HIV prevention services among children and adults in Nigeria
2. To scale up chronic HIV/AIDS treatment among adults and children in Nigeria
3. To scale-up gender sensitive care and support for people living with HIV/AIDS, orphans and vulnerable children
4. To create a supportive environment for delivery of comprehensive gender sensitive HIV/AIDS services, and
5. To enhance the management and coordination of the HIV/AIDS Programmes in the country

The Service Delivery Areas under the above objectives will be implemented through the strengthening of 925 PHC facilities to deliver an integrated essential package of services including HIV/AIDS, Tuberculosis and malaria, in keeping with the current GON initiative. The implementation of this proposal will be linked to, and depend on the implementation of the cross-cutting health and community system strengthening activities contained in section 4B leading to the following results:

i) 3.8 million pregnant women will be tested out of whom 134,429 (80%) positive ones will receive a full prophylactic course of ARV prophylaxis to prevent MTC transmission of HIV;

ii) About 12 million people will be enabled to know their HIV status and supported to make critical decisions pertaining to their lives through facility-based and outreach HIV counseling and testing services;

iii) General population HIV/AIDS messages for service promotion, stigma reduction and adoption of safer sexual practices will be disseminated through electronic, interpersonal and print media, while more than 2 million students will receive Family Life and HIV education through curricular and co-curricular activities. Sex workers men having sex with men, long distance drivers and other MARPS will also receive outreach services.

iv) More than 400,000 people living with HIV/AIDS including more than 50,000 children will receive life prolonging ARV drugs, opportunistic infection prevention and treatment, care and support services; Communities will be empowered to care for more than 28,000 orphans and vulnerable children who will receive a basic package of support while about 172,500 people will receive home based care services through community based organizations.

v) More than 200 small and medium enterprises (SMEs) will be supported to implement workplace policies and interventions and selected ones will be supported to implement stigma reduction strategies through meaningful engagement of PLWHA.

The National Agency for Control of AIDS (NACA), Planned Parenthood Federation of Nigeria (IPPFN) and the Civil Society HIV/AIDS Network (CiSHAN) has been selected as PRs. In addition, 25 SRs have been selected to implement these activities. The funding sought in this proposal will expand the coverage of HIV/AIDS services in Nigeria and ensure greater access to services, especially for women and other underserved groups. It will fund a new and critical phase of the national HIV/AIDS programme, building on achievements made through Round 5 funding and benefiting from lessons from programmes supported by other partners in order to reduce overlaps and increase efficiencies. This proposal will increase Nigeria's chances of meeting the Millennium Development Goals MDGs especially as they relate to halting the spread of HIV and AIDS by 2015 and reducing HIV and AIDS associated morbidity and mortality.

4. PROGRAM DESCRIPTION

4.1. National prevention, treatment, care, and support strategies

(a) Briefly summarize:

- the current HIV national prevention, treatment, and care and support strategies;
- how these strategies respond comprehensively to current epidemiological situation in the country; and
- The improved HIV outcomes expected from implementation of these strategies.

ONE PAGE MAXIMUM

Nigeria's HIV/AIDS prevention, treatment, care and support strategies are well elaborated in the National Strategic Framework for HIV/AIDS, and they include scaling up prevention, treatment, care and support interventions for both the general population and most-at-risk populations, including women, youth, high-risk groups, orphans and vulnerable children. Line Minstries and states have developed strategies in line with the NSF.

The HIV and AIDS Division of the Federal Ministry of Health has coordinated the development and implementation of the Health Sector Strategic Plan for HIV and AIDS (HSSP) which emanates from the NSF. The health sector strategies are: major interventions under this health sector response are as follows:

Prevention: This encompasses 1. Behaviour change for reduction in high risk behaviours; 2. Prevention of mother-to-child transmission (PMTCT); 3. HIV counseling and testing (HCT), 4. Blood safety and Universal Precautions, STI and Condom use programming.

Treatment: This encompasses: 1. Treatment for AIDS with anti-retrovirals (adults & children), 2. Treatment of opportunistic infections and 3. TB/HIV co-infection interventions

Care and support: This includes Home/Community based care, and palliative care. The health sector undertakes HIV/AIDS and STI sentinel surveillance, population surveys (NARHS) and special surveys (IBBS, HDR).

Additionally, the HIV/AIDS programme undertakes various activities that contribute to the strengthening of the health system to enable sustainable health sector response to the epidemic.

The National Plan of action on OVC (2006-2010) was developed to guide interventions targeted at orphans and vulnerable children. It recommends seven priority areas of service for care and suppport for OVC. These include health, education, nutrition, protection, psychosocial, economic strengthening/household care and shelter. The plan aims to reach at least 25% of orphans with these services by 2010. This plan of action is being implemented by a multisectoral approach coordinated by the Federal Minisitry of Women Affairs and Social Development.

The Federal Ministry of Education has developed a HIV/AIDS policy in 2005 based on which an Education Sector Strategic Plan for HIV/AIDS was developed. The National Education sector HIV/AIDS Strategic Plan (2006-2010) has four objectives, namely: 1. Promote awareness on HIV and AIDS and other sexually transmitted infections, 2. Develop strategies and interventions that support behaviour change; 3. Create a supportive work and learning environment for the infected and affected staff and learners; and 4. Provide a workplace environment devoid of stigma and discrimination on the basis of real or perceived HIV status, or vulnerability to HIV infection. The education Sector responds to HIV/AIDS through curriclar and co-curricular approaches to educate learners in the basic and secondary schools on family life and HIV/AIDS issues.

(b) From the list below, attach* **only those documents that are directly relevant** to the focus of this proposal *(or, *identify the specific Annex number from a Round 7 proposal when the document was last submitted, and the Global Fund will obtain this document from our Round 7 files).*

Also identify the specific page(s) (in these documents) that support the descriptions in s.4.1. above.

	Document	Proposal Annex Number	Page References
☐	FMoH: Medium Term Sector Strategic 2007 – 2009	Annex 4.1-1	
☐	National HIV Control Strategy or Plan	Annex 4.1-2	

☐	Important sub-sector policies that are relevant to the proposal *(e.g., national or sub-national human resources policy, or norms and standards)*	Annex 4.1-3
☐	Most recent self-evaluation reports/technical advisory reviews, including any Epidemiology report directly relevant to the proposal	Annex 4.1-4
☐	National Monitoring and Evaluation Plan (health sector, disease specific or other)	Annex 4.1-5 Annex 4.1-6
☐	National policies to achieve gender equality in regard to the provision of HIV prevention, treatment, and care and support services to all people in need of services	Annex 4.1-7

4.2. Epidemiological Background

4.2.1. Geographic reach of this proposal

(a) Do the activities target:

☐ Whole country ☐ Specific Region(s) ***If so, insert a map to show where* ☐ Specific population groups ***If so, insert a map to show where these groups are if they are in a specific area of the country*

***** Paste map here if relevant***

(b) **Size of population group(s) targeted in Round 8**

Population Groups	Population Size	Source of Data	Year of Estimate
Total country population (all ages)	140,003,542	National Population Commission (Census Report)	2008
Women > 25 years	27,562,035	National Population Commission (Census Report)	2008
Women 19 – 24 years	7,739,063	National Population Commission (Census Report)	2008
Women 15 – 18 years	6,074,293	'' National Population Commission (Census Report)	2008
Men > 25 years	26,720,053	National Population Commission (Census Report)	2008

(b) **Size of population group(s) targeted in Round 8**			
Population Groups	**Population Size**	**Source of Data**	**Year of Estimate**
Men 19 – 24 years	7,748,622	National Population Commission (Census Report)	2008
Men 15 – 18 years	6,266,798	National Population Commission (Census Report)	2008
Girls 0 – 14 years	31,397,321	National Population Commission (Census Report)	2008
Boys 0 – 14 years	32,614,223	National Population Commission (Census Report)	2008
Other **: ***Refer to the Round 8 Guidelines for other possible groups*			
Other **:			
Other **:			[*use "Tab" key to add extra rows if needed*]

4.2.2. HIV epidemiology of target population(s)			
Population Groups	**Estimated Number**	**Source of Data**	**Year of Estimate**
Number of people living with HIV *(all ages)*	3,191,200	FMoH ANC HIV/AIDS Sentinel Surveillance Report	2005*
Women living with HIV > 25 years (25 – 80+)	1,205,461	FMoH ANC HIV/AIDS Sentinel Surveillance Report	2005*
Women living with HIV 19 – 24 years (20 – 24)	294,997	FMoH ANC HIV/AIDS Sentinel Surveillance Report	2005*
Women living with HIV 15 – 18 years (15 – 19)	119,114	FMoH ANC HIV/AIDS Sentinel Surveillance Report	2005*
Pregnant women living with HIV (15 – 49)	274,695	FMoH ANC HIV/AIDS Sentinel Surveillance Report	2005*
Men living with HIV > 25 years (25 – 80+)	1,123,676	FMoH ANC HIV/AIDS Sentinel Surveillance Report	2005*
Men living with HIV 19 – 24 years	111,446	FMoH ANC HIV/AIDS Sentinel Surveillance Report	2005*

4.2.2. HIV epidemiology of target population(s)

Population Groups	Estimated Number	Source of Data	Year of Estimate
(20 – 24)			
Men living with HIV 15 – 18 years (15 – 19)	57,207	FMoH ANC HIV/AIDS Sentinel Surveillance Report	2005*
Girls (0 – 14 years) living with HIV	136,284	FMoH ANC HIV/AIDS Sentinel Surveillance Report	2005*
Boys (0 – 14 years) living with HIV	142,639	FMoH ANC HIV/AIDS Sentinel Surveillance Report	2005*
Other**: ***Refer to the Round 8 Guidelines for other possible groups*			
Other**: Average number of new cases of HIV reported annually	369,870 (adults and children)	FMoH ANC HIV/AIDS Sentinel Surveillance Report	2005*
Number of people in need of ARVs	507,440 (adults and children)	FMoH ANC HIV/AIDS Sentinel Surveillance Report	2005*
Estimated annual number of women (15 – 49) with unmet need for contraception	17%	National Demographic and Health Survey Report	2003**
Other**:			[*use "Tab" key to add extra rows if needed]*
Number of orphans	7,000,000	UNAIDS, UNICEF & USAID : Children on the Brink, July 2004	2004
Estimated number of people with TB/HIV co-infection	51,163	WHO Country TB Estimates	March, 2007
Number of women and men separately >14years in need of ARVs	Men – 125,753 Women – 158,925	FMoH ANC HIV/AIDS Sentinel Surveillance Report	2005*
Number of women and men separately >14years receiving ARVs	Total – 187,000	NACA M&E Reports	2007

* The most current data is not yet published. This will be available in Dec 2008 as the survey is ongoing.
**NDHS 2009/10 is currently ongoing.

4.3. Major constraints and gaps

(For the questions below, consider government, non-government and community level weaknesses and gaps, and also any key affected populations[4] who may have disproportionately low access to HIV prevention, treatment, and care and support services, including women, girls, and sexual minorities.)

4.3.1. HIV program

Describe:

- the main weaknesses in the implementation of current HIV strategies;
- how these weaknesses affect achievement of planned national HIV outcomes; and
- existing gaps in the delivery of services to target populations.

ONE PAGE MAXIMUM

The Mid-term Review of the NSF (Nov 2007) reveals the following challenges and constraints to delivery of HIV/AIDS services:

i) The national strategies for HIV/AIDS prevention, treatment, care and support are limited by inadequate resources and inefficiencies in resource allocation and management. Although the national HIV/AIDS programme has developed national scale-up plans and targets, and attracted significant resources, significant unmet programmatic and corresponding gaps remain. Consequently, many programmes are still way off meeting their national targets.

ii) Inadequate HIV Prevention: Coverage of HIV prevention services are still low: only 11% of adults in the country have ever tested for HIV, and only 6% of antenatal women currently have access PMTCT services. Risk perception amongst Nigerians remains low with 67% perceiving themselves at no risk of contracting HIV and 29% perceive themselves to be at low risk; yet multiple sexual partnerships are common especially amongst sexually active men. Gender considerations that contribute to driving the epidemic in Nigeria including power relations have not been adequately addressed. Legal, policy and religious barriers also prevent service providers from working among some MARPS including sex workers and MSM.

iii) Inadequate dissemination of treatment, care and support guidelines: To achieve rapid scale-up of HIV/AIDS prevention, care and treatment, national frameworks and guidelines have been developed. However, these are not produced in sufficient quantity to reach all stakeholders who would wish to use them. Most guidelines remain separate, limiting their use in supporting decentralised integrated services at PHC facility level.

iv) Poor state of infrastructure and staffing**:** Most health facilities especially in rural areas are dilapidated, often without electricity and water supply and experience significant shortage of health care workers. This has severely constrained service delivery.

v) Inadequate attention to socio-economic drivers of HIV/AIDS: Cultural and societal attitudes and practices such as severely entrenched resistance to condom promotion and use on religious grounds are inadequately addressed in the national response.

vi) Limited Integration of services: Although a guideline has been developed for integrating HIV/AIDS into reproductive health services, implementation remains largely parallel in facilities. This leads to missed opportunities to reach clients who might not seek stand alone reproductive health or HIV/STI services.

vii) Inequities in distribution of service delivery outlets: Most HIV/AIDS service delivery outlets are urban-based leaving the rural areas underserved. This increases the cost of accessing services by rural communities resulting in poor access especially to prevention and treatment services. Furthermore, the limited number of very under-resourced organizations working at community level exacerbates inequities.

viii) Inadequate institutional and coordination mechanism: Although the HIV/AIDS multi-sectoral response is now well coordinated by NACA at the national level, coordination of state & local government responses has remained weak due to limited organisational and human capacity and systems at these two levels.

ix) High cost of service delivery: The costs for treatment and laboratory tests are very high in Nigeria which restricts access to services by the most vulnerable population groups. Even though HIV/AIDS services are free, many poor people especially those in the rural areas cannot meet the transport costs to access urban-based services and charges for associated laboratory services.

[4] Please refer back to the definition in s.2 and found in the *Round 8 Guidelines.*

4.3.2. Health System

Describe the main weaknesses of and/or gaps in the health system that affect HIV outcomes.

The description can include discussion of:

- *issues that are common to HIV, tuberculosis and malaria programming and service delivery; and*
- *issues that are relevant to the health system and HIV outcomes (e.g.: PMTCT services), but perhaps not also malaria and tuberculosis programming and service delivery.*

ONE PAGE MAXIMUM

The health system in Nigeria has several weaknesses that affect the efficient delivery of health services overall as well as HIV specific interventions. The major weaknesses that affect the delivery of all services including HIV/AIDS, tuberculosis and malaria include:

1. Inadequate decentralisation of services. PHC facilities offer a limited package of services, yet they are more evenly spread out, compared to tertiary and secondary health facilities. Most health services can only be accessed at secondary and teriary levels that are concentrated in urban areas. This limits access and increases service delivery cost to the beneficiaries.
2. Weak referral linkages: The existing health care delivery system in Nigeria is characterised by weak referral linkages between the differerent levels of health care, limiting the provision of HIV/AIDS and other health services across a continuum of care.
3. Critical shortage of human resources: The existing health care delivery system in Nigeria is characterised by critical shortage of human resources, especially at lower levels and in rural areas. This shortage of staff affects the delivery of all health services. This constraint is compounded by high attrition of health care workers due to poor remuneration and other motivation.
4. Dilapidated health infrastructure: Although Nigeria has numerous health facilities at different levels, the current health care delivery system in Nigeria is characterised by dilapidated structures in need of refurbishing and equipment in order to deliver even the basic services. These constrants also affect HIV/AIDS services.
5. Weak public/private partnerships: The linkages between the public and private remains weak and informal, limiting optimization of public/private synergies.
6. Weak institutional and capacity: Currently, there is no effective system for regulation and supervision of HIV/AIDS services, particularly in the private sector. This is responsible for the poor quality of delivery of health and HIV/AIDS services in the public and private sectors.
7. Weak Procurement and Supply Management systems: Currently in Nigeria, there are multiple, parallel uncoordinated health supply and commodity management systems operated vertically by the various health programmes, limiting efficiency, and sustainability
8. Inadequate strategic information base: This is characterised by inadequate capacity of HMIS staff especially at lower levels for data management, poor infrastructure for data management and inadequate funding for M&E activities. There is also inadequate coordination amongst M&E systems of NACA, HIV/AIDS division and the NHMIS of FMOH which increases ineficiencies in collection and use of strategic infornation.
9. The major HIV/AIDS- specific health system challenge/constraint is the inadequate integration of RH and HIV services. The two programmes still deliver largely vertical services. Denying beneficiaries of opportunities of receiving both services in the same facilities that would have increased access to VCT services by clients seeking FP and other RH services on the one hand, while on the other hand it denies HIV positive pregnant women an opportunity for making optimal and informed reproductive health decisions. Increased access to HCT, as an entry point, will increase access to HIV treatment, care and support; increase PMTCT of HIV by increasing the prevention of unintended pregnancies amongst women of reproductive age. This in turn reduces infant deaths from HIV-related illnesses; increased awareness of HIV through the provision of HIV information as part of all RH service delivery.

4.3.3. Efforts to resolve health system weaknesses and gaps

Describe what is being done, and by whom, to respond to health system weaknesses and gaps that affect HIV outcomes.

The Federal Government of Nigeria has established the Health Sector Reform Programme (HSRP) 2004-2007 that provides a framework to guide the work of the Health sector including the FMoH, State Ministries of Health and the country's health development partners in improving sector performance. The improved health sector performance

will results in improved HIV/AIDS outcomes. The priority issues addressed by the HSRP are:

- Improving stewardship role of Government
- National health system and its management
- Reduction of disease burden
- Improving health resources and their management
- Improving access to quality health services
- Improving consumers awareness community involvement
- Promoting effective partnership and collaboration and coordination

The Health Sector Strategic Plan (HSSP) for HIV and AIDS in Nigeria 2005-2009 is the vehicle for the delivery of the outcomes of the HSRP. It outlines seven strategies to overcome the main constraints identified:

i. Strengthen capacity of health sector institutions, systems and personnel to plan and manage a well-coordinated and adequately resourced response to HIV/AIDS in the health sector based on the principles of the 'Three Ones';

ii. Increase coverage and improve access to HIV/AIDS related services through effective public-private partnerships;

iii. Deliver sustainable, comprehensive prevention, treatment and care services for HIV/AIDS and related problems, that are guided and monitored by national protocols;

iv. Establish an efficient and sustainable logistics system for improved access to health commodities in order to address identified PSM weaknesses;

v. Harmonise M&E and surveillance systems used for effective tracking of the HIV/AIDS epidemic and the health sector response

vi. Establish an effective mechanism for defining research priorities; coordinate and disseminate research on HIV/AIDS related issues and ensure that results inform policy, planning and implementation of the health sector response,

vii. Institute measures for effective advocacy with political, traditional and religious leaders to mobilise support for the response to the HIV/AIDS epidemic and help reduce stigma and discrimination of PLHA and most-at-risk groups.

As part of improvements in sector performance, the Federal Govervenment of Nigeria is committed to addressing the high cost of medical services by providing free ARVs to all that need them, a move that is enhanced by a number of partners that provide free ART. The National health insurance scheme further subsidises medical costs for registered participants.

Over the last three years, the FMoH and State Ministries of Health have been implementing the Health Systems Development Project (HSDP II) supported by the World Bank which aims at:

a) Strengthening capacities for health system management at state level and encouraging an environment of broad-based consultations

b) Improving the delivery of primary health care services with particular focus on maternal and child health, and reproductive health services

c) Assisting the FMoH to strengthen its policy formulation, systems development and reform initiatives and to further develop the system to monitor the health sector performance

d) Building capacity and strengthening key public health systems functions in support of the health sector strategic development and reform initiatives.

Under the health reform agenda, tertiary facilities infrastructure is being rehabilated. Some States are also rehabilitating their secondary facilities.

Regarding weaknesses in mangement of strategic information, it is estimated that $620 million is needed to strengthen HMIS in order to achieve the set targets in all 774 LGAs over the next five years. A $12.6million World

Bank loan under the Health Systems Development Project (HSDP II) will contribute towards strengthening HMIS.

With regards to integrating RH and HIV services, the Nigerian Government has remained committed to the Programme of Action of the 1994 International Conference on Population and Development (ICPD), which urged countries to provide a full range of RH services in an integrated manner within the PHC system. Government instituted an advisory committee to advise it on integrating FP and HCT services, as well as the development of national guidelines for the integration. While the national guidelines identifies the integration of family planning with HCT as the easiest entry point, it goes ahead to provide a framework for integrating RH and HIV services generally and identifies several key integration opportunities. One of the most feasible opportunities is the integration of HCT services into all RH service delivery Adolescent reproductive health, STI management, family planning, post-abortion care, etc.

On the flip side of the coin, the guideline advocates for the integration of key RH services particularly family planning, management of STIs, adolescent RH, safe motherhood, post-abortion care and andropause/menopause services into HIV services generally and particularly where there are clear needs e.g. post-abortion care for OVCs, and andropause/menopause services for clients on long term ART. Currently, partners are engaged in efforts in Nigeria to implement integrated RH (specifically FP and STI management) and HIV service delivery. While most models focus on strengthening linkages, programme reports indicate that there is a considerable movement of clients from FP service delivery points to HCT and vice versa. This further buttresses the argument that integration of services will expand access to HCT services as a key entry point to HIV services, leveraging on the established RH infrastructure in Nigeria.

ROUND 8 – HIV

4.4. Round 8 Priorities

Complete the tables below on a program coverage basis (*and not financial data*) for **three to six areas** identified by the applicant as priority interventions for this proposal. Ensure that the choice of priorities is consistent with the current HIV epidemiology and identified weaknesses and gaps from s.4.3.

Note: All health systems strengthening needs that are most effectively responded to on an HIV disease program basis, and which are important areas of work in this proposal, should also be included here.

Priority No:	Prevention of Mother-to- Child HIV Transmission	**Historical**		**Current**		**Country targets**			
Intervention	HIV screening of antenatal Women	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
A: Country target *(from annual plans where these exist)*		444,000	888,000	1,332,000	1,776,000	2,220,000	2,664,000	3,108,000	3,552,000
B: Extent of need already planned to be met under other programs		133,145	270,107	270,107	270,107	270,107	270,107	270,107	270,107
C: Expected annual gap in achieving plans		310,855	617,893	1,061,893	1,505,893	1,949,893	2,393,893	2,837,893	3,281,893
D: Round 8 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			75,000	390,000	690,000	1,332,000	1,332,000
Priority No:	HIV Counseling and Testing	**Historical**		**Current**		**Country targets**			
Intervention	HIV screening of Adults	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
A: Country target *(from annual plans where these exist)*		5,000,000	8,000,000	10,000,000	15,000,000	18,000,000	18,000,000	18,000,000	18,000,000
B: Extent of need already planned to be met under other programs		447,788	963,419	1,500,000	2,000,000	2,500,000	3,000,000	3,500,000	4,000,000
C: Expected annual gap in achieving plans		4,552,212	7,036,581	8,500,000	13,000,000	15,500,000	15,000,000	14,500,000	14,000,000
D: Round 8 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			307,200	1,286,400	2,126,400	4,634,400	4,634,400

ROUND 8 – HIV

Priority No:	Antiretroviral Therapy	Historical		Current		Country targets			
Intervention	Provision of Antiretroviral Therapy to Children & Adults	2006	2007	2008	2009	2010	2011	2012	2013
A: Country target *(from annual plans where these exist)*		300,000	450,000	600000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000
B: Extent of need already planned to be met under other programs		75,000	166,374	320,000	320,000	417,460	497,709	431,061	433,269
C: Expected annual gap in achieving plans		225,000	283,626	280,000	680,000	582,540	502,291	568,939	566,731
D: Round 8 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			203,524	282,160	362,409	436,361	438,569

Priority No:	Behaviour Change Communication	Historical		Current		Country targets			
Intervention	Provision of Family Life Education to students	2006	2007	2008	2009	2010	2011	2012	2013
A: Country target *(from annual plans where these exist)*		2,776,000	3,052,000	3,204,600	3,364,800	3,533,200	3,710,000	3,895,400	4,071,000
B: Extent of need already planned to be met under other programs		1,110,000	1,200,000	1,300,000	1,450,000	1,600,000	1,780,000	1,850,000	2,200,000
C: Expected annual gap in achieving plans		1,666,000	1,852,000	1,904,600	1,914,800	1,933,200	1,930,000	2,045,400	1,871,000
D: Round 8 proposal contribution to total need		*(i.e., can be equal to or less than full gap)*			300,000	480,000	600,000	840,000	0

Priority No:	Orphans and Vulnerable Children Support	Historical		Current		Country targets			
Intervention	Provision of social support to orphans and vulnerable children	2006	2007	2008	2009	2010	2011	2012	2013
A: Country target *(from annual plans where these exist)*		664,362	897,208	1,134,717	1,134,717	1,134,717	1,134,717	1,134,717	1,134,717
B: Extent of need already planned to be met under other programs			70,000	94,000	118,000	142,000	166,000	166,000	166,000
C: Expected annual gap in achieving plans		664,362	827,208	1,040,717	1,016,717	992,717	968,717	968,717	968,717
D: Round 8 proposal contribution to total need		*(i.e., can be equal to or less than full*			1,250	3,250	5,750	9.250	9.250

ROUND 8 – HIV

Priority No:	Orphans and Vulnerable Children Support	Historical		Current		Country targets			
Intervention	Provision of social support to orphans and vulnerable children	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
		gap)							

➔ *If there are six priority areas, copy the table above once more.*

4.5. Implementation strategy

4.5.1. Round 8 interventions

Explain: (i) who will be undertaking each area of activity (which Principal Recipient, which Sub-Recipient or other implementer); and (ii) the targeted population(s). *Ensure that the explanation follows the order of each objective, service delivery area (SDA) and indicator in the 'Performance Framework' (Attachment A) and work plan, and budget.*

Where there are planned activities that benefit the health system that can easily be included in the HIV program description (because they predominantly contribute to HIV outcomes), include them in this section only of the Round 8 proposal.

***Note**: If there are other activities that benefit, together, HIV, tuberculosis and malaria outcomes (and health outcomes beyond the three diseases), and these are not easily included in a 'disease program' strategy, they can be included in s.4B **in one disease proposal** in Round 8. The applicant will need to decide which disease to include s.4B (but only once). ➔ Refer to the Round 8 Guidelines (s.4.5.1.) for information on this choice.*

BETWEEN 4 to 8 PAGES

The goal of this proposal is to contribute to the reduction in HIV incidence and to mitigate the impact of HIV/AIDS on women, children and other vulnerable groups and the general population in the country, through the achievement of five specific objectives, i.e.:

i. To scale up gender sensitive HIV prevention services among children and adults in Nigeria
ii. To scale up chronic HIV/AIDS treatment among adults and children in Nigeria
iii. To scale-up gender sensitive care and support services for PLWHA, orphans and vulnerable children
iv. To create a supportive environment for delivery of comprehensive gender sensitive HIV/AIDS Services, and
v. To enhance the management and coordination of HIV/AIDS Programmes

Under each of the five objectives, Service Delivery Areas (SDAs) and the corresponding activities are detailed below. Three PRs have been selected to coordinate these objectives and the SDA appropriately share based core competence, experience and capacity. About seventeen SRs have similarly been selected along the same criteria. Cross-cutting activities that benefit the wider health system are detailed in section 4B (Health Systems Strengthening) of this proposal. The PR will be NACA while several SRs have also been selected to implement these activities.

i) Objective 1: To scale-up gender sensitive HIV Prevention Services for Children and Adults.

Within this objective to be coordinated by two PRs (NACA and PPFN – split along Public and Private sector focus)an integrated service delivery approach will be promoted to deliver PMTCT, SRH, Medical Infection control and HCT services will be expanded to five Primary Health Care facilities in each of the 185 clusters supported under the Round 5 grant. These services will target rural dwellers, women as well as children. The Behavior change communication component and civil society organizations' activities of this objective will mobilize communities to access and utilize services people. MARPs will be reached through intensive peer education activities while youths in and out of school will be reached through the FLHE programs.HCT will be delivered through facilities and community based organizations and mobile campaigns. System wise, about 925 PHCs will be rehabilitated and strengthened. All services to be delivered at the PHCs will be integrated while the capacity of health care workers will be strengthened to deliver. Medical waste management will be improved through the provision of incinerators and infection control through consumables supplies. In addition, expansion of medical infection control as well as behavior change communication interventions will be supported. The facility-based services will be integrated in the activities undertaken in the selected 925 PHC facilities including family planning, STI, post-abortion care and adolescent RH services. Therefore activities such as advocacy to state and LGA Authorities, facility identification, assessment, and strengthening, health worker training, mentoring and supervision and implementation monitoring, evaluation and reporting will be integrated and done jointly with malaria and tuberculosis (see section 4B).. The outcomes of this component will be increased utilization of quality HIV prevention services by adults and children including vulnerable and MARP groups, leading to an increase in the number of people that practice HIV preventive behaviors.

The service delivery areas and corresponding activities that will be supported under this component are as follows.

SDA 1: Prevention: PMTCT: This proposal will address this low coverage of 6% PMTCT through the delivery of services through the strengthened 925 PHCs over the proposal period. Advocacy will target key gatekeepers. To achieve this, high level advocacy targeting state and LGA authorities to obtain political support for expansion of PMTCT services will be conducted in all the states, particularly the 185 clusters in the country where the present Round 5 clusters are located and where the five additional PHCs facilities will be activated to offer PMTCT, HCT, Infection Control and Reproductive Health (RH) services. Innovative approaches will include mobilizing the wives of the local government chairmen and other highly placed political leaders to mobilize political commitment for scaling up these interventions as well as all other services including integrated maternal, newborn and child health (IMNCH) services. These efforts will be complemented with community based and other information, education, communication and social mobilisation activities (elaborated under SDA 4) leading to increased utilisation of antenatal care services from 61% (2005 NHDS) to about 80% as well as the percentage of women delivering in health facilities from the current figure of 36% to 50%.

National PMTCT, HCT, Infection Control, ARV, nutrition, TB, STI and Family Planning guidelines will be simplified and integrated in the existing Standing Orders and standard operating procedures (SOPs). An integrated training curriculum for healthcare workers will be developed and used for training PHC facility staff., This integrated approach will require strong coordination and management at the operational level; therefore skills of programme managers and unit heads will be upgraded to enable them carry out integrated supervision by multidisciplinary LGA teams. These are supported under the HSS component of this proposal. In addition, facility identification, assessment and infrastructure upgrading has been elaborated under the Section 4B (HSS) as well as procurement, storage and distribution of medicines, supplies and commodities.

A total of 925 sites will be activated under this grant while in year 4 and 5 of the grant implementation the 185 PMTCT site operating under GF Round 5 grant will be taken over bringing the total cumulative number of sites to be supported to 1110 by the year 2013. All of the 1110 sites will be supported to collect dry blood spots (DBS) for onward transmission to the 6 Early Infant HIV Diagnosis laboratories supported in this grant. The 1110 facilities will be provided with IEC materials and cue cards. By 2013 a cumulative total of 3.8 million pregnant women will have been counselled, tested and received their HIV test results. Of those tested about 168,036 are expected to be HIV positive and 80% (134,429) will be provided with ARV prophylaxis. The state task team on PMTCT in collaboration with the National Primary Health Care Development Agency (NPHCDA) shall be responsible for this task with NACA as the principle recipient for this component.

SDA 2: HIV Prevention: HIV Counselling and Testing (HCT): HIV counselling and testing is an essential entry point to prevention, treatment, care, support and other HIV/AIDS programme activities. However, according to the National HIV/AIDS and Reproductive Health Survey (NARHS, 2005), only about 11% of Nigerians have ever been tested for HIV. HCT services in Nigeria are provided by a number of service providers including government, NGOs, FBOs and private sector, with support from development partners, including the Global Fund Round 5 grant. HCT services are presently provided in 640 sites countrywide by December 2007. Many of these sites are supported by the GF Round 5 grant, which at its expiry in 2012 would have supported the establishment of 555 sites. However, the number of sites providing HCT services countrywide is still very inadequate. Accordingly, the national HCT Scale-Up plan targets establishing 1,000 new sites annually for the next 5 years (2009 – 2013) to improve coverage and increase access to HCT services. The Round 8 proposal will support the establishment of an additional 925 new HCT sites in PHC facilities. Each of the 925 new sites will provide HCT services to 200 clients monthly. In 2012, the 555 HCT sites established under the GF Round 5 grant will migrate to the GF Round 8 grant when the Round 5 grant ends in 2011. Thus in the last year of the Round 8 grant, the GF will be supporting a total of 1480 (555 Round 5 + 925 Round 8) HCT sites.

In line with the national guidelines for integrating HIV and RH services, HCT and FP services are recognised as strategic entry points. Integrating FP services into HCT presents a unique opportunity to meet the FP needs of HIV positive clients, serving 2 purposes – to provide dual protection as prevention for positives and to prevent infant infections by preventing unintended pregnancies in HIV positive women. About 46% of the total female population in Nigeria is of reproductive age; this translates to approximately 30milion women of whom 4.4% (1.3 million) will be HIV positive. Applying the national unmet need for contraception (17%), will mean approximately 200,000 HIV positive women will have an unmet need for contraception and therefore are at risk of unintended pregnancies and of mother-to-child-transmission of HIV. This approach also promotes dual

protection amongst HIV-negative clients accessing HCT. HCT provides a unique advantage to ensure no missed opportunity in that HIV positive clients will be counselled to use contraceptive methods. i.e., FP commodities will be made readily available at these PHC sites to ensure that consenting HIV positive women and men can access dual protection. This will therefore require the availability of at least pills and injectable contraceptives, which are the basic methods that can be dispensed at the PHC facility level. These commodities will be made available for initiation at the HCT service points.

The higher prevalence of HIV among MARPs relative to the national average supports the establishment of mobile and community outreach HCT services for MARPs in order to increase access among these often marginalized population groups. The grant arising from this proposal will support the provision of 12 mobile vehicles each manned by a team of six staff to provide services targeted at MARPs in 37 states, reaching about 874,800 MARPs with HCT services in 5 years. The key target groups for these mobile HCT services will be young people, female sex workers (FSWs), men who have sex with men (MSMs), injecting drug users (IDUs), transport workers and out-of school youths. HIV tests kits, reagents and other consumables will be procured and distributed to the mobile HCT teams for the outreach work.

The HCT program will also include a community HCT component to be coordinated and supervised by the Mobile teams spread across all states and covering the clusters. This community component will scale up the number of faith-based organisations (FBOs) offering HCT services. Two (2) FBO testing sites will be established in each of the 185 clusters. Thus a total of 370 FBO sites (to offer HCT to 200 clients per month per site) will provide HCT services to 2,700,000 clients in five years. The grant will support FBO facilities assessment and selection, infrastructural upgrades, training for at least 3 persons per FBO and the provision of test kits and associated consumables Monitoring and supervision of FBO activities will be carried out by the mobile HCT teams to assure quality and ethical standards set in the national policy on HCT
The HCT services will be based on the national serial testing algorithm. The programme will provide support supervision and HCT quality assurance, whereby PHC facilities will participate in one annual external quality assurance (EQA) programme. There will be periodic visits by the PRs, SRs and external M&E teams to HCT sites for onsite review, mentoring and supervision of HCT staff. The PRs and SRs will also undertake routine visits to sites for data quality assurance. The GF Round 8 grant will enable about 13 million people in Nigeria to be counselled and tested for HIV in 5 years.

SDA 3: BCC: Mass media: The media is critical in HIV/AIDS programmes as a veritable source of information in raising public awareness, promoting behaviour change and promoting utilisation of HIV/AIDS prevention, treatment, and care and support services. Over the past decade, the media has contributed immensely to shaping public opinion on HIV/AIDS. The National HIV/AIDS and reproductive health survey (NARHS 2005) revealed the acceptability of the mass media in the following order of preference, radio (95%), television (87%) and print media (81%).

Radio spot announcements aimed at increasing awareness, demand and uptake of health services will be developed and aired. Audience segmentation has shown a high proportion of respondents in the northern part of the country that never watch television obviously reducing the potential of the reach of TV media in that zone. This proposal will support the production and airing of TV and radio spots in the four main languages (Hausa, Yoruba, Igbo and Pidgin English) promoting HIV/AIDS services, HIV preventive behaviour and addressing issues of stigma and discrimination. It is planned that 4 spots will be aired per week over the proposal period. An estimated target of 80million people will be reached through the proposed media activities. Expected outcomes of these activities are increased awareness about available services, utilization of existing services, and associated reproductive health issues. These activities will be implemented by the private sector, with NACA as the principal recipient.

SDA 4: Prevention: BCC - Community outreach: In order to scale up behaviour change among in-school and out-of-school youths, most-at-risk population groups, OVC and PLWHA, four pronged series of activities will be conducted under this SDA. The Government's Family Life Health education (FLHE) programme is currently being implemented in schools and has been scaled up to reach all schools covering all students. The Government through the Ministry of Education has always sought to expand the pool of Master Trainers of the FLHE program; this grant will expand the pool of Master Trainers by 370 spread across all states equally by the end of grant period in 2013 through a series of 10-day residential training programme. The Master Trainers will be expected to train 20 teachers per state per year (37,000 in 5 years), in the art of mainstreaming FLHE into core teaching subjects in schools. These FLHE teachers will in turn be expected to reach 200 in-school youths per teacher repeatedly over the 5years of the programme. Cumulatively a total of 2,200,000 students will be reached

through the scale up of the FLHE programme. Refresher training will also be conducted for the teachers every 2 years while they will also attend coordination/performance review meetings annually. There are existing FLHE teaching and training materials developed by the NERDC, these are available for purchase and will be distributed to all teachers (Master Trainers and teachers). 37 Project Management Committees (PMCs) will be established to coordinate and advocate for public support for FLHE implementation at the state level. The PMC activities will be supported under this grant.

The National Youth Service Corps (NYSC) peer education training programme receives support from the Round 5 grant which runs out in the third year of this Round 8 grant. This program has over the years strengthened behaviour change among youths and supported anti AIDS extracurricular activities amongst in-school youths as a complement to the FLHE curriculum implementation. 100 NYSC members will be trained in 37 state camps in 2012 & 2013 (7,400 in the 2 years), on HIV/SRH (through the NYSC camps). This will increase the national pool of knowledgeable personnel to complement the implementation of the FLHE in secondary school. The 100 trained NYSC members will all be posted in pairs to 50 secondary schools annually in each state. From the pool of NYSC peer education training members trained annually, 10 will be selected in each state and posted to 5 secondary schools around each cluster on annual basis. Each of the corps members will be expected to select, train and mentor 40 young people during the service year. The young people mentored in turn will reach 20 students each. Cumulatively 592,000 students will be reached in five years. Each of the mentored peer educators will be provided with IEC materials. Transport of NYSC members for quarterly review meetings at state level will be supported. A total of 925 secondary schools will be reached, and 925 Anti- AIDS clubs will be established.

At community level, CBOs will increase access of out-of-school youths and most-at-risk population to HIV preventive information and facilitate HIV preventive behaviour change using community dialogue and rallies. One CBO from each of the 5 clusters in each of the 37 states of the country will conduct community outreach activities making a total number of 185 CBOs. Each of these 185 CBOs will carry out ten outreaches every year reaching 300 people per CBO per outreach making a total of 3,000 people/CBOs/year. Overall a total of 555,000 people will be reached per year and 2,775,000 over the five year project period. This activity will specifically be targeted at the most-at-risk population groups. Activities under this SDA will be steered through NACA as the PR and implemented by various SRs including the Ministry of Education, NGOs and CBOs.

SDA 5: Universal Precautions / Injection Safety: Unsafe injections and medical practices are responsible for about 5% of new HIV infections worldwide including in Nigeria. Unsterile medical procedures and injections spread infectious diseases such as HIV, Hepatitis B and Hepatitis C virus infections. In addition, incorrect disposal of medical waste presents a continued risk to people who are exposed to them, especially healthcare workers, patients and communities. A 2004 Federal MOH baseline assessment reported overuse of injection, with 4.9 injections per person per year, and high rate of needle-stick injuries among health workers. The baseline assessment showed that in majority of facilities, practice of universal precaution was moderate-to-poor, largely due to low knowledge of universal precaution and inadequate supply of safe injection safety equipment. Currently, the FMOH with support from PEPFAR is implementing Making Medical Injections Safer (MMIS) project in the country using the WHO three pronged approach of behavioural change of health care providers and patients, provision of adequate equipment and appropriate environmentally acceptable medical waste management. The Injection Safety programme is currently operational in 38 LGAs located in 12 states.

This proposal will support the expansion of the programme to cover the remaining 25 states. Training will be conducted for health care providers and waste handlers on infection prevention and control and medical waste management. The existing pool of master trainers will be used to conduct the training through the proposed integrated training module for staff of the 675 PHC facilities in these 25 states Auto-destruct syringes bundled with safety boxes, Personal Protective Materials (PPE) and medical waste disposal colour coded materials will be procured and supplied to all facilities. The Federal Ministry of Environment and Urban Development through the Ecological Fund commenced the supply of incinerators to some tertiary institutions. Through this proposal, one functional incinerator will be provided for each of the 675 PHCs to reduce indiscriminate dumping of medical waste. Infection Prevention and Control Committees will be established and supported to supervise and monitor the implementation of universal precautions and PEP protocols and guidelines at the PHC facilities in their cluster. BCC materials (IEC and jingles) will be adapted and or modified, printed and distributed to health workers. The educational materials for clients and communities will be developed and disseminated in an integrated manner along the integration strategy described earlier (see SDA 1 above).

ii. Objective 2: To scale up chronic HIV/AIDS treatment for adults and children in Nigeria

The activities and services under this objective complements the Round 5 grant which supports scale up of comprehensive HIV treatment services to secondary and primary level facilities using the "cluster approach" with involvement of communities. The strategy for this proposal is to strengthen six facilities per zone, a total of 6 facilities out of the 185 facilities supported under Round 5 grant to deliver paediatric treatment and care services. All the 185 adult ART sites will be supported in the 4th and 5th years of this proposal after the Round 5 grant ends. Resources will be specifically dedicated to paediatric HIV/AIDS interventions, which require additional support and attention due to their complexity, cost, the relative lack of expertise among implementing institutions and the low coverage of paediatric treatment to date compared to adult ART. The following SDAs with corresponding activities will be supported to achieve this objective:

SDA 6: Antiretroviral therapy and Monitoring:

The Nigeria National HIV Scale-up Plan (2005-2009) commits to providing ART to 1 million PLWHAs by 2009. By December 2008 there will be 320,000 PLWHAs on ART in the country. Efforts will continue to reach the target of 1 million PLWHAs on ART by 2009 and, at a minimum, maintain this level till 2013. In addition to the Federal Government and State Governments of Nigeria other major organizations providing support for ART services include the USG/PEPFAR, the Global Fund, and the Clinton Foundation. The latter focuses primarily on support for paediatric ART. By the end of Dec 2008, PEPFAR funding will support 200,000 ART patients whilst 70,300 patients will be supported by the GF Round 5 grant by December 2010. Following consultations on the government's efforts to harmonize and integrate the multi-partner oriented treatment program in Nigeria, USG/PEPFAR and the Nigerian government have reached an understanding for PEPFAR to concentrate on providing second line ARVs whilst the government focuses on providing first line ARVs. The Clinton Foundation will also focus its efforts on supporting second line paediatric treatment. As the greater proportion of first line drugs is taken over by this proposal, PEPFAR, which has provided sizable portion of first line antiretroviral drugs to date, will shift its resources to focus on the provision of second line regimens and expanded support for strengthening the commodity supply systems for Nigeria. Additionally, PEPFAR will engage in expanded capacity development activities for clinical service provision within the national response.

As a result of this understanding and with effect from 2009, this proposal makes provision for supporting the 200,000 patients presently on PEPFAR support by migrating them to the GF Round 8 grant. In addition, the 70,300 patients who will be on GF Round 5 grant support when the grant ends in 2011, will be migrated into the Global Fund Round 8 grant and maintained there for the last 2 years of GF Round 8 grant. Thus this proposal makes provision for providing first line ARVs for 203, 524 patients (adults and children) in 2009, reaching 438,569 patients by 2013. This proposal will double the number of children on ART from the current low of 6% to 12%.

With additional support from Round 8 grant, the same infrastructure, staff and management systems built for care and treatment under the Round 5 grant will be strengthened in 6 sites (one site per zone) to deliver early infant diagnosis (EID) and treatment services. Routine multipoint testing within facilities and the communities will specifically be targeted at children in order to achieve the global commitment of identifying and placing more infected children on ART. Health workers in all the 925 PHC facilities will be trained in paediatric and adult ART care using the integrated training curriculum. .

Since sustained effectiveness of ART is dependent on near perfect adherence, this proposal will support patient follow up, adherence support and clinical and immunological monitoring. In order to further strengthen capacity for quality monitoring of patients as well as for evaluating the effectiveness of the ART programme, laboratories in the six zonal facilities will be strengthened to conduct viral load assessment to be used in determining first-line treatment failure before switching to second-line ART regimen. In addition, infrastructural upgrade, purchase of equipment, reagents and other consumables, training of health workers and state maintenance engineers will be conducted. Service contracts for maintenance of ART clinical monitoring laboratory equipment procured under the Round 5 grant will be supported under this proposal.

All the 925 new PMTCT sites will be supported to collect dry blood spots (DBS) for EID for onward transmission to the strengthened zonal facilities for DNA-PCR based Early Infant Diagnosis. Test results will be sent back to the PHC facilities. For children older than 18 months, serological HIV testing using rapid test kits will be undertaken in each of the 925 PHC facilities. HIV positive infants and children will be referred to the strengthened zonal facilities for further assessment and ART initiation if indicated. The proposal will support the

quality assurance and proficiency testing of all laboratory tests as well as mentoring and supportive supervision of health care providers. The procurement & supply management system for paediatric and adult first and second line ARVs and other commodities will be supported under the HSS component of this proposal.

In order to provide comprehensive services for HIV-positive clients, patient's RH needs will be addressed in a holistic manner particularly as their health status improves and they resume their normal lives and functions. Service providers will be equipped with the skills and knowledge to discuss fertility desires and contraceptive methods with HIV positive adults and couples in order to avert unintended pregnancies. These activities will be undertaken by NACA as PR, the Ministry of Health, FHI , states and local governments etc.

SDA 7: Prophylaxis and Treatment of Opportunistic Infections: The treatment of opportunistic infections is currently on-going only at the sites offering comprehensive care within the Round 5 clusters of implementation. This proposal will support the expansion of diagnosis, prophylaxis and treatment of OIs to the PHC level. The last 2 years of this proposal will also cover the cost of OI treatment of persons currently supported under the Round 5 grant. Building the capacity of health care workers at the PHCs will be an essential component of Round 8 in order to increase access to the appropriate prophylaxis and management of OIs. Health care workers will be trained using the integrated service delivery curriculum. The capacity of laboratories at the PHCs will be strengthened to diagnose the common opportunistic infections through training, infrastructural upgrade and procurement of equipment, reagents medicines and other commodities. Co-trimoxazole will be procured for all the 925 facilities for administration to TB and HIV patients for prophylaxis, where indicated. This proposal will also support the procurement and distribution of other drugs for management of opportunistic infections. These activities will be undertaken by NACA as PR and her SRs including the Ministry of Health, the Family Health International, other SRs, and state and local governments.

SDA 8: TB HIV Collaborative activities: The TB HIV co epidemic represents a major public health threat to people living with HIV and the community. All the selected 925 PHC facilities supported under this grant will have TB DOTS services enabling implementation of TB/HIV collaborative activities to reduce the impact of TB among HIV infected individuals through, intensified TB case finding (ICF) for active TB, TB Infection Control (IC) and administration of Isoniazid prophylaxis (IPT). HIV positive children without symptoms of active TB will be referred to a secondary health facility for ruling out active TB and initiation of IPT. Those with TB related symptoms and signs will have a sputum microscopy and treated for TB if indicated. In addition, health care workers will be supported with the provision of basic protective materials and job aids for TB infection control. The accessibility to HCT in the 925 PHCs will enable the screening of all the TB suspects for HIV infection. Health care workers will be trained in TB/HIV co-management as part of the integrated training. These activities will be undertaken by NACA as PR and her SRs including the Ministry of Health, the Family Health International, other SRs, and state and local governments.

iii) Objective 3: To scale up gender sensitive care and support services for PLWHA, Orphans and Vulnerable Children:

This objective will be achieved through the implementation of the following activities under each SDA below:

SDA 9: Care and support for orphans and vulnerable children: Nigeria has a high burden of orphans and vulnerable children (OVC). Given that focus on OVC issues are new and emerging within the national response, most of the CBOs and FBOs working in this area need capacity building and institutional support to respond appropriately in accordance with national and international standards. The National Plan of Action (NPA) stipulates the standards of practice for OVC programming to which these CBOs/FBOs will be introduced. This proposal will support advocacy to community leaders & gatekeepers. Advocacy will be carried out to stakeholders in communities around the clusters of operation to facilitate the support for the project and to sensitize community leaders on OVC and the role of communities in their care. It will also support training of caregivers in psychosocial support for OVC and income generation activities. One CBO will be identified per cluster and trained (the integrated service delivery package to be designed for training of CSOs and CBOs). The training will cover psychosocial support, health care and education, Adolescent SRH issues and HIV/AIDS prevention. Specifically, support will then be provided to OVC to address these needs. The activities under this SDA will target about 28,750 OVCs and will be implemented by NGOs/CBOs and the Federal Ministry of Women and Children Affairs, coordinated by the Civil Society HIV/AIDS Network (CiSHAN) as the PR.

SDA 10: Care and support for the chronically ill: To build on the existing cluster model under the Round 5

grant, 925 PHC facilities will be identified for upgrading to provide services in the area of management of opportunistic infections for PLWHA. Three additional CBOs will be identified and strengthened to provide HBC services within the cluster. Key activities to be carried out to realize this will among other things proposed include building the capacity of the service providers in health, education, legal protection, nutrition, economic strengthening and psychosocial support. Advocacy and sensitization to communities is vital to enhance participation, impact, ownership and sustainability. This will be done through community outreaches and IEC materials and radio/TV messages. The capacity of CBOs/FBOs will be strengthened to provide HBC, palliative care and nutritional support. The CBOs/FBOs will be trained in HBC, palliative care and nutritional support using existing curricular; 555 CBOs/FBOs will be targeted. The trained CBOs/FBOs will thereafter be provided with HBC kits. The trained CBOs/FBOs will provide HBC services to about 172,500 PLWHAs in five years. These CBOs/FBOs will be provided with grants to enhance their activities.

Two support groups will be identified or established in each cluster to strengthen stigma reduction activities and create greater awareness for services at the community level. The new support groups will absorb the emerging PLWHAs and catalyze the formation of additional groups. In total about 370 support groups will be created. In year 4 of this grant, the 185 support groups created under the Round 5 grant will be absorbed and supported. The support groups (555 in all) will serve about 45, 600 PLWAs. These activities will be implemented mainly by NGOs/FBOs with support from the NEPWHAN under the CISHAN as the PR.

iv) Objective 4: To Create Supportive Environment to Deliver Comprehensive HIV/AIDS Services:

The following services and activities will be delivered under this objective:

SDA 11: Workplace HIV/AIDS Programmes: The majority of PLWHA are in their productive age and workplace HIV/AIDS interventions are strategic in containing the pandemic in this population segment. In Nigeria, under the Round 5 grant, 170 Small-Medium Enterprises (SMEs) were targeted for workplace-based intervention programmes. However, this is inadequate in comparison to the number of SMEs in the country, and was limited to only 17 of the 37 states. The Round 8 proposal will scale up this programme to the remaining 20 states.

This proposal will support advocacy visits to the managers of selected SMEs. Ten SMEs will be selected in each of the 20 states not covered under the Round 5. The implementation of this activity will be collaborative among the Public-Private-Partnership (PPP) stakeholders involved in workplace programming. The 200 SMEs selected will be supported to domesticate the National Workplace Policy and develop their SME specific workplace HIV policy.

To further behavior change in the workplaces, peer education programming will be implemented. It is expected that in all, 400 peer educators will be trained with each PE expected to mentor at least 10 workers every month through formal and informal education sessions. There shall be bi-annual refreshers for the peer educators. The peer educator trainers will serve as mentors to the peer educators throughout the life of this project holding quarterly one day mentoring and review meetings with the peer educators. The project will support monitoring visits and provision of technical support to trained peer educators by the mentors. The sub recipients are FLoP, NIBUCCA & SFH with PPFN as the principal recipient.

The strategy to minimize stigma and discrimination against PLWHAs in workplaces will be the expansion of the Meaningful Involvement of Persons Living with AIDS (MIPA) initiative to 30 institutions (mix of Public and Private). 40 PLWAs will be recruited and trained as MIPA officers before posting to institutions. These MIPA officers will be supported through the duration of the proposal. It is anticipated that by this time, having realized their contributions, the SME will sustain the salaries of the MIPA staff.

V) To enhance the management and coordination of gender sensitive HIV/AIDS Programmes

The service delivery areas and activities that will be supported to achieve the above objective are as follows:

SDA 12: Information Systems: Programme M&E: The aims of this SDA are twofold: strengthening the performance management of the Round 8 programme through effective and timely availability of information to support decision making by management of the grant and; strengthening to the National Monitoring and Evaluation system in Nigeria.

The intended outcome of this service delivery area is to employ evidence based management of Round 8 programme through routine collection and utilization of programme input, process and outputs based on the set

of indicators in attachment A and, enhanced management information system through availability and utilization of strategic quality information on HIV/AIDS in Nigeria through a strengthened Nigerian National Response Information Management System (NNRIMS) and the Nigerian Health Management Systems (NHMIS), both of which provide and anchor monitoring and evaluation of this proposal.

In addition to the activities in the HSS proposal, the following activities will be undertaken by the PRs, SRs and implementing partners under Round 8, as reflected in attachment A:- Capacity assessment of M&E structures at national, sectoral, state, LGA and community levels and service delivery points;, review the indicator data sets and baselines in NNRIMS; costing of NNRIMS operational plan; printing and distribution of NNRIMS operational plan; printing and distribution of data collection tools; capacity building for zonal, state, LGA, Federal line ministries, CSOs M&E officers for data collection; supervision and quality assurance; support supervision in 27 out of 37 states and roll out the use of electronic platform for ART, PMTCT, VCT, OVC to 36 states. There will also be step down training on the use of data collection tools and electronic platform for reports; quarterly (PRs) and monthly (SRs) supportive supervision and monitoring; internal data verification exercise, quarterly data analysis and report consolidation meetings, joint bi-annual data quality assessment, CCM briefing and M&E oversight meetings, quarterly cohort analysis and reporting by SRs on treatment outcomes, M&E report production and dissemination, provision of technical assistance on data utilization to improve programme performance, M&E performance on programme implementation impact review meetings, quarterly assessment review of SR performance, plan and technically steer and coordinate national surveys.. Other activities to be supported include costing the NNRIMS operational plan, building capacity at facility level for use of harmonized NNRIMS tools and data management, decentralization and roll out NNRIMS (DHIS software) to states and LGAs, linkage between NNRIMS and programme specific MIS by PRs and SRs, building the capacity at state level for data management, data collection, reporting, analysis & feedback, build capacity at facility level for data management, and data verification and quality assurance..

SDA 13: Strengthening Programme Management and Administration: The Management of the Round 8 grant will to a large extent draw from the experience of the implementation of the Round 5 grant. The three PRs will in the first and second quarter of grant signing be involved in grant activation activities such as finalizing negotiations (with GFTAM, government, partners, etc), recruitment, training, advocacy and equipping. Memoranda of Understanding (MOUs) will be signed after negotiations with SRs, LGAs and PHCs. Proposed institutional capacity issues are in the areas of personnel development, office equipment and supplies as well as running costs. Generally, training needs and activities will be in two categories: managerial and technical. The managerial training will address development of skills in advocacy including negotiation and presentation skills; coordination and networking; team building and resource management. It will also aim at developing skills in planning, resource mobilization, management of technical assistance, programming, monitoring and supervision. The key personnel in the responsible agencies will need project management skills and orientation to meet the added demands of this programme. Such training will be outsourced to capable institutions within the country.

The Principal Recipients for this proposal are the National Agency for Control of AIDS (NACA), The Civil Society for HIV and AIDS in Nigeria (CISHAN), and the Planned Parenthood Federation of Nigeria (PPFN). The sub-recipients include the HIV/AIDS Division of FMOH, Federal Ministry of Women Affairs and Social Development (FMOWA), Federal Ministry of Education, Federal Ministry of Intergovernmental Affairs and Special Duties (FMIA) and National Youth Service Corps (NYSC). Others include NGOs and FBOs. This proposal will support forums for programme coordination. Under this proposal, the following coordination meetings will be supported: i) quarterly task team meetings (M&E task team, HCT task team, ART Committee, PMTCT task team, national TB/HIV technical working group, OVC task team, ii) quarterly coordination meetings at all levels (Health facility, LGA, state and federal), annual review meetings, monthly Principal Recipients' coordination committee meetings, PR/SR bi-annual forum where all three PRs meet with all SRs to review grant progress and proffer solutions to emerging issues.

The Ministry of Health through its HIV/AIDS Division is responsible for the health sector response to HIV/AIDS. There is a Head of Division and focal persons for each of the key areas of. ART, PMTCT, TB/HIV, STI, and Laboratory. These focal persons will coordinate the national implementation of their areas on day-to-day basis. The task teams provide expert support to the FMOH for the development, implementation and coordination of the relevant programme areas. Activities in the states and local government areas are routinely coordinated through the State Ministries of Health with the State AIDS Coordinators as managers.

Stringent implementation monitoring schedules will be developed including the development of data quality assurance mechanisms. There will be regular supervisory visits to grant implementation sites. An electronic platform will be established for collating the data for reporting while regular communication with the general

public on grant and implementation progress. The PRs will interact regularly with the CCM and GFTAM.

4.5.2. Re-submission of Round 7 (or Round 6) proposal not recommended by the TRP

If relevant, describe adjustments made to the implementation plans and activities to take into account each of the 'weaknesses' identified in the 'TRP Review Form' in Round 7 (or, Round 6, if that was the last application applied for and not recommended for funding).

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This proposal is a re-submission of the proposal Nigeria submitted to the Global Fund under the Round 7 call for proposals. The Global Fund Board approved the TRP comments on the Round 7 proposal that included strengths and weaknesses in that proposal ranked as category 3. The Nigerian CCM decided to re-submit the proposal, after revising it taking into account the comments raised by the TRP of the previous proposal. During development of this proposal, the strengths noted in the Round 7 proposal were taken into consideration. The extensive revision of the proposal address each of the comments raised on the Round 7 proposal and also to takes into account new evolving needs and other circumstances.

The following weaknesses pointed out by the TRP on the Round 7 proposal were addressed as follows:

1. Comment 1: The proposal lacks a convincing strategy to address the challenge of national capacity to implement two large grants simultaneously, especially as the Round 5 program commenced only 8 months ago.

Response: The CCM and national stakeholders took note of this comment. It was noted that the duration of implementation of the Round 5 grant has increased since the Round 7 proposal was reviewed. The Round 5 grant is now in its second year of implementation. The recent Global Fund assessment of the implementation of this grant had very satisfactory results. All the three Principal Recipients were scored A in the latest reports submitted in April 2008. In fact, one of the components of the Round 5 grant superseded its targets and has been recommended for fast tracking to Phase 2.

The satisfactory performance of the Round 5 grant was a result of the re-invigorated oversight role of the Nigerian CCM. The CCM has strengthened its capacity and has been able to provide the necessary oversight to the implementation of the R5 grant. The oversight by CCM consists of technical support, data verification, advocacy at the highest decision making levels in Nigeria, and monthly committee meetings with the PRs and SRs to critically review progresses of grant implementation. The three Principal Recipients (the National Agency for the Control of HIV/AIDS (NACA), the Society for Family Health and the Association of Reproductive and Family Health) established a mechanism for joint coordination. The PRs formed a project Coordinating Committee (PCC) which holds monthly meetings to: i) share experiences (financial and progress of the programmatic implementation), ii) Logistics experiences including implementation of the procurement and supply chain management for progresses and challenges, iii) updates on the Round 5 cluster model.

In addition, the CCM has selected two additional PRs to the existing 3 PRs with proven institutional and grant management capacity and experience and extensive networks and National spread to lead the implementation of the grant that will arise from the approval of this proposal. Similarly, additional SRs with huge implementation potentials, experience and reach have been added to the pool. Grant implementation by multiple PRs& SRs has become a feature that Nigeria finds essential for expediting implementation of national programmes.

The satisfactory Round 5 grant performance has demonstrated that Nigeria now possesses the requisite implementation and grant management capacity to implement fairly large HIV/AIDS grants. This, along with the project design will ensure that this grant is successfully implemented.

2. Comment 2: The data provided in this proposal indicate that Nigeria is significantly behind its planned ART and PMTCT coverage targets. In this context, the rationale is not adequately given for increasing targets for coverage by PMTCT, ART, and support to OVC established under the Round 5 grant and complemented by significant other available resources.

Response: The coverage targets for ART, PMTCT and OVC have increased since submission of the Round 7 proposal, and are all now aligned with national targets. It is for this reason that all PRs had favorable ranking of their grants. Similarly the compartmentalization of ART program in the country along donor support will be eliminated with the integration of the projects into a national program with the assignment of roles and division of labor. In this proposal it is planned to increase the targets and achieve improved coverage to meet national targets. The rationale is as follows:

- Infrastructural upgrade that is needed for expansion of service delivery that was responsible for late start of the Round 5 grant are now in place to support the rapid roll out of the Round 8 grant.
- National guidelines and tools developed and are being used. Training programmes have already been developed and experienced trainers are now available to train an increasing number of health care providers;
- Implementation experience has accumulated over time by the coordinating and implementation institutions
- PEPFAR and other development partners in the country have proposed and committed to harmonize their projects with the National program and leverage their resources along national needs.
- The plans to integrate services (PMTCT/HCT/RH/DOTS/Injection safety) deliver same through the PHCs with strong community mobilization activities will expand utilization and reduce access barriers at the community levels.

All the above factors will make it possible to achieve the set targets and increase coverage through additional resources requested in this proposal.

3. Comment 3: The gap analysis does not include an amount in the years beyond 2007 for the most significant donor (PEPFAR); therefore, it is difficult to objectively assess the actual financial needs gap.

Response: At the time the Round 7 proposal was developed, it was not possible to access planned financial commitment by PEPFAR beyond 2007. The financial gap analysis in this proposal faced a similar constraint in that most external development partners that do not have a bilateral agreement with Nigeria are not able to provide projections beyond 2008. However, in the financial gap analysis, we have maintained the funding levels at the last available statistics i.e. 2007 funding levels, for partners where there are indications of continued funding commitments, but the exact funding levels are not known. This has markedly improved the funding gap analysis.

4. Comment 4: There is no explanation of the 30% increase in the financial need for the HIV programme from 2007 to 2008 and the 63% increase from 2008 to 2009.

Response: The stakeholders noted with regret the errors that were made in the estimation of funding needs for the Nigeria HIV programme in the Round 7 proposal. The estimation of the financial need for the HIV programme was not based on objective assessment. To rectify this problem, the financial requirements for the national programme in this proposal were based on the quantified costs in the NSF, a report of which is attached. This objectively assessed cost of the financial needs do not reflect the marked fluctuation noticed in the Round 7 proposal submissions.

5. Comment 5: The procurement and distribution system as described in the proposal is complex and its capacity to absorb the additional requirements outlined in this proposal is not adequately described:

Response: The National procurement & distribution system since the commencement of Round 5 implementation has undergone major improvements. Currently, procurement is driven by needs and available funds in budgets. The system adopts the "Pull system" of distribution to the ART and other service delivery sites from which data for forecasting and quantification is generated.

The current PSM system comprises of partnership with local and international companies who are responsible for procurement (Crown Agents & International Dispensary Association), Supply and peripheral distribution (CHAN Medi-Pharm & Darlez), Procurement, Supply and Management Coordination (JSI /SCMS& Logistics unit in the Food & Drugs Department of the Federal Ministry of Health). For ART commodities, the logistic system has been integrated into the national ART programme. All accredited ART sites providing comprehensive services have undergone training on LMIS for effective commodity management, in addition to the overall ART training modules. A pool of already trained logistic personnel is used as master trainer for newly accredited ART sites.

The described procurement and distribution system has been time-tested and proven to work for delivery of commodities under the Round 5 grant (currently rated 'A'). In the current proposal, activities for further strengthening the national procurement and distribution system have been proposed. These measures will facilitate the absorption of the requirements of the current proposal.

6. Comment 6: There is no explanation of the respective roles and responsibilities of the two PR's and their relationship to the sub-recipients (SR's) to be selected in the future.

The PRs and SRs for this grant have been selected by the CCM were involved in the development of this proposal. Section 4.9.2 provides the details of the PRs and SRs elected to implement this grant along with clear delineation of roles and responsibilities. The work plan indicates the activities to be undertaken by the respective PRs and their associated SRs.

The coordination arrangements between the various PRs have also been worked out. This is elaborated under section 4.9.5 of this proposal.

7. Comment 7: The capacity of ARFH to absorb the additional workload for this grant is not adequately elaborated.

ARFH is a PR under the Round 5 grant, implementing strengthening of community, CSOs and NEPWHAN in order to provide HIV/AIDS services and to increase access to care and support services for OVC. Under the Round 5 grant, ARFH works with four SRs(FMWA&SD, NYSC, NEPWHAN and CiSHAN) in a 'Public-Private-Partnerships' mix to expand access to services.

ARFH is a national non-governmental organization established in 1991 to initiate, promote, implement and monitor quality community-based reproductive health programmes through training, provision of technical assistance and programme development, evaluation and operations research. It has a dedicated workforce of about 77 highly skilled personnel and professionals. It has managed over 70 projects with budgets ranging from US $ 1 million – US $ 250 million, sourced from more than 20 international and national development partners. ARFH has a history of working with the public sector and has been a technical partner in the implementation of the NYSC HIV/AIDS prevention project in Nigeria in collaboration with UNICEF.

ARFH as a Principal Recipient of GFTAM Round 5, it has provided oversight functions to its four sub-recipients and maintained an excellent performance record of 'A' grade in all Service Delivery Areas. The activities in 24 states will expand to all states in phase II. Correspondingly, ARFH is increasing the human resource base with additional hire and expansion to six geopolitical offices from the existing four offices located in Ibadan, Abuja, Owerri and Minna.

4.5.3. Lessons learned from implementation experience

How do the implementation plans and activities described in 4.5.1 above draw on lessons learned from program implementation (whether Global Fund grants or otherwise)?

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The design of the Round 8 programme draws important lessons from previous programme implementation, especially the ongoing Round 5 grant that is currently in second year of implementation, as well as other ongoing programmes funded from domestic, bilateral and multilateral sources. Most of these implementation experiences have been incorporated in the design of this proposal and will inform the implementation strategies of the Round 8 proposal. The key lesson that will have implications on this round 8 proposal are as follows:

1. *The "cluster model" approach to service delivery*: The "cluster model" that is currently in place in the Round 5 HIV grant has had positive impact on scaling up of the national ART program. It has increased geographical spread of service delivery points and ensured the expansion of the continuum of care from prevention, testing, to treatment care and support services and across health care delivery levels for people living with HIV/AIDS (PLWHA). This has been possible through strengthened referral linkages and greater community involvement thereby enhancing the fight against stigma and discrimination. Monthly coordination meeting of providers within the clusters have increased information sharing, data collection and

programme accountability. The Round 8 proposal will build on this model to further expand access and community involvement. It will be strengthened through the integration of other services (RH/OIs/DOTS etc) into the HIV/AIDS packages. The HSS component, will build integration linkages across the three diseases.

2. *Partnerships and Collaborations*: Under the Round 5 grant, collaborations and partnerships were strengthened and new ones established with implementers of other programmes as well as other funding agencies and multilateral organizations. These partnerships often backed by memoranda of understanding (MOUs) drew on the strengths of individual organisations and programmes to produce synergy in the implementation process. Inputs ranged from technical assistance to donation of paediatric ARVs and deployment of resources for infrastructural upgrade of facilities. The Round 8 proposal will continue to create avenues for collaboration with partners and to draw from their strengths and leverage investments. Through the HSS component, collaboration across disease programmes will be enhanced. These will leverage resources across programmes to enhance implementation of the Round 8 proposal.

3. *Leveraging resources to enhance programme roll-out*: There was no upgrade of infrastructure in Round 5 proposal which constrained programme implementation. In order to address this constraint, an arrangement was made for State Governments to utilise part of their World Bank credits to fund the required upgrades. Unfortunately, some states had challenges accessing the funds, resulting in delay in the upgrade with subsequent delay in the roll-out of services. The Round 8 proposal will address this through appropriate investments in health systems in the HSS component of the proposal.

4. *Appropriate skills building*: The Round 5 grant provided training to health workers as well as site record officers, local government and states' M&E focal persons. This needs to be further strengthened for efficient and effective service delivery as a result of the increased demand and client flow. This was further complicated by the reality of staff attrition. The Round 8 proposal provides for adequate capacity building and technical assistance based on identified needs.

5. *Intractable shortage of health workers:* The Round 5 grant focussed on secondary and primary health facilities where there are challenges with the number of health workers for HIV/AIDS and health care. Loss of staff after training to urban areas or better paying organisations proved to be a major constraint. The Round 8 proposal will address this by engaging in high level advocacy to states and local governments to ensure political commitment, recruitment of more staff and retention of those trained in the facilities to enhance sustainable service delivery.

6. *Inadequate planning for diagnosis and treatment of opportunistic Infections:* The Round 5 programme implementation progressed with no provisions made for diagnosis of opportunistic infections which were thought to be available in the facilities. Procurement of drugs for treatment of common opportunistic infections was however covered by the grant. During implementation, secondary and primary facilities in the Round 5 grant faced challenges with availability of test kits and reagents for diagnosis of opportunistic infections. This proposal has incorporated strengthening diagnosis of opportunistic infections in addition to prophylaxis and treatment. The targets set for OI prophylaxis in this proposal have been reviewed based on experience during implementation of the Round 5 grant to avoid the challenges faced with meeting the targets for opportunistic infections.

7. *Inadequate plans for the weak laboratory capacity:* The limited availability of facilities for viral load determination in the country has posed a challenge in the monitoring of HIV patients. The provision of viral load facilities at zonal level using the Round 8 grant is designed to address this. In addition, with 6 years of ART delivery in Nigeria there is a need to develop the capacity of at least one center as a referral center, to provide HIV drug resistance testing.

8. *Shortage of HIV test-kits:* The shortage of rapid HIV test kits experienced has affected implementation of the Round 5 grant. This was occasioned by shift in the policy direction from treatment to prevention in the period between the development & submission of the Round 5 proposal (2004) and its award and signature (2006), to its actual implementation commenced in (2007). The projections in this proposal are derived from the National HCT Scale up plans and the programmatic gap analysis.

9. *Increasing linkages for TB/HIV collaboration:* The cluster model used in Round 5 strengthened linkages between TB and HIV services which naturally evolved whilst not provided for in programme design. This proposal will build on this natural evolution, establish formal linkages and strengthen referral linkages between TB and HIV services

10. *Commodity Supply Management:* The procurement and supply chain mechanisms used under Round 5 for HIV/AIDS commodities were successful in maintaining the integrity of the supply chain. The Round 8 programme will draw on lessons learnt in the Round 5 grant implementation to further strengthen the supply chain mechanism for medical and pharmaceutical supplies.

11. *Inadequate consideration of changes in the National ART guideline*: The ART national guidelines were reviewed during the implementation of the Round 5 proposal. The review introduced more expensive ARVs as part of the National first-line ART regimen which was not budgeted for in the Round 5 proposal. The design of the Round 8 proposal ensures that such possibilities are considered in advance in the budget.

12. *The Expansion of Community Services:* The implementation of community services components showed great promise in the Round 5 grant. This component also helped in creating demand for services as it reduced stigma and discrimination within the communities. Having just one or two community groups providing HBC, fighting stigma and providing support to PLWHA on treatment adherence compared to the number requiring such services had been a major drawback. The Round 8 proposal will increase the number of community groups providing such services within the clusters. For the OVC programme, the provision of material and psychosocial support services for OVC provided relief to the weak community support systems for OVC in Nigeria. An increased response of this component is proposed in Round 8.

13. *Multiple PRs:* Having multiple PRs in the Round 5 grant was vital in rapidly rolling out programme implementation across multiple partners. The coordination mechanism that was set up through the auspices of the CCM and the Project coordination committee was vital for coordination of the PRs and SRs. The Round 8 proposal will draw on this experience. Activities in the Round 8 proposal have been allocated to PRs and SRs drawing on their competences and comparative advantage.

14. *Budget:* The Round 5 budget did not envisage the operational and transactional costs of appointing multiple PRs and SRs. This proposal has anticipated capacity limitations among SRs and PRs and has provided appropriate activities to address these shortfalls.

4.5.4. Enhancing social and gender equality

Explain how the overall strategy of this proposal will contribute to achieving equality in your country in respect of the provision of access to high quality, affordable and locally available HIV prevention, treatment and/or care and support services.

*(If certain population groups face barriers to access, **such as women and girls, adolescents, sexual minorities and other key affected populations**, ensure that your explanation disaggregates the response between these key population groups).*

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One of the critical limitations of current HIV/AIDS interventions in the country is inequalities in the provision of information and services. While some categories of people are appropriately targeted, there are many groups that are not adequately served. Currently, 55% of HIV infected Nigerians are women and young women constitute 60% of infected persons aged 15-24 years. (2005 sentinel survey data). Furthermore, women bear disproportionate disease burden as caregivers and the hub around which social support systems pivot in communities. Although the impact of HIV/AIDS on women makes a compelling case, national response to the social, economic and cultural determinants of their vulnerability remains slow and hesitant.

This proposal proactively addresses the issues at the core of the trend by adopting a gender equity strategy aimed at reducing 3 gender related *differentials* namely; differential vulnerability to infection, differential access to information and services and differential participation in decision making.

These differentials shall be addressed by applying the principle of affirmative action to the implementation of key service delivery areas.

To the extent feasible, a *"50% gender equity rule" shall apply to outreach targets, selection of CBOs, capacity building and the composition of management and structures of CBOs. It should be emphasized that the rule shall not exclude any group and is intended to expand the inclusion of women.*

The strategy ensures the development of a gender sensitive work plan, M&E framework. Also, it improves the collection and transmission of sex disaggregated data and promotes gender responsive resource allocation.

The gender equity rule may not be applicable in all service delivery areas or in all locations. For example, due to increased availability of ARV, a gender disparity in treatment access is negligible in some urban sites. However, significant gender access disparity exists in rural areas and in many high prevalence states.

Implementation guidelines *shall be developed to assist PRs, SRs and sub grantees to apply the gender equity rule. Also, training curriculum in key service delivery areas shall be engendered and capacity of CBO strengthened to intensify advocacy on issues such as gender based violence and stigma and discrimination.*
Like women and girls, the sexual minority group including MSM, bisexual and lesbians also has limited access to HIV/AIDS information and services. Many of the stakeholders in HIV/AIDS have negative attitude towards providing services for those engaged in same sex relationship. This negative attitude is caused by religious and socio-cultural a belief which frowns at same sex relationship. Thus it is usually difficult for many people who engage in same sex practice to have access to appropriate information and services. In addition to negative attitude of service providers, the law in Nigeria which outlaws same sex practice has driven most people underground making it difficult for them to come out and access services.

Other groups not appropriately targeted with HIV/AIDS prevention, care and treatment services include children living with HIV as most of the ARV that have been provided in the country are mostly for adults leaving out children.. In the same vein, most interventions are urban based leaving out rural areas especially those in hard-to-reach communities. The same situation applies to people with special needs including the deaf, dumb blind etc. Similarly underserved, are the young people particularly the out-of-school youths.

To address this inequality, and ensure that those in need are appropriately targeted with HIV/AIDS information and services, the overall strategy of this proposal will include providing a service delivery area that will address meeting the needs of young people as well as most-at-risk people through community intervention mobilization programme which will facilitate information sharing and access to services for young people and the other most-at-risk population groups, which could includes sex-workers, MSMs, military , out-of-school young people etc.

Since children living with HIV have not been appropriately targeted in the national ART program, the provision of ART in the Round 8 proposal will specifically target children age 0-14 years. Also, in order to expand access to counseling services, the proposed HCT in the Round 8 proposal will focus on the provision of community-based service delivery to increase access of people in the rural areas and rural residents to HCT services and facilities.

The component of care and support particularly for orphans and other vulnerable children is another aspect of the strategy in this proposal to address gender inequities. Institutions that will be invited to provide these services will be required to demonstrate how emancipation of minority and disadvantaged groups will be stressed and how progress towards that attainment will be monitored.

Other strategies that will be adopted to ensure increased access of people in the rural areas to appropriate intervention are the adoption of the cluster model that will guarantee adequate service delivery for this category of people.

The Monitoring and Evaluation design of this proposal will ensure that data necessary to track access of less advantaged population groups such as young people, women and girls is routinely collected, analyzed and utilized to inform targeting and planning. Strategic information will be appropriately disaggregated by gender and monitored for inequalities as well as progress towards bridging gaps in access and utilization of services. It will also be monitored for impact of the epidemic on the population sub-groups and the interventions of this proposal. This information will be appropriately used to inform redirection of efforts to ensure that progress in bridging gender inequalities is maintained.

4.5.5 Strategy to mitigate initial unintended consequences

If this proposal (in s.4.5.1.) includes activities that provide a disease-specific response to health system weaknesses that have an impact on outcomes for the disease, explain:

- the factors considered when deciding to proceed with the request on a disease specific basis; and
- The country's proposed strategy for mitigating any potentially disruptive consequences from a disease-specific approach.

This proposal has some specific activities that will have direct impact on the outcome of HIV/AIDS and at the same time strengthen the health system. Activities which also impact on Malaria and Tuberculosis outcomes are discussed in the HSS component of this proposal i.e. section 4B. Health system strengthening activities for which we proceeded on a HIV/AIDS specific basis is the strengthening of the HIV/AIDS Monitoring and Evaluation system.

Strengthening of the Health Management Information System is provided for under the cross-cutting category because it supports malaria and tuberculosis programmes as well, in addition to supporting the overall health systems. Currently, the National Health Sector M& E system (NHMIS) collects health sector data while NACA runs a separate system for obtaining multi-sectoral HIV/AIDS data , the NNRIMS. Most M&E officers at the PHC levels are familiar with the NHMIS, but it obtains limited information on HIV/AIDS indicators. However, using both systems in health facilities has a potential for duplication of efforts with the obvious risk of confusing and overburdening staff. To mitigate this consequence, the strategy adopted is to strengthen both systems, but with clear lines of demarcation to avoid duplication. However, the design of the systems will ensure that while duplication is avoided, the two systems are able to communicate. Points of convergence will be defined at various level e.g. state and local government levels. More importantly, the NNRHIMS will collect non-health sector HIV/AIDS information, while the NHMIS will collect health sector-based HIV/AIDS data. However, the NHMIS will expand the range of HIV/AIDS indicators. One PHC facility in each local government area will be strengthened to provide comprehensive data based on the two systems. Such sites will have one additional M&E staff recruited. Furthermore, M&E officers at the PHC level will be equipped with necessary skills to use the National Health M&E framework to collect both HIV specific and health system specific data to ensure that HIV/AIDS related data.

The community systems strengthening activities are intended for outreaches for HIV/AIDS service delivery to support expansion of HCT activities in 3 additional FBOs facilities per cluster. The decision to proceed with this activity on a HIV/AIDS specific basis is due to the fact that most of the existing CBOs are HIV/AIDS-focused. However, we also recognize that most of these CBOs only need minimal capacity strengthening in order to carry out comprehensive community outreach activities including Malaria and TB. However, in order to avert a situation where malaria and tuberculosis also select different CBOs to carry out similar community outreach programmes in the same locations, the PRs and SRs leading this activity under the HIV/AIDS component will work with their malaria and tuberculosis programme counterparts to conduct joint CBO assessment as well as capacity building. This will ensure integration of activities at the PHC level.

4.6. Links to other interventions and programs

4.6.1. Other Global Fund grant(s)

Describe <u>any</u> link between the focus of this proposal and the activities under any existing Global Fund grant. *(e.g., this proposal requests support for a scale up of ARV treatment and an existing grant provides support for service delivery initiatives to ensure that the treatment can be delivered).*

Proposals should clearly explain if this proposal requests support for the same interventions that are already planned under an existing grant or approved Round 7 proposal, and how there is no duplication. Also, it is important to comment on the reason for implementation delays in existing Global Fund grants, and what is being done to resolve these issues so that they do not also affect implementation of this proposal.

BETWEEN 2 to 4 PAGES

The design of the Round 8 proposals is to complement the existing Round 5, mainly through scaling up and increasing the scope of activities supported under the Round 5 grant. The cluster approach will remain the dominant

strategy for Round 8. This will adopt the cluster model around which R5 is built with a view to consolidate its gains. This proposal will mobilize resources to ensure funding for key component of the treatment interventions initiated using the Round 5 grant when it expires in 2011. The scale-up of activities will be designed to reach new areas, facilities, providers, clients, etc. Efforts will be made to ensure that there is no duplication of funding for activities between the rounds and also with other funding sources, since Global Fund support in Nigeria is additional to other sources of funding.

The National HIV/AIDS prevention plan 2007-2009 recommends the establishment of 2 HCT sites in each of the 774 LGA with equal number of CBOs in the country. There is an annual gap of 1200 sites in 2009 to 2013. The Round 5 supports the establishment of 111 HCT sites per annum till 2011. It is planned to link the new PHC facilities with the existing comprehensive ART sites. Following from the Round 5 experiences, the Round 8 proposals seeks participation of the National Partners Forum for HCT activities especially on improving logistics management and quality assurance. Staff from the comprehensive secondary facilities supported under Round 5 grant will serve as trainers and mentors of the PHC facility staff within their respective clusters.

While some activities under the *BCC community outreaches and youth* in Round 5 like 'Reaching young people with factual information on HIV and AIDS using the NYSC scheme' will be scaled up in Round 8 at the conclusion of Round 5 to avoid overlap, newly introduced activities like 'Facilitation of the teaching of FLHE in primary, secondary and tertiary institutions', will not only promote the prevention of HIV as in Round 5 among In-school young people but will also enable the mainstreaming of gender and human rights into the activities of Round 8. Other activities not included in Round 5 include 'Promotion of safer sex practices among MARPs, scaling up interventions among PLWHAs' and 'Community mobilization to reduce stigma and create demand for services.

There is a need to further harmonize and integrate the treatment program and scale up it up along the national treatment scale up plans to 1.3 million people by 2013 according to the national ART scale up plan. This proposal seeks to contribute to meeting this national target with emphasis on pediatric ART and the provision of first line ARVs to all previously exclusive PEPFAR patients being absorbed into the national program.

The Round 5 grant focused on scaling up of ART without emphasis on the treatment of OIs. In this proposal however, the diagnosis and treatment of OIs is a priority area The proposed strengthening of the laboratories for diagnosis of opportunistic infections supports the on-going activities of treatment of opportunistic infection. Furthermore, the Round 8 grant will also strengthen the TB/HIV component of the Round 5 grant.

Under the Round 5 grant, clinical monitoring of existing patients essentially is being done using CD4 count. The Early Infant Diagnosis (EID) and viral load testing components of the Round 8 proposal will further strengthen patient monitoring and management and provides early diagnosis for exposed infants.

This proposal fills the gap in the national programme and the ongoing Round 5 grant. Some of the identified gaps include:

- Treatment, care and support services that comprehensively integrate HCT, TB, SRH and STI and HBC management are not adequate. Hence, Round 8 will expand coverage of the integrated service delivery. One of the gains of Round 5 grant is the reduction of stigma & discrimination, which has consequently led to increasing demand for treatment, care and support services. There is however inadequate human, technical and institutional capacity in terms of infrastructure, staff, equipment and supplies for sustainable impact. Hence the need for a scale up of institutional and human resource capacity to meet the country targets.

- The existing treatment centers are located mainly within secondary and tertiary facilities. This proposal will support further decentralization of services to primary health care facilities thereby improving access to services at PHC level.

- Increasing numbers of OVC and deepening poverty is overstretching and overburdening the traditional support systems of the extended families and communities. Under the current Round 5 grant, national efforts are aimed at strengthening the capacity of CBOs to address this short coming. There is need for more strengthening of the CBOs and care givers. The community systems strengthening component of this proposal will contribute to more strengthening of community systems for this purpose.

- There is also inadequate human, technical as well as weak institutional capacity to effectively respond to the provision and support for treatment, care and support services including OVC issues. This proposal will scale up the institutional and organizational capacity of all stakeholders for effective service delivery.

- The Round 5 grant was designed to provide for both adult and children's treatment. It however succeeded more

with the provision of adult ART and the gaps in ART service provision are more glaring in the paediatric ART component. Special efforts will be made in Round 8 to focus on paediatric ART.

- Two components of materials support namely, educational and health supports for OVC are being provided in Round 5 grant. The two major gaps are the limited number of interventions compared to the recommendations of the OVC National Plan of Action (NPA) and standard of practice (SOP). The other is that care givers such as volunteers, family members, CBOs, FBOs etc who need to be adequately taken care of in order to gain sustainability at the community level are not being served. This is the main focus of the Round 8 proposal. Though OVCs are been generally taken care of in the Round 5 proposal, special attention will be given to OVC that are HIV-positive in the Round 8 that are in dire need of educational, health, nutritional, legal and psychosocial support.

- There is a need to scale up PMTCT sites and services across the country in line with the national PMTCT scale-up plan. In 2008 the number of pregnant women accessing PMTCT services under the Round 5 grant is 78,144, but projected to increase to 156,288 by 2011. The number of sites targeted for the end of 2007 was 370 sites, but we have been able to achieve only 253 sites. In order to rapidly scale-up service delivery to meet national targets, the Round 8 proposal will roll-out PMTCT service delivery to an additional 925 PHC sites strengthen community mobilisation and enrol more women into the programme.

- The Round 5 proposal provided resource for two trained volunteers per comprehensive site to provide adherence for PLWHA on ART and two CBOs to provide HBC for those living with HIV. Each of the trained volunteers was estimated to be able to provide effective adherence support for a maximum of 15 PLWHA making a total of 30 per site. Two major gaps with this arrangement are inadequate number of individuals providing services translating to inadequate coverage and inadequate resources for the provision of comprehensive adherence support and HBC at the community level. The strategy of this proposal is to expand this capacity through alleviating the identified gaps.

- Cluster level coordination meetings provides the avenue for the proper coordination for the Round 5 activities and reports from the community and state levels have been quite successful at doing this. However, there is need for the inclusion of the pharmacist; the CBOs providing community mobilization services, M&E officers and laboratory technicians within the clusters, but resources in the Round 5 grant are inadequate for this. The Round 8 proposal will provide additional resources expansion of the membership of these meetings.

- Currently, PPFN, one of the proposed PR, is implementing Round 5 project as a sub-Recipient in CT and Malaria. Also the International Planned Parenthood Federation, of which PPFN is a member, provides grants for the integration of RH with HIV. Specifically the proposal takes into account the gaps of the Round 5 proposal and current funding of HIV and RH by strengthening areas of needs for a wider reach. It also addresses the RH needs of people accessing HIV services and vice versa in the round 5 proposal thus increasing service utilization and effective use of personnel. It also adopts the principle of private public partnership.

- The Round 5 grant and the Round 8 proposal aim to expand access and uptake of HCT, PMTCT, ART, RH, DOTS and Care and support services. At the heart of this scaling up is a good BCC strategy which combines both the mass media and community outreach programmes to target the populace. The target of the proposed BCC strategy is to promote services, behavior change and increase clients' uptake of services. It will also improve treatment adherence. This will address the major challenge of the existing interventions for HIV/AIDS has been that while efforts have concentrated on expanding the supply of services, demand for such services has remained very low. Major factors responsible for this low demand have included low awareness about location of existing facilities, stigma and discrimination, limited access to SDPs due inequitable distribution and distances to facilities and poor treatment literacy levels. The BCC mass media activities proposed in the Round 8 proposal will bridge the gap between supply of services and the demand for the services.

4.6.2. Links to non-Global Fund sourced support

Describe <u>any</u> link between this proposal and the activities that are supported through non-Global Fund sources (*summarizing the main achievements planned from that funding over the same term as this proposal*).

Proposals should clearly explain if this proposal requests support for interventions that are new and/or complement existing interventions already planned through other funding sources.

ONE PAGE MAXIMUM

There are other HIV/AIDS programmes supported from other sources. The major programmes are supported with funding mainly from the Federal Government of Nigeria, PEPFAR, the President Clinton Foundation, DFID, etc. All these programmes support implementation of activities in a broad range of HIV/AIDS technical areas, with many interventions being similar to what is proposed under this grant proposal. However, this proposal strategy is to build on what the other programmes are supporting in order to scale up HIV/AIDS prevention, treatment, care and support service. The proposal will be providing additional outputs, as detailed in the programmatic gap analysis, integrating services and promoting partners' projects harmonisation into programs. Special efforts have been taken to ensure that neither duplication nor displacement of efforts or resources occurs.

During implementation of the programme arising from approval of this proposal, linkages will be established with the various programmes. The major programmes include:

- USG PEPFAR project provides ART to about 200,000 clients across the nation; this grant will allow the harmonisation of all first line treatment regimens and clinical practice in the country under one program. The USG has committed through PEPFAR to subsequently focus on the provision of second line drugs and other services. PEPFAR has also committed to help build and strengthen capacities across the national response. When approved the program will strengthen the existing linkages with PEPFAR supported programme and other partners involved in treatment and leverage resources, expertise and experiences.

- USAID currently supports the integration of RH (FP in particular) into HIV service provision within FHI's HIV service delivery system. Specifically, the integration of FP and HCT, strengthening the FP component of PMTCT and meeting the FP needs of clients with HIV (including those on ART). This proposal builds on this framework and the lessons learnt in implementation to expand the integration of RH and HIV services within the GF grants.

- The Federal Government of Nigeria has developed the framework and structures for managing OVC programmes, but resources are inadequate for provision of material support. The Round 5 grant provides resources to support this activity. The FGN through the MDG provided resources for the mapping of OVC service provision in Nigeria. Further resources from the Round 8 proposal will sustain gains already achieved while efforts are made to engage the FGN to allocate resources for increased OVC programming in Nigeria.

- Behavior Change communication using media campaigns are being conducted by a wide range of players funded under Round 5 and other sources. Currently, DFID and USAID funded projects such as the PSRHH by SFH and BBCWST etc are also implementing similar programmes. Private foundations such as MTN, Coca-Cola Africa foundation and some media houses are also supporting related activities. This has contributed to stigma reduction and changing negative public perception about HIV/AIDS. While these media interventions have only focused on promoting awareness the proposed intervention under the Round 8 will aim at mobilizing the general public towards making informed decisions about their health and promoting health-seeking behavior. This will be reinforced by BCC using community outreaches. Lessons learned by various programmes, capacity built and other resources will be leveraged by this project in order to rapidly scale up services.

- Activities for reaching young people with HIV/AIDS information using the NYSC scheme like refresher training activities and production of IEC/BCC materials are supported mainly by the Round 5 grant. However, other partners like UNICEF, SFH, FHI/GHAIN also support similar activities. UNICEF supports capacity building for NYSC staff; SFH provides training materials needed in the camps while FHI/GHAIN and SFH also supports the HCT component of the project. The FLHE is being supported at the national level by the UNICEF and CIDA; very few states have been able to enlist government support thus leading to little or no efforts at the state level. The Round 8 proposal will build the capacity to manage and source for funds for the training of teachers and enhance implementation at state level.

- Other activities like promotion of safer sex practices among MARPs and scaling up interventions among PLWHAs are obtaining supports from USAID and DFID. Funds will be leveraged from the Round 8 grant to strengthen weak components of the activities.

4.6.3. Partnerships with the private sector

(a) The private sector may be co-investing in the activities in this proposal, or participating in a way that contributes to outcomes (even if not a specific activity), if so, summarize the main contributions anticipated over the proposal term, and how these contributions are important to the achievement of the planned outcomes and outputs.

*(Refer to the Round 8 Guidelines for a **definition of Private Sector** and some examples of the types of financial and non-financial contributions from the Private Sector in the framework of a co-investment partnership.)*

ONE PAGE MAXIMUM

The private-for-profit sector in Nigeria is being increasingly harnessed for HIV/AIDS interventions especially in supporting the technical area of workplace-based HIV/AIDS interventions. The programme that will arise from this proposal will establish linkages with these private-sector initiatives, leverage the investments made therein. However, their activities do not fall under the framework of co-investment schemes described in the Round 8 guidelines and are therefore not discussed any further in this context.

(b) Identify in the table below the annual amount of the anticipated contribution from this private sector partnership. *(For non-financial contributions, please attempt to provide a monetary value if possible, and at a minimum, a description of that contribution.)*

Population relevant to Private Sector co-investment (*All or part, and which part, of proposal's targeted population group(s)?*) ➔	-

Contribution Value (in USD or EURO)

Refer to the Round 8 Guidelines for examples

Organization Name	**Contribution Description** (*in words*)	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
-	-	-	-	-	-	-	-
[use "Tab" key to add extra rows if needed]							

4.7. Program Sustainability

4.7.1. Strengthening capacity and processes to achieve improved HIV outcomes

The Global Fund recognizes that the relative capacity of government and non-government sector organizations (including community-based organizations), can be a significant constraint on the ability to reach and provide services to people (e.g., home-based care, outreach prevention, orphan care, etc.).

Describe how this proposal contributes to overall strengthening and/or further development of public, private and community institutions and systems to ensure improved HIV service delivery and outcomes. ➔ *Refer to country evaluation reviews, if available*.

ONE PAGE MAXIMUM

The proposed activities in this proposal are in line with national HIV/AIDS priority and the nation's development plan. The proposed activities are consistent with and part of the national HIV/AIDS and health sector strategic plans in Nigeria. Implementation of the proposed activities will therefore strengthen the achievement of the nation's development objectives. Furthermore, the activities will be implemented by national systems and institutions. It is not envisaged that new structures or institutions will be established for grant implementation. However, in view of the limited institutional capacity of existing institutions, we propose significant capacity building for these institutions. This will cover public and private as well as community institutions. It will comprise of strengthened capacity in the areas of organizational management, health systems as well as human resource capacity. This strengthened capacity will contribute to sustainability since the capacity once established will remain to serve the country in future.

One area where the proposal will strengthen capacity is the national capacity to coordinate the diverse stakeholders involved in HIV/AIDS control. In Nigeria, the coordinating structure at the national level headed by the National Agency for the Control of AIDS (NACA) coordinates the national response. There are State Action Committee on AIDS (SACAs) and Local Action Committee on AIDS (LACAs) at the state and LGA levels respectively, but their coordination capacity is still weak. This proposal will contribute significantly to strengthening coordination at those levels and this will be a sustainable investment since in the future, these institutions will be able to coordinate resource mobilization and advocacy for HIV/AIDS.

At the community level, this proposal has provisions for institutional capacity development for Community Action Committee on AIDS (CACAs) using the existing structures in the communities to promote community ownership. There will also be capacity building for networks for various target groups, CBOs and other community support systems including workplaces, etc. These institutions will thereafter be in position to scale up HIV care and support interventions in a sustainable way.

The joint mid-term review of the NSF showed that the advocacy efforts of NACA have resulted in the National Economic Commission which consists of the 36 State Governors ant FCT Minister dedicating at least one percent of their budget to HIV/AIDS. The Federal Government allocations to HIV/AIDS rose from about US $ 13 million in 2004 to about US $ 51 million in 2007.

Some service delivery points particularly those being funded by international, bilateral and multilateral donors already have appropriate medical equipment for diagnosis, monitoring and treatment and this proposal will continue in that direction to facilitate provision of medical equipment for diagnosis, monitoring and treatment especially at the local level. These SDPs will be strengthened through development of improved management practices, investment in infrastructure particularly the size and quality of buildings and maintenance of environment of the SDPs. These investments will continue to be available in the long-term after the life of the project, which is one of the measures that assure sustainability of the Global Fund support.

The proposal has provisions for strengthening of the capacity of the PRs and their corresponding SRs for a sustained HIV and AIDS response. These PRs and their SRs already have the basic structure in terms of skilled workforce and effective management mechanisms. They also have track records of working at different levels of the intervention cadre and have the competency to generate additional resources elsewhere to sustain the process at the expiration of the grant period. The strengthened capacity availed through this grant will enhance their capacity for future resource mobilization and management.

The cluster model approach initiated in Round 5 will be expanded under the Round 8 proposal to ensure consistency, guarantees active involvement of people at the grassroots and ensures that capacity for community level actors to own the process is in place. This model will also facilitate capacity building of various levels of facilities to provide patient care and follow up between different cadres of health care workers. The proposal will support improvement in existing skills and devolve responsibilities to lower level health care service providers such as nurses, clinical officers and pharmacy technicians that are more likely to be available in lower level facilities to facilitate roll-out of various services.

4.7.2. Alignment with broader developmental frameworks

Describe how this proposal's strategy integrates within broader developmental frameworks such as Poverty Reduction Strategies, the Highly-Indebted Poor Country (HIPC) initiative, the Millennium Development Goals, an existing national health sector development plan, and other important initiatives, such as the 'Global Plan to Stop Tuberculosis 2006-2015' for HIV/TB collaborative activities.

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This proposal supports the implementation of the National HIV/AIDS Strategic Framework on HIV/AIDS (NSF) 2005-2009 which aims to scale up HIV/AIDS prevention, care and treatment services countrywide. This is consistent with the wider National Economic Empowerment and Development Strategy (NEEDS), the home-grown version of the national poverty eradication strategy. The NEEDS will contribute to the attainment of the Millennium Development Goals (MDGs) and the Universal Access targets to which Nigeria has subscribed.

This proposal was developed in the context of broader international and national development frameworks that Nigeria subscribes to. It is aligned to the poverty reduction strategy in the country, contributes to the attainment of the MDGs and universal access targets, and implements the National Health Sector Strategic plan as well as the National HIV/AIDS Strategic plan.

The proposal aims to improve the quality of life of the people thereby assisting in the attainment of the Millennium Development Goals (MDG). The poverty reduction strategy in the country, i.e. the National Economic Empowerment Development Strategy (NEEDS) is one of the vehicles for attainment of the MDGs. The NEEDS makes provision for improvement in the health care delivery system, with emphasis on HIV/AIDS and other preventable diseases such as malaria, tuberculosis and reproductive health related illnesses. This proposal targets HIV/AIDS and health services in general that are central pillars in the NEEDs.

The proposal is designed to finance funding gaps in the National Health sector Development Plan as well as the National Strategic Framework for HIV/AIDS, all of which were conceived within the broader development framework. These plans take into account Nigeria's commitment to the attainment of Universal Access to HIV/AIDS prevention, treatment, care and support. The NSF objectives and the national priority targets take this requirement into consideration. The Health Sector Development Plan aims at strengthening health system at various levels towards improved service delivery including improved infrastructure and quality human resources.

Nigeria is one of the beneficiaries of the Highly-Indebted Poor Country (HIPC) initiative. This debt relief initiative is coordinated in the office in the presidency. Some of the savings from this initiative support priority HIV/AIDS and health service delivery geared towards the attainment MDGs. This proposal takes into account the priorities and the funding made available through this channel.

This proposal is designed to give equal opportunity to all through its innovative gender sensitive and integration of service delivery approaches. It is also designed to bridge inequality in the existing service delivery. Population groups like women, out-of-school youths, most-at-risk population groups and sex workers are some of the groups that are not adequately catered for by the existing service delivery mechanisms. This proposal is designed to ensure equitable access to HIV/AIDS services by such population groups.

This proposal also aligns well with the National Policy on Population for Sustainable Development which is designed to improve standards of living and quality of life. Under this strategy, adolescent reproductive health, HIV/AIDS, and other sexually transmitted infections as well as poverty reduction are addressed. The design of this proposal was aligned to the priorities under this initiative. In particular, all service delivery areas have been designed taking into consideration the need to integrate sexual and reproductive health services.

With respect to alignment with other funding for HIV/AIDS programmes, the donor partner group (DPG) i.e. the

partnership that supports partner coordination ensures that support from these donors contributes to sustainability of HIV/AIDS programmes. The National Planning Commission (NPC) ensures that all foreign aid coming into Nigeria is aligned to country priority as stated in the NSF and other existing country policies. Currently, joint funding arrangements are also being piloted by several developmental partners including DFID, USAID and the World Bank, in order to address holistically issues of programme capacity and implementation of the AIDS response. This will ensure full alignment of donor support to national priorities.

4.8. Measuring impact

4.8.1. Impact Measurement Systems

Describe the strengths and weaknesses of in-country systems used to track or monitor achievements towards national HIV outcomes and measuring impact.

Where one exists, refer to a recent national or external evaluation of the IMS in your description.

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The Nigeria Round 8 GFATM supported project will contribute to the Goal, impact and outcome indicators set in the Nigeria National Strategic Framework (NSF 2005-2009) together with non GF supported interventions in the national response.

The measurement of Impacts and outcomes of the project will be anchored in the Nigerian National Response Information Management System (NNRIMS) the Nigerian Health Information Management System (HMIS) in the health sector, other sectoral MIS and project specific Evaluation (Refer to extracts from the M&E Plan). The NNRIMS has an operational plan and national sets of priority impact, outcome and output indicators that are linked to the sources of data at all levels. It also outlines a data flow pathway that includes frequency of collection, responsibility, indicators, targets, and standard tools.

The project will make use of (and in part contribute to supporting) the following surveys, surveillances and impact studies that are conducted periodically to measure Impacts and outcomes as part of the contributions to the ‘’three ones’’ meaning one Coordinating body, One Frame work and one

National Monitoring and Evaluation system:

- **The ANC HIV Sentinel Surveillance System** is used to measure prevalence of HIV based on antenatal clinic surveillance as a proxy to the general population and is conducted using an internationally accepted protocol. It is limited to the female reproductive age group (15-49 years) and conducted bi-annually. Data obtained is useful for monitoring HIV prevalence trends while the prevalence among young women is a useful proxy for HIV incidence. The information obtained from the system is triangulated using mathematical and demographic modeling / estimation methods to obtain non-HIV prevalence estimates including HIV/AIDS morbidity, mortality and incidence for the entire population and different demographic groups and geographical areas.
- **National HIV/AIDS and Reproductive Health Survey (NARHS+):** This survey comprises of both behavioral and serological testing among females aged 15-49 years and males aged 15-64 years in Nigeria. It provides estimates of behavioral outcome indicators and impact indicators. This survey is normally conducted with leadership of the Federal MOH and NACA every two years with support from Development partners.
- **Integrated Bio-Behavioral Sentinel Survey (IBBSS):** The survey comprises both behavioral and serological testing among most at risk populations (MARPS) and is conducted every 2 years. They also measure prevalence of STI by collecting blood samples in sampled states and FCT of the federation and are a good source of outcome and impact indicators.
- **OVC Survey:** In line with the National OVC action plan, OVC surveys provide important input, process, output, outcome and impact indicators, on OVC and children population.
- **Other National Surveys/ major data collection exercises** that will generate impact and outcome indicators useful to the GF Rd 8 supported project will include: the Nigeria Demographic and Health Survey (last one in 2003 and 2008 - ongoing); the Health Sector Facility and quality of care and service delivery surveys by the FMOH; Integrated Socio Economic Household survey by the National Bureau of Statistics (NBS) and the National Population and Housing census. The last census report projections have provided the baseline data for some of the impact and demographic indicators in developing and setting targets for this proposal.

The weaknesses with the part-anchoring the measurement of impact and outcome indicators (as highlighted in the MESST report of 2007) include:

- The NNRIMS operational plan has not been costed, thus hindering full implementation and though the tools have been developed and harmonized, some partners are yet to start using them.
- Measuring impacts and outcomes on the populations not recognized by law such as MSM and IDU

The project performance measurement/the specific M&E Plan: A monitoring and evaluation plan specific to the project with performance measurement indicators will be the main guide to the data collection, management, reporting under the project . The project M&E plan uses the standard indicators of the NNRIMS and in line with the UNGASS and GF guidelines.

The plan elaborately presents: the objectives of the different service delivery areas; the indicators; the targets; data collection methods; frequency of data collection; and sources; information products; reporting formats; dissemination; management and coordination as well as responsibilities and time line for the different M&E activities between the PR, the SRs and the SSR as well as the National, States, Local Government and development partners. The project will use the harmonized national M&E tools at different service delivery points.

The PRs will report to the GF quarterly while the SRs will report monthly to the respective PRs. The various implementing partner organizations for specific interventions under the project grant will report to the respective SRs on quarterly basis. The PRs, SRs and the SDP/ organizations supported under the grant will also report to NACA, SACAs and LACAs depending on the programme level where they are operating.

4.8.2. Avoiding parallel reporting

To what extent do the monitoring and evaluation ('M&E') arrangements in this proposal *(at the PR, Sub-Recipient, and community implementation levels)* use existing reporting frameworks and systems (including reporting channels and cycles, and/or indicator selection)?

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Given the above Monitoring, Evaluation and Reporting arrangements as well as the multiplicity of actors/ partners using the same M&E frameworks that are involved in the GF supported project. The following measures will be put in place to prevent parallel system and double counting of efforts in reporting:

- Supporting the roll-out and adoption of the harmonized National reporting system under NNRIMS. (integrated data flow path for all diseases, one reporting cycle, and integrated platforms for data management by all stakeholders at different programme levels)All Indicators for GFATM round 8 proposal are derived from the NNRIMS
- Adequate supervision, data verification and quality checks by units responsible for monitoring and evaluation at the SRs, PRs, SACAs and NACA are incorporated into the project to minimize or entirely avoid double counting in data capture, collation, aggregation, analysis and reporting levels.
- Utilization of the relevant NNRIMS derived data collection tools.
- Joint data quality assessment missions by the 3 PRs coordinated by NACA will also be undertaken as enshrined in NNRIMS Operational Plan.

4.8.3. Strengthening monitoring and evaluation systems

What improvements to the M&E systems in the country (including those of the Principal Recipients and Sub-Recipients) are included in this proposal to overcome gaps and/or strengthen reporting into the national impact measurement systems framework?

➔ *The Global Fund recommends that 5% to 10% of a proposal's total budget is allocated to M&E activities, in order to strengthen existing M&E systems.*

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A national M&E system assessment was undertaken (see report in annex 4.8.3.) by NACA in February 2007 and

highlight the following major weaknesses:

In relation to OVC programmes:

- Capacity at the community level for data collection, reporting, aggregation and quality control not yet developed
- Lack of Standard Operating Procedures (SOPs) for data management and quality assurance

In relation to ART, PMTCT, VCT programmes

- Two parallel systems of reporting from lower to intermediate levels
- Possibility of double-counting across service delivery points
- Inadequate human capacity for data management at local Government Area (LGA) level

In relation to Data Management

- Overworked staff, to ensure timely delivery of reports
- Procedure for ensuring quality and managing data not documented
- Insufficient training of M&E staff at the service delivery points
- Insufficient plans for on-going training in data quality assurance
- Quality control mechanism at the community level not yet established

In relation to the M&E Plan

- Some indicators are not adequately defined
- Linkages between health sector HIV/AIDS response MIS and HMIS not well defined
- Insufficient capacity for data management and quality assurance at State and LGA levels
- Tools for assessing quality not yet finalized
- No firm commitment of the necessary resources to ensure that frequency of data collection is adhered to
- Baseline data for some indicators not available
- Inadequate feedback (dissemination) to private sector, LGA levels & service points

The Round 8 GF grant supported project will contribute to the strengthening of M&E systems in the country. by supporting key M&E activities including the following:

- Costing and roll out of the existing NNRIMS operational plan to guide implementation at all levels.
- Capacity building of service providers at all levels to operationalize the harmonized national reporting tools, reporting channels and flow path will be strengthened.
- Integration of electronic base data reporting platform (e.g. LHPMIP/DHIS) to support the existing NNRIMS Database.
- Strengthening the existing health management information system in the country.
- Built capacity for M&E at the community to provide statistical information not only on malaria, HIV/AIDS and TB but all other 21 priority diseases in the country.
- Provision of IT infrastructures at service delivery points to improve data capture, analysis, storage, retrieval and reporting to improve service.
- Development, documentation and induction of Quality management and Standard operating procedures for NNRIM
- Strengthened M&E Coordination at National (NACA), Sectoral and State (SACA) and Local Government levels
- Strengthening of M&E Technical Resource Networks (Technical Working Groups) and reference resource centers at national, sectoral and State levels

Joint funding of the national population based biological, sero, behavioral, demographic, operational, formative, facilities and quality of service delivery surveys and HIV and AIDS related research.

4.9. Implementation capacity

4.9.1 Principal Recipient(s)

Describe the respective technical, managerial and financial capacities of each Principal Recipient to manage and oversee implementation of the program (or their proportion, as relevant).

*In the description, discuss any anticipated barriers to strong performance, referring to any pre-existing assessments of the Principal Recipient(s) **other than 'Global Fund Grant Performance Reports'**. Plans to address capacity needs should be described in s.4.9.6 below, and included (as relevant) in the work plan and budget.*

PR 1	Civil Society for HIV/AIDS in Nigeria (CiSHAN)
Address	4, Jaba Close, Off Dunukofia Street, Area 11, Abuja.

Civil Society for HIV/AIDS in Nigeria (CiSHAN) is a Non Governmental body, set up in August 2000 by the Nigerian Civil Society Organizations along with other stakeholders to be the umbrella coordinating body for the NGOs, CBOs and FBOs working within the Nigerian National Response CiSHAN has an official registration with the Corporate Affairs Commission as an NGO. The main objectives of CiSHAN include coordination and management of the civil society response, resource mobilization, advocacy, monitoring and evaluation and capacity building and enhancement.

Leadership and coordination: CiSHAN has about 2000 member organizations located within the 37 states of the Federation and in each state. Nationally, CiSHAN is coordinated by the National Office under the leadership of the Executive Secretary, who chairs the Management Team. The National Office and the Management Team reports to the Governing Council which is responsible for policy making, and for evaluating the work of the Management Team At the National Office, CiSHAN has 14 staff members, and over 400 Volunteers serving at the zones and states. In each zone there is a leadership which is elected into office for renewable terms of two years each. These zonal leadership teams coordinates give leadership to and mentor the activities of the six states under each zone. In each state, there is also a state leadership team made up of eleven elected members who oversee and give leadership to the activities of member organizations in each zone. CiSHAN also has twelve resource centers located in twelve states across the country.

In addition to coordinating the activities of the member organizations, CiSHAN is also responsible for the coordination of the Constituency Coordinating Entities which are Network of People Living with HIV/AIDS (representing the people living with HIV/AIDS; NYNETHA (representing youth led and youth focused organizations); SWAN (representing the women focused organizations); Media, Arts and Entertainment (representing the Mass Media); Diversity Network (representing the sexual minority focused organizations); and the Nigerian HIV/AIDS Research Network (representing the Research Focused organizations). CiSHAN thus represents the civil society within the national response. Its responsibilities to its members include capacity building, leveraging of financial resources, advocacy, M & E and participation in policy formulation and development.

Capacity Assessment and gaps: A capacity assessment conducted by UNDP in March 2007 on all PRs and SRs involved in GFATM R7 revealed some weaknesses and strengths of CiSHAN. (Pages 39 – 41 of report on capacity assessment of stakeholders involved in the implementation and management of global funds for HIV/AIDS, Tuberculosis and Malaria. Country Coordinating Mechanism, Principal Recipients, sub-recipients & implementing agencies. Some of the weaknesses include: low capacity of member organizations, irregular visits to zonal officers, inadequate staff at national office, reports from states to national office not sent on timely basis, weak management information system and inadequate M & E systems. In spite of the above, the closing statement made in the capacity assessment reveals a capacity gap and it states: "CISHAN occupies a central place in the fight against HIV/AIDS. Because of the urgency with which it addresses issues, CISHAN is paying more attention to its programme and activities as against its internal growth and development. Continuing in this direction will be counterproductive in the long term. There is therefore the need to renew concerted effort to put in place plans for CISHAN's organizational development." The revealed gap forms the basis for some of the activities provided for in the workplan and budget and in section 4.9.6.

Managerial capacities: CiSHAN has developed strong technical capacities in different areas of management. Overall management is provided by the Management Team which comprises of the Executive Secretary, the Finance and Administrative manager, the Programmes Manager and Communications/external relations Manager. The functions of these managers are as clearly stated in job descriptions and include the following:

The Executive Secretary chairs the management team meetings and has overall responsibility for day to day operation and implementation of CiSHAN projects. The Executive Secretary is also responsible for the finances of CiSHAN and is accountable to the Governing Council for resources and results. The Executive Secretary has a background in the social sciences and is a professional accountant as well, and has had over twelve years of national and international experience in developing and implementing HIV/AIDS programmes at national and regional level. The finance and administrative manager has oversight of finance and administrative related issues. The Programmes Manager is responsible for providing oversight for timely and effective implementation of projects, and of preparing reports to donors, partners and stakeholders. He provides technical support and guidance to programmes officers to who are delegated different projects for implementation. The communications and external relations manager oversees the communications and relationship building of CiSHAN with partners and donors. The manager also works on communications with zonal and state leadership teams of CiSHAN. Together the Management team provides leadership for the project staff and support staff in the National Office. CiSHAN has a procurement committee, which ensures procurement of goods, equipment and commodities in compliance with standard procurement procedures.

Financial Management capacity: Over the years, CiSHAN has developed its capacity in managing, reporting and disbursing financial resources. All the financial systems are computerized and all the donor funds and internal CiSHAN resources are kept by the computerized system. Competence in this area has been further enhanced under the GF R5. The Finance team is headed by a chartered accountant who serves as the manager. This person has a professional accounting qualification and over 10 years relevant post qualification experience in managing large grants, including USAID, DFID and GFATM grants. He is supported by two other staff (an accountant and a cashier) and one internal auditor who ensures compliance with standard financial procedure for all expenditures. CiSHAN financial statements are audited annually by a competent chartered accounting firm in line with the requirements of the Companies and Allied Matters Act of the Federal Republic of Nigeria. The Cash office is strengthened with iron bars serving as burglary protection, whilst there is provision for safes and cash boxes.

M & E Capacity: CiSHAN has developed a robust and dynamic M&E unit with a dedicated M & E officer. The unit's capacity has been improved over with the initiation of an electronic and computerized M & E platform, which is being built to capture information from the civil society organizations and communities. NACA and International HIV/AIDS Alliance based in Brighton, UK help provide the technical assistance for the capacity build up in M & E. The M & E capacity of the civil society and communities need to be further strengthened and is being further provided in the GF R8 proposal.

Procurement: CiSHAN has established a procurement system, and a procurement committee, which will handle all procurement issues under GF R8, in line with the CiSHAN Procurement policy and manual.

Partnerships and Networking: CiSHAN has developed partnerships and relationships with several national and international organizations which have in turn helped develop its capacity in different areas. Examples are: Management, financial management and M & E by International HIV/AIDS Alliance, based in Brighton, UK: Capacity in Advocacy and Campaigns was built by World AIDS Campaign, based in South Africa, Good Practices in Civil Society work is being done by Code of Good Practice based in Geneva and Policy and Leadership issues by ENHANSE based in Abuja.

Capacity of member organizations: CiSHAN has available, a wealth of technical expertise and experience, in all the thematic areas, through her member organizations, located in all the states of the Federation and Abuja.

All of the above have ensured effective performance by CiSHAN in the implementation of GFATM Round 5 as an SR. during which it was responsible for Care and Support, Stigma Reduction and Community activities.

PR 2	National Agency for the Control of AIDS (NACA)
Address	Plot 823, Ralph Shodeinde Street, Central Business Area, Abuja

The National Coordinating Authority for HIV/AIDS (NACA) was established by an act of parliament in 2007 under the supervision and control of the Presidency and governed by an expert multi sectoral representative Board. NACA has the legal mandate to plan, coordinate and facilitate the engagement of all tiers of Government and all sectors on issues of HIV/AIDS prevention, care and support; to formulate policies and guidelines on HIV/AIDS, to support HIV/AIDS Research; mobilize resources and coordinate equitable application, provide and coordinate linkages with the Global community on HIV/AIDS; to monitor and evaluate all HIV/AIDS activities in the Country and facilitate development and management of the policies and strategies of all sectors to ensure the human, financial and organizational resources to support the successful execution of the National

HIV/AIDS programme. NACA has the power to enter contracts within or outside Nigeria, with any persons, government or institutions, or any foreign country, for the purpose of combating HIV and AIDS.

Organizational capacity: With the support of development partners, NACA has effectively reengineered its structure, systems and further developed its core human resources to significantly enhance its managerial, technical and financial capabilities. NACA has over 70 core managerial, technical and support staff. It has successfully coordinated and managed complex programmes and achieved project goals, objectives and outputs across Nigeria including The World Bank HIV/AIDS Programme Development Project (HPDP) from 2002 to date involving 35 states. It is one of the three Principal Recipients for the Round 5 HIV Grant. It has successfully coordinated and managed the phased scale up of treatment across all states of Nigeria. NACA has also successfully coordinated the scale up of private sector work place policies and programmes in 12 States under Round 5. Under Round 5 GFATM NACA has achieved A1 rating.

The World Bank in 2006 upgraded the HPDP to its highest possible rating and in May 2007 approved an additional $50m for the project and extended its duration to June 2009.

Technical Capacity: NACA's senior and programme management staff has expertise in medicine, public health, hospital management, primary health care, epidemiology, research, pharmaceutics, policy, strategy, behavioral change communications, systems strengthening and planning, procurement and supply management and M&E.

Managerial Capacity: NACA adopts an integrated and comprehensive approach to major funding agencies and has avoided adopting a project approach. This allows the skills and resources of the whole organization to be directed towards major programmes and reduces transactional costs. The core team includes experienced and highly qualified HIV/AIDS, health services and public health managers with international, regional and national expertise. NACA has provided leadership in developing key platforms across all sectors and particularly across civil society and the organized private sector to coordinate the vibrant multi sectoral response through the National Strategic Framework, the National Priority Planning Process, key strategic documents and policies and in delineating roles and responsibilities with key partners and the health sector at Federal and State levels.

NACA's senior management has successfully innovated and brokered National Partnerships between the Federal Government of Nigeria, The GFATM represented by the CMM, The World Bank, USAID, The UN System and Clinton HIV/AIDS Foundation in greater collaboration, integration of support and funding and greater leverage of resources to achieve National targets. NACA is currently leading on the development of a joint funding agreement with the National Planning Commission and development partners to further reduce transactional costs through pooling of funding and alignment with the National priority planning process.

Financial Management Capacity: NACA has progressively developed its financial management capacity and developed computerized accounting and reporting systems that have been successfully rolled across all funding streams including Federal Government, The World Bank and Global Fund grants. NACA's financial systems and capacity has been evaluated and rated satisfactory by The World Bank and no audit objections have been received across Government, The World Bank and GFATM streams.

Development: NACA has enjoyed support from major development partners (World Bank, DFID, USAID, CIDA, UNDP and CHAI) to provide technical assistance in key areas including institutional development, systems strengthening and management development. Agreements are in place for further drawing down of support from these key partners and the Joint Funding Agreement being developed will also prioritize TA across the National response.

Independent evaluations: The World Bank prior to approving additional financing of $50m for the HIV/AIDS programme development project assessed the capacity of NACA and concluded that it has the institutional infrastructure to effectively utilize donor funds. On financial management, the assessment found them satisfactory and fiduciary risk is low. It also found the procurement management function to be satisfactory.

PR 3	Planned Parenthood Federation of Nigeria (PPFN)
Address	4, Baltic Crescent off Danube Street, Maitama, ABUJA

PPFN is a nation-wide NGO present in all 36 states of Nigeria and the FCT. It is the largest SRH NGO, with formally established structures (board of trustees, National Council/National Executive Committee, senior management team, and staff organized under zones, states, departments and units). PPFN has established linkages and good working relations with the government and other partners. It has over 4000 volunteers and 214 staff positions at the national headquarters and in the different regional/states. The PPFN was registered in 1984 under Nigeria's Company and Allied Matters Act, and is also an affiliate member of International Planned Parenthood Federation (IPPF). PPFN operates a decentralized decision making process reflecting its federal character comprising.

Core Competences: As an affiliate to IPPF, it has core competencies in clinical RHS and training. It leverages the experiences of international affiliate staff to bring to bear in all its clinical operations and training. It has 44 clinics delivering SRH/FP, with 10 out of the 44 offering integrated SRH and HIV/AIDS (prevention and care) services. PPFN also supervises 68 HIV counseling and testing sites under the Global Fund Round 5 grant.

Training and technical assistance: The organization has competence in centralized (national) training and technical assistance along with tailored, local-specific training, six regional training centers along with tailored, local-specific technical assistance within each region, training and TA to address advocacy and BCC/IEC; RH and contraceptive technology; quality of care; gender and reproductive rights; youth-friendly information and services; and project planning, proposal writing and project management.

Target, Client and Beneficiary Groups: PPFN focuses on seven groups i.e. Adolescents and young people in and out of school, aged 10-24, women in the reproductive age, leadership of relevant government and semi-government institutions/organizations, leadership and membership of civil society organizations, national and international donor organizations, media and academia and Corporate bodies

Partnership and Collaboration: PPFN collaborates with a large number and wide range of organizations within and outside SRH circles. Currently, PPFN is a member of various SRH and SRH-related coalitions and networks, including CiSHAN, National Association for Promotion of Adolescent Health and Development (NAPAHD), and Coalition of NGOs Health and Development (CONOPHD). Through these and other memberships and active participation in national task forces and committees, PPFN continues to contribute SRH expertise as needed.

Management and Staff Structure: PPFN has staff at National headquarters, regional, state and branch offices .The National HQ plays a three-fold role: supporting the field (six regions, which are the federating units); develops and implements national programs, and serves as national and international representative of PPFN.

PPFN Financial system and procedures: PPFN has an organized and well coordinated financial management system. The financial accounting system is driven by database software (2008 Premium Peach Tree multi-users). The software consolidates different donors or projects and chart of accounts makes rooms for reporting based on predetermined criteria such as segment, projects, location or period. The financial statements and management accounting and reports analysis is done by the same software and the preparation of the report is guided by structured tools such as PPFN Financial Manual; IPPF External Audit Manual. There is adequate delegation of authority and segregation of duties with necessary supervision and review. Individual project/donor funds are handled as separate entities with separate bank accounts. In addition, a petty cash imprest system is used for disbursements on routine expenses with necessary controls of authorization, approval and reconciliation before the replenishment is approved. PPFN applies a bottom-up approach in the preparation of its annual programme and budget; review, harmonization and finalization process. Budget monitoring is done through monthly preparation of management reports showing the comparison of budget and actual with analysis of variances. In the same vein, budget review and updates are done on quarterly and half–yearly basis for progress monitoring on the implementation and to consider necessary adjustments where applicable.

Management accounting reports are prepared on monthly and quarterly basis for basis of comparison of actual performance with annual budget and analysis. Strong emphasis is placed on half year management accounting report for the global review and adjustment of the annual budget. Quarterly, half year reports are consolidated for annual reports which are one of the statutory reports of all member associations of IPPF. Financial accounting reports are being prepared on annual basis in compliance with IAS, SAS. The reports are submitted to the external auditor, Akintola Williams Deloitte for an independent opinion on the true and fair view of the financial statements. The Organization's internal control system are guided by the following documentations, the Constitution, the financial manual, the Supplies and Logistics manual, the External Audit Manual, the

Procurement and Logistics Manual and the personnel Policy & Procedure Manual

Procurement and Supply Chain Management Capacity: The bulk of PPFN commodities are from IPPF donation and locally purchased items. PPFN has a central store at the Lagos liaison office which takes care of all incoming commodities. National headquarter supplies unit provides effective strategies for procurement, storage and distribution of commodities/materials to operational outlets of the state association units. A functional commodity and supply management system is maintained for effective management of commodities at headquarters and regional levels. At the national headquarters, PPFN maintains data base management information system, which keeps track of stores and maintain the inventory control management. PPFN stores are fitted with burglary proof and employed security personnel. In addition, all its stores are fully air-conditioned and all assets are insured. PPFN has registered and reputable suppliers who have been certified by relevant regulatory bodies and standard organization of Nigeria such NAFDAC, SON, Pharmaceutical Society of Nigeria, etc

Needs Assessment: An independent needs assessment conducted by Management Strategy for Africa (MSA) in 2004 prior to the development and subsequent implementation of PPFN strategic plan (2005-2009) revealed the following weakness in the organization's system, i.e. inadequate Management Information System; Data management system, LHMIS and M&E, inadequate Staffing at national and regional offices for its wide service provision and project activities. Though some changes have occurred over the years, these two areas still require strengthening for improved performance.

The strengths of IPPFN include full membership of the IPPF allowing access to world-wide membership experience and learning. This network ensures that PPFN operates within internationally recognized management, accounting and financial guidelines. National coverage, high caliber, capable staff at national, regional and state levels, a nation-wide infrastructure, ability to partner and network with other organizations and experience with the Global Fund mechanism as Sub-recipient in Rounds 5 (HIV/AIDS) and Round 4 (Malaria).

➔ ***Copy and paste tables above if more than three Principal Recipients***

4.9.2 Sub-Recipients

(a)	Will sub-recipients be involved in program implementation?	☐ Yes ☐ No
(b)	**If no**, why not?	
(c)	**If yes**, how many sub-recipients will be involved?	☐ 1 – 6 ☐ 7 – 20 ☐ 21 – 50 ☐ more than 50
(d)	Are the sub-recipients already identified? *(If yes, attach a list of sub-recipients, including details of the 'sector' they represent, and the primary area(s) of their work over the proposal term.)*	☑ Yes ***[Annex Number 4.9.2.]***

☐ No

Answer s.4.9.4. to explain

(e) **If yes**, comment on the relative proportion of work to be undertaken by the various sub-recipients. If the private sector and/or civil society are not involved, or substantially involved, in program delivery at the sub-recipient level, please explain why.

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i) NACA: NACA has provisionally selected about 18 SRs from the designated short list of 70+ organizations evaluated and identified by the Nigerian CCM as having capacity to undertake selective roles as part of the proposal and its integration within the National Response. The 15 SRs cover the public sector, civil society and the private sector and embrace regulation, policy and standards and curriculum development, capacity building, systems development, implementation and support to service delivery, BCC/Communications and M&E required under this proposal as part of the scale up of comprehensive services at the primary level and the expansion of the cluster network across Nigeria involving public, faith based (NGO) and private sector facilities. The expansion of private sector involvement will also include scale up of private sector work place policies and programmes and the piloting and scale up of community / private insurance schemes. The following table sets out the initial broad areas of responsibility, the SR provisionally selected and the sector the SR represents (e.g. P = Public sector PV = Private CS = Civil Society).

i. FMOH HIV/AIDS Division (Formerly NASCP)
ii. Family Health International
iii. HYGEIA Foundation
iv. Institute for Human Virology
v. Planned Parenthood Federation
vi. Federal Ministry of Education
vii. ActionHealth Inc
viii. British Broadcasting Corporation World Service Trust
ix. Society for Family Health
x. FMOH/DEPT OF PLANNING AND HEALTH RESEARCH
xi. NATIONAL PRIMARY HEALTHCARE DEVELOPMENT AGENCY
xii. Management Science for Health
xiii. Journalists Against Aids
xiv. Association of Reproductive and Family Health
xv. ACTIONAID
xvi. National Youth Service Corps
xvii. AIDSRELIEF
xviii. Harvard University/AIDS Prevention Initiative in Nigeria

Primary Area	Sub Recipients and sectors
Regulatory / Accreditation	FMoH (P); FMoE (P)
Policy & Guidelines	FMoH (P); FMoE (P)
Curriculum development	FMoH (P) FMoE (P)
Central training	FMoH/NIMR (P) MSH (CS)
Standard setting / QA	FMoH (P); FMOE (P)
Design Health Systems	FMOH (P) HYGEIA Foundation (PV) FHI (CS) IHV (CS) APIN(CS)
Site assessment & selection	FMoH (P); FMoE (P)NPHCDA (P)
Facility level training / Infrastructure development / system development & Implementation (scale up of comprehensive integrated programs and services at PHC and community level)	FHI-GHAIN (CS) SFH (CS) ARFH (CS) IHV (CS) HYGEIA Foundation (PV) MSH (PV) NPHCDA(P)
Health System Strengthening	FMoH (P):DHPR(P): (PV) SFH (CS)
Strengthening Civil Society Networks and CBOs	ACTIONAID (CS);
Behavior Change Communications –Mass media	BBC WST; SFH, JAAIDS

Piloting of private / community based insurance schemes	HYGEIA Foundation (PV) SFH (CS) ARFH (CS)
Scale up of HIV AIDS curriculum Schools	FMoE (P) ActionHealth Inc. (CS)
Development of community based communication strategies and BCC programmes	SFH (CS) Journalists Against Aids (CS)

i) CISHAN: This PR has identified six sub-recipients as follows:

a. Network of People Living with HIV/AIDS: Core Programme area: Stigma Reduction, care and support for PLWHA

b. Ministry of Women and Social Affairs: Care and support - OVC

c. National Youth Service Corps: BCC- Youth

d. Action Aid International Nigeria: Civil Society and Community Systems Strengthening

e. Interfaith coalition against HIV/AIDS in Nigeria: BCC, Prevention and HCT

f. National HIV/AIDS Research Network: Operations Research, M & E.

ii) Planned Parenthood Federation of Nigeria (PPFN) has identified three Sub-recipients as follows;

a) Institute of Human Virology, Nigeria (IHVN): Core programme area, HIV/AIDS Prevention (Laboratory Diagnostic, External Quality Assurance), Care and Treatment.

b) Association for Reproductive and Family Health: Core programme area, Sexual Reproductive Health services/ HIV/AIDS Prevention:

c) Adolescent Health and Information Projects (AHIP): Core Program area, Advocacy, Community organizing, Capacity Building and multi-level Partnerships for HIV/AIDS/Sexual and Reproductive Health

4.9.3. Pre-identified sub-recipients

Describe the past **implementation experience** of key sub-recipients. Also identify any challenges for sub-recipients that could affect performance, and what is planned to mitigate these challenges.

The past implementation experience of the sub-recipients affiliated to NACA are as follows:

i. Family Health International is an International NGO with offices worldwide. An implementing partner of USAID for the PEPFAR project and Also a GFATM Round 5 sub – recipient

ii. HIV/AIDS Division FMoH: The Lead Government division in charge of the Health Sector response to HIV/AIDS. Also a GFATM Round 5 sub – recipient

iii. HYGEIA Foundation: A charitable foundation of the Largest Nigerian Health Management Organization. One of the current implementers of the Round 5 grant that has an A1 rating

iv. FMOH/DPHR: A public sector ministry with the legal mandate to oversee health Plan development, HMIS and coordination of development assistance within the national response. Harvard /APIN – An international Organization in partnership with Harvard University that implemented the PEPFAR one in Nigeria.

v. AIDSRELIEF – a USG contractor implementing the PEPFAR program in Nigeria.

vi. Management Sciences for Health – an international NGO involved in Logistics management, treatment and training in Nigeria.

vii. BBCWST – A British Broadcasting Corporation World Service Trust engaged in mass media broadcast material development and capacity building. Key implementer within the DFID BCC initiatives.

viii. ActionHealth Inc. – A Nigerian NGO facilitated the development of the FLHE curriculum for the FMoE and implements substantial ARH interventions

ix. Society for Family Health is a national NGO in partnership with PSI. A principal recipient for objective 2 and a sub recipient for objective 5 of the GFATM Round 5 grant

x. Association for Reproductive and Family Health: A national NGO with expertise in Reproductive and Family Health and community based initiatives. Also a PR for the Round 5 HIV grant

xi. Institute of Human Virology Nigeria: A University of Maryland USA affiliate and a implementer of the PEPFAR programme in Nigeria

xii. Journalists Against AIDS: A Nigerian NGO with the capacity to handle communications and Behavioral Change Communications programmes
xiii. Federal Ministry of Education: The national ministry responsible for the implementation of the Family Life HIV/AIDS Education curriculum. It is also a successful implementer of the World Bank MAP programme in Nigeria
xiv. Institute of Human Virology, Nigeria (IHVN): Core programme area, HIV/AIDS Prevention (Laboratory Diagnostic, External Quality Assurance), Care and Treatment.
xv.

The implementation experiences of sub-recipients affiliated to PPFN are as follows:

i. The Institute of Human Virology Nigeria (IHVN) collaborates with the Ministry of Health and Nigerian Action Committee on AIDS (NACA). IHVN includes the ACTION Project, and also provides technical oversight for AIDS relief Project, Fogarty Scholars, the REACH Project, and the Doris Duke Foundation research. The organization provides medical training, clinical services and laboratory support to public and private sector organizations in HIV/AIDS prevention, treatment care and support and TB programmes. IHVN established systems including programme, financial and commodity management.
ii. The Association for Reproductive and Family Health (ARFH) is an indigenous national not-for-profit, NGO with the vision of enhanced SRH in Nigeria. Its mission is to initiate, promote, implement and manage in partnership with other organizations, sustainable SRH and family planning/HIV/AIDS programmes for youth and adults through training, TA, evaluation and operations research. Currently, under the Round 5 grant, ARFH is a PR for HIV/AIDS. It also managed various projects, such as Vision project, and Clinton Foundation project among others.
ii. Name of Organization: Adolescent Health and Information Projects (AHIP), a NGO, non-partisan and not for profit organization works in partnership with other CSOs, NGOs and stakeholders to empower young people and women. The major program thrusts of the organisation are in the areas of health, social and economic issues affecting young people and women. Areas of focus and strength includes: Advocacy, Community organizing, Capacity Building and multi-level Partnerships for HIV/AIDS SRH. The organization also provides leadership and mentoring support to other NGOs in Northern Nigeria to build their organisational capacity in integrating and expanding sexuality education programmes in their areas of operations.

The Implementation experiences of organisations affiliated to CISHAN are as follows:

a. Network of People Living with HIV/AIDS: The National Network of PLWHA, with about 400 Support Groups registered. NEPWHAN is an SR under the ongoing GF R5. It has also has experiences in implementing PEPFAR projects.
b. Ministry of Women Affairs and social affairs: The Lead Government ministry on issues of OVC. It is a GFATM R5 Sub recipient for OVC
c. National Youth Service Corps: It is the Government ministry in charge of the Youth Corp Scheme which trains Peer Educators and places them in communities all over the nation. It is a Sub recipient under GFATM R5
d. Action Aid International Nigeria: A Nigerian NGO which is an affiliate of Action Aid International. It has valuable experience in forming, training and empowering networks. It has implemented several significant projects with national and international scope.
e. Interfaith Coalition Against HIV/AIDS: a national network of Faith Based organizations involved in the national HIV/AIDS response.
f. National HIV/AIDS Research Network: a network of researchers on HIV/AIDS, registered as an NGO with the Government of Nigeria. Has a membership that includes some of the topmost researchers on HIV/AIDS in Nigeria. It has successfully implemented several operations research projects and hosted national conventions of scientists.

4.9.4. Sub-recipients to be identified

Explain why some or all of the sub-recipients are not already identified. Also explain the transparent, time-bound process that the Principal Recipient(s) will use to select sub-recipients so as not to delay program performance.

Not applicable – All sub-recipients were identified

4.9.5. Coordination between implementers

Describe how coordination will occur between multiple Principal Recipients, and then between the Principal Recipient(s) and key sub-recipients to ensure timely and transparent program performance.

Comment on factors such as:

- **How Principal Recipients will interact where their work is linked** *(e.g., a government Principal Recipient is responsible for procurement of pharmaceutical and/or health products, and a non-government Principal Recipient is responsible for service delivery to, for example, hard to reach groups through non-public systems)*; and

- **The extent to which partners will support program implementation** *(e.g., by providing management or technical assistance in addition to any assistance requested to be funded through this proposal, if relevant).*

Under the Round 5 grant which is still running, the multiple PR established a coordination platform which meets regularly to share reports, experiences, plans etc and coordinate procurement and other related or interlinked functions. This forum is called the Project Coordination Committee (PCC). These meetings are always attended by the CCM chair. The PCC also reports periodically to the CCM. These meetings are held monthly, with adhoc meetings depending on needs. The coordination is documented in a memorandum of understanding. These modalities were agreed in a retreat at the beginning of the implementation of the Round 5 grant.

The Round 8 proposal also proposes a similar model for coordination of the three PRs that have been selected to lead implementation of the grant if approved.

Coordination of SRs and PRs: This will replicate the Round 5 coordination PR-SR quarterly meetings of all PRs and SRs along with partners providing technical support to the program.

Technical support for the implementation of the Global fund grant round 5 was contributed by partners like Clinton HIV/AIDS Initiative(CHAI) (complementary pediatric drug and technical skills donation);the World bank supports through state credits for health infrastructure while and the USG PEPFAR leverages the equipment access and capacity training to the round 5 implementation. An MOU has been signed between these partners, implementers and local authorities. Measure evaluation provides M&E capacity building to PRs and SRs while Institutional capacity support e.g. IT, Computing support, accounting system support is provided by the World Bank.

4.9.6. Strengthening implementation capacity

The Global Fund encourages in-country efforts to strengthen government, non-government and community-based implementation capacity.

If this proposal is requesting funding for management and/ or technical assistance to ensure strong program performance, summarize:

(a) the assistance that is planned;**

(b) the process used to identify needs within the various sectors;

(c) how the assistance will be obtained on competitive, transparent terms; and

(d) The process that will be used to evaluate the effectiveness of that assistance, and make adjustments to maintain a high standard of support.

*** (e.g., where the applicant has nominated a second Principal Recipient which requires capacity development to fulfill its role; or where community systems strengthening is identified as a "gap" in achieving national targets, and organizational/management assistance is required to support increased service delivery.)*

TWO PAGE MAXIMUM

A. In order to facilitate effective utilization of both human and material resources at various level of programme implementation, each of the three PRs has planned series of needed assistance. NACA plans to complement the existing work force by the recruitment of an assistant Director of programmes, two additional M & E Officers and two assistant procurement officers to oversee the capacity building and start up of services at the primary level. PPFN planned acquisition of a web-based software to effectively drive the Logistics and Health management Information Sytem and facilitated automated operation for data management to be able to improve from manual to automated operations while at the same time Strenghten its M&E systems by establishing M&E units in its regional and state offices.. Other areas of assistance needed is in the area of program management and support services. CiSHAN's planned assistance include recruitment of a project coordinator, Zonal program managers, Internal auditor, accountant, IT manager, Admin/procurement manager, secretarial staff and drivers and the re-training of existing and new staff in the areas of Financial and project management, monitoring and evaluation and procurement

For the SRs, NACA has 15 sub recipients which include government and non- governmental organizations. Out of this number, NACA plans to access Technical Assistance, both International (Short term & intermittent) and National, for seven of them that have limited or no track record of GFATM work, in key areas such as GFATM policies and procedures, management support, financial management and mentoring capacity. To strengthen its 3 SRs, PPFN planned to provide Quality assurance training for them, and support the recruitment of additional staff for each of them to provide administrative, programme management and monitoring and evaluation support to the project. CiSHAN planned system stregthening TA for its SRs that have participated in the GFATM in the past and provide TA in orientation on GFATM policies and procedures, management support, financial management and capacity training for those SRs with no track record of GFATM.

For the key players at the actual project implementation level, the CBOs, FBOs, would have their capacity strengthened in project management. The Programme managers and unit heads at the secondary and PHC facility level will be trained in coordination, leadership and management to be able to coordinate the effective integration of PMTCT into maternal and child health in the overall context of Sexual and Reproductive Health. Since the integration of all these diverse units needs effective coordination. The support groups and caregivers for orphans and vulnerable children will be trained on psycho social support, Home based care as well as community care and support services for PLWHA and OVC.

B. In order to determine technical assistance needs as highlighted above, the draft CCM Consolidated Report of Capacity Assessment of Stakeholders Involved in the Implementation and Management of Global Funds for HIV/AIDS, Tuberculosis and Malaria was reviewed. Parts of its recommendations include recruitment of additional staff for the present PRs and SRs, and proper orientation of new SRs to strengthen capacity. Apart from that, An independent needs assessment conducted by Management Strategy for Africa (MSA) in 2004 prior to the development and subsequent implementation of PPFN strategic plan (2005-2009), and IPPF accreditation and assessment report of November 2006 was also used to determine the assistance needed by PPFN.CiSHAN relied on the organizational assessment report conducted by UNDP in the year 2006; an assessment conducted by International HIV/AIDS Alliance in 2007 and another internal assessment carried out in 2008 using the template and framework provided by International HIV/AIDS

Alliance Brighton, UK. The assessments identified shortage of staff, need for strengthening the MIS, procurement of project vehicle. All the above will be carried out as well as the need for orientation of SRs that are new to GFATM

C. All the PRs will adopt World Bank procurement procedures and their procurement Staff include Specialists with expertise to comply with World Bank procedures for the sourcing and selection of consultants in accordance with Bank procedures

Terms of reference and contracts used to hire consultants include clear standards of performance and deliverables to be achieved (Outputs) as determined by the PRs senior management and key technical Staff. The deliverables expected from these contracts are based on performance criteria dictated by the GFATM performance agreements signed with the PRs and between the PRs and respective SRs. Each TA is assessed and performance QA undertaken on a periodic basis and at the end of the individual assignments before final payment is made under the contract. The PRs are developing a pool of quality TAs and have access to support from several International Development partners for specialized TAs. In cases where gaps are identified, the PRs' in- house management, technical and specialist staff will be available to mentor and provide guidance to indigenous Nigerian consultants to provide feedback and support to achieve required standards and support the long-term development of local consultants.

4.10. Management of pharmaceutical and health products

4.10.1. Scope of Round 8 proposal

Does this proposal seek funding for any pharmaceutical and/or health products?	☐ **No** ➔ ***Go to s.4B if relevant, or direct to s.5.*** ☐ **Yes** ➔ ***Continue on to answer s.4.10.2.***

4.10.2. Table of roles and responsibilities

Provide as complete details as possible. *(e.g., the Ministry of Health may be the organization responsible for the 'Coordination' activity, and their 'role' is Principal Recipient in this proposal). If a function will be outsourced, identify this in the second column and provide the name of the planned outsourced provider.*

Activity	Which organizations and/or departments are responsible for this function? *(Identify if Ministry of Health, or Department of Disease Control, or Ministry of Finance, or non-governmental partner, or technical partner.)*	In this proposal what is the role of the organization responsible for this function? *(Identify if Principal Recipient, sub-recipient, Procurement Agent, Storage Agent, Supply Management Agent, etc.)*	Does this proposal request funding for additional staff or technical assistance
Procurement policies & systems	Federal Ministry of Health (DFDS/Procurement Unit), NACA (PSM)	Sub-recipient Principal Recipient	☒ Yes ☐ No
Intellectual property rights	Ministry of Commerce and Ministry of Justice	Patent Regulatory Institution	☐ Yes ☒ No
Quality assurance and quality control	NAFDAC SON	Food and Drug Regulator Control Compliance with national and international standards	☐ Yes ☒ No
Management and coordination	Federal Ministry of Health NACA	Sub-recipient Principal Recipient	☒ Yes

More details required in s.4.10.3.			☐ No
Product selection	Federal Ministry of Health	Sub-recipient	☉ Yes ☐ No
Management Information Systems (MIS)	SCMS	Supply Management Agent	☉ Yes ☐ No
Forecasting	SCMS	Supply Management Agent	☉ Yes ☐ No
Procurement and planning	Federal Ministry of Health, Outsourced to Crown Agents and International Dispensaries Association (IDA)	SR Procurement Agent Procurement Agent	☉ Yes ☐ No
Storage and inventory management *More details required in s.4.10.4*	Federal Ministry of Health, CMS	SR Warehousing Agent	☉ Yes ☐ No
Distribution to other stores and end-users *More details required in s.4.10.4*	Will be sub-contracted to several firms e.g. CHAN MEDI PHARM DARLEZ	Distribution Agent	☉ Yes ☐ No
Ensuring rational use and patient safety (pharmacovigilance)	NAFDAC	Regulatory Institution	☉ Yes ☐ No

4.10.3. Past management experience

What is the past experience of each organization that will manage the process of procuring, storing and overseeing distribution of pharmaceutical and health products?

Organization Name	PR, sub-recipient, or agent?	Total value procured during last financial year *(Same currency as on cover of proposal)*
IDA	Procurement Agent	$20million
CROWN AGENT	Procurement Agent	$160million
Federal Ministry of Health	SR	$7million
CHAN MEDI PHARM	Distribution Agent	$20Million
DARLEZ	Distribution Agent	$4million
Federal Ministry of Health – CMS	(SR) (Warehousing)	$30million

4.10.4. Alignment with existing systems

Describe the extent to which this proposal uses existing country systems for the management of the additional pharmaceutical and health product activities that are planned, including pharmacovigilance systems. If existing systems are not used, explain why.

ONE PAGE MAXIMUM

This proposal will use the existing national systems for product regulation, quality and safety control,

compliance with Trade Related Intellectual Property Rights (TRIPS), commodity procurement, warehousing and distribution. However, where there are limitations in capacity of existing systems, this grant will either utilize project resources to strengthen the capacity of the relevant institutions, or the services will be outsourced to private firms. In particular, this proposal will ensure that the procurement and supply management functions relating to the various stages are handled as follows:

- The National Agency for Foods and Drugs Administration and Control (NAFDAC), a statutory regulatory body in Nigeria for food and pharmaceutical products will be responsible for overseeing the processes of assuring product quality and safety for health and pharmaceutical products procured in the Round 8 proposal. NAFDAC will also monitor all reported cases of adverse drug reaction occasioned by the implementation of the Grant.
- Nigeria as a member country of World Trade Organization (WTO) and a signatory to Trade Related Intellectual Property (TRIPS) will ensure strict adherence to intellectual property regulations in all operations related to this grant. The Federal Ministry of Justice will ensure compliance with relevant IPR and WTO agreements.
- The procurement of pharmaceutical and health products in the proposal will align with the existing national procurement and supply chain management backbone. This backbone addresses both local and international procurement which ensures compliance with due process as enshrined in the National Procurement act of 2007.
- The planned upgrading of the existing infrastructure at the Central Medical Stores in this proposal will provide additional capacity required for the storage of pharmaceutical and health products in the proposed grants. This will ensure that procurement and warehousing of these commodities is aligned to national systems.

4.10.5. Storage and distribution systems

(a) Which organization(s) have primary responsibility to provide storage and distribution services under this proposal?

- ☑ National medical stores or equivalent
- ☐ Sub-contracted national organization(s) *(specify)*
- ☐ Sub-contracted international organization(s) *(specify)*
- ☐ Other: *(specify)*

(b) For storage partners, what is each organization's current **storage capacity** for pharmaceutical and health products? If this proposal represents a significant change in the volume of products to be stored, estimate the relative change in percent, and explain what plans are in place to ensure increased capacity.

The Central medical Store is currently responsible for warehousing of all pharmaceutical and medical products for HIV/AIDS programme. The warehouses of the central medical stores are located in Lagos. There are also six zonal medical stores under the central medical stores, all run by the Federal Ministry of Health. These facilities will be available to the procurement and supply chain management of medical and pharmaceutical commodities procured under this proposal.

The proposed scale up of services under this Round 8 proposal involves a massive increase in the volume of commodities which demands more storage capacity at the central, zonal and facility level. It is estimated that the current storage capacity at CMS can accommodate about 70% of the projected commodity needs for the Round 8 proposal. Therefore, there is need for expansion of storage space at Central level by 30%. Similar constraints are anticipated at facility, zonal and facility levels.

The plan is to upgrade and utilize existing structures within CMS premises and outsource the warehousing of some of the commodities to private organizations. This activity is included in the HSS component of the

proposal

(c) For distribution partners, what is each organization's **current distribution capacity** for pharmaceutical and health products? If this proposal represents a significant change in the volume of products to be distributed or the area(s) where distribution will occur, estimate the relative change in percent, and explain what plans are in place to ensure increased capacity.

The National Programme embraces the private–public initiative for distribution of medical and pharmaceutical products. The current capacity is estimated to be about 65%. To meet the expected expansion in distribution of commodities, this proposal will invest in upgrading the current distribution capacity in terms of staff strengthening and training, and increase the fleet of distribution trucks.

In the project that will arise from approval of this grant, it is proposed that peripheral distribution of commodities from central medical stores warehouses to zonal warehouses as well as from zonal warehouses to peripheral facilities will be outsourced to private companies. The outsourced companies will be required to demonstrate the capacity to distribute the commodities timely, efficiently and professionally, and maintain adequate security controls. It is expected that at least seven companies will be contracted, each to serve peripheral distribution of commodities in the corresponding zone.

Clarified section 4.10.6

4.10.6. Pharmaceutical and health products for initial two years

Complete 'Attachment B-HIV' to this Proposal Form, to list all of the pharmaceutical and health products that are requested to be funded through this proposal.

Also include the expected costs per unit, and information on the existing 'Standard Treatment Guidelines ('STGs'). **However**, if the pharmaceutical products included in 'Attachment B-HIV' are not included in the current national, institutional or World Health Organization STGs, or Essential Medicines Lists ('EMLs'), describe below the STGs that are planned to be utilized, and the rationale for their use.

All the listed pharmaceuticals in Attachment B-HIV are included in both the National Standard Treatment Guidelines and WHO Standard Treatment Guidelines.

4.10.7. Multi-drug-resistant tuberculosis

Is the provision of treatment of multi-drug-resistant tuberculosis included in this HIV proposal as part of HIV/TB collaborative activities?

☐ Yes

In the budget, include USD 50,000 per year over the full proposal term to contribute to the costs of Green Light Committee Secretariat support services.

☐ No

Do not include these costs

4B. PROGRAM DESCRIPTION – HSS CROSS-CUTTING INTERVENTIONS

Optional section for applicants

SECTION 4B CAN ONLY BE INCLUDED IN ONE DISEASE IN ROUND 8 and only if:

- *The applicant has identified gaps and constraints in the health system that have an impact on HIV, tuberculosis and malaria outcomes;*
- *The interventions required to respond to these gaps and constraints are 'cross-cutting' and benefit more than one of the three diseases (and perhaps also benefit other health outcomes); and*
- *Section 4B is not also included in the tuberculosis or malaria proposal*

Read the Round 8 Guidelines to consider including HSS cross-cutting interventions.

'Section 4B' can be downloaded from the Global Fund's website here if the applicant intends to apply for 'Health systems strengthening cross-cutting interventions' ('HSS cross-cutting interventions').

~~***OPTIONAL ADDITIONAL SECTION FOR ONE DISEASE IN ROUND 8 GLOBAL FUND PROPOSALS***~~

Copy the material under this text box into the applicant's Round 8 proposal form after s.4.9.7 (for either HIV or Tuberculosis proposals) or after s.4.9.6 (Malaria proposals).

SECTION 4B CAN ONLY BE INCLUDED IN ONE DISEASE IN ROUND 8 and only if:

- *The applicant has identified gaps and constraints in the health system that have an impact on HIV, tuberculosis and malaria outcomes;*
- *The interventions required to respond to these gaps and constraints are 'cross-cutting' and benefit more than one of the three diseases;*
- *Section 4B is not also included in another disease in the Round 8 proposal;*
- *The applicant is requesting funding for disease interventions (e.g., provision of ARVs to people in need). That is, HSS cross-cutting interventions **ARE NOT** offering a HSS only component in Round 8; and*
- *The applicant also downloads 'Section 5B' from the Global Fund website and includes it **after s.5.5** in the same disease proposal **as the applicant has inserted this section 4B**.*

➔ ***Read the Round 8 Guidelines to consider including HSS cross-cutting interventions***

4B.1 Description of 'HSS cross-cutting intervention'

➔ ***Refer to the Round 8 Guidelines for information completing this section.***

Title: Intervention 1 ** *(Change number for each intervention)*	Strengthened basic health service systems to scale up ATM interventions through accelerated national roll-out of the Ward Minimum Health Care Package
Beneficiary Diseases: *(e.g., HIV, tuberculosis, and malaria?)*	All
WHO "Building Block" category *(Refer to the Round 8 Guidelines)*	Good health service delivery, i.e. the ability to efficiently deliver effective, safe, quality personal and non-personal interventions to those who need them.

(a) **Description of rationale for and linkages to improved/increased outcomes in respect of HIV, tuberculosis and/or malaria:**

Given the health system constraints in Nigeria (set out in sections 4.3.2 in the HIV/AIDS, TB and Malaria proposals), five mutually reinforcing cross-cutting HSS interventions are proposed. These encompass measures to strengthen (i) the primary health care service system; (ii) supply chain management (to ensure consistent access to quality and safe drugs at the facilities receiving support); (iii) the national health information system, and (iv) leadership and governance – in relation to PHC service delivery at the LGA level. (In accordance with the 1999 Constitution, LGAs are responsible for day-to-day PHC service delivery in Nigeria.) The fifth SDA addresses community systems strengthening. (These are covered in detail in the following sections.)

These actions are proposed in the light of HSS concerns expressed about Round 7 and earlier Global Fund submissions – where HR, and integrated information and supply chain issues have all been highlighted. Equally important, the proposed actions will accelerate implementation of key national health policies and strategies.

The National Health Bill, approved by the National Assembly in May 2008, and now awaiting Presidential assent, legislates that "all Nigerians shall be entitled to a guaranteed minimum package of services". (Annex 1 : Part 1, 3 (3).) In 2007, the Ward Minimum Health Care Package (WMHCP) 2007-2012 (Annex 2) was ratified and adopted by the Nigerian National Council on Health as a minimum standard for the delivery of primary health care services in Nigeria. Several states have adapted the WMHCP and developed their own minimum service packages (MSP). The WMHCP (and all state MSPs) encompass Malaria, TB, HIV/AIDS and Reproductive Health (RH).

With the measures to be supported in this proposal, the planned facility refurbishment and re-equipping via the GAVI HSS strengthening support (approved in early 2008), and other planned efforts (including those being supported via World Bank and other development partners), Nigeria will be in a position to achieve the national target of 50% of PHCs implementing the Ward Minimum Health Care Package (WMHCP) by 2013. (Currently, less than 15% of wards have at least one fully functioning PHC facility.)

The PHC service strengthening actions will combine :

a) basic **refurbishment** and equipping of 925 primary health care facilities. This refurbishment will directly complement the on-going national government plans to construct an additional 100 new PHCs annually in wards where these do not currently exist, and the proposed GAVI financed PHC refurbishment covering an additional 960 facilities. (Annexes 3, 4 and 5 MDG workplan 2007; FMOH 2009-2011 MTSS; GAVI HSS Proposal 2007.) Only limited refurbishment will be undertaken in the 925 PHC facilities selected to participate in the GF Round 8 grant implementation. The aim will be to complete the minimum refurbishment and re-equipping required to enable quality HIV/AIDS, TB, Malaria and Reproductive Health (RH) services to be provided. Factors such as ensuring privacy, safe storage, effective waste management and infection control will all be taken into account in deciding what actions will be required in a given facility. The re-equipping will include (inter alia) the provision of microscopes.
b) instituting preventative **maintenance** systems (for refurbished and new facilities) at LGA level. Here, the approach which has been developed and implemented in Enugu state (based on successful practice in a faith based hospital) is being adapted for application at the LGA level. (Annex 6 PATHS Technical Brief : Developing a Planned Preventive Maintenance Culture in Enugu.) In addition, training on first-line maintenance is being introduced into programs offered at the four national schools of biomedical engineering;
c) **integrated training** to address the immediate challenge of upgrading technical and managerial competencies of PHC workers. This instruction will combine updating knowledge and skills in relation to HIV/AIDS, TB, Malaria and Reproductive Health (RH), with training to enable individuals to refresh and regain the other competencies which enable them to be effective primary health care workers. These latter range across inter-personal

communication, the collection and use of data (and the roles of individual workers in the NHMIS), infection control and waste management, reporting, monitoring and evaluation and other management responsibilities, and the roles that PHC staff should embrace in liaising with the community. Implementation will encompass revising training modules, training of trainers, and step-down roll-out of the actual training through a series of two- and one-week training 'courses' (with the former to cover technical issues, and the latter to focus on managerial and other competencies). This training proceed in parallel with, and draw from, the equivalent training being introduced for the staff of 960 PHCs in 100 LGAs as part of the forthcoming GAVI HSS initiative.

d) Ensuring **integrated supportive supervision** (ISS) by LGA PHC managers and program coordinators for PHC staff and facilities. In addition to disease specific service delivery, this supervision will span information systems, drug supplies, infection control and maintenance. A key first step in rolling this out will be agree processes, guidelines and checklists. ISS has already been introduced in some states, and some LGAs are now committing the funds to cover the necessary overhead costs.

The National Primary Health Care Development Agency (NPHCDA) will lead in implementing these actions, given its role in steering the national roll-out of the WMHCP. Since merging with the National Program on Immunization in 2007, the NPHCDA has completed a detailed functional review, and developed a new draft PHC strategic plan (in February 2008).

A fundamental aim in proposing these actions is to restore public confidence in primary health care services in Nigeria, and thereby reverse declines in the utilization of PHC facilities. (See Round 8 Malaria proposal, sections 4.3.2 and 4.3.3). Fully functional PHC facilities constitute the foundation for effective community based ATM interventions and other PHC outreach services. ATM (and other health) services at primary care level are delivered by the same (or set of) health workers. Without a sufficient degree of integration of systems and activities, not only are opportunities for synergies being missed, but the risks are greater of some aspects of PHC suffering as an unintended consequence of efforts in other programmes.

To implement this SDA, Memoranda of Understanding (MOU) will be agreed between the NPHCDA and each of the 185 LGAs. This MOU will set out "mutual commitments", covering both what the LGA will contribute in terms of staffing and overheads (recurrent costs), and what support will be forthcoming for the LGA in the form of one-off, and ongoing inputs (funded through this proposal). (If appropriate, this MOU may also be used for other national inputs into LGA PHC activities, including any finances made available through the MDG Debt Relief Gain (DRG) initiative, or via the National Primary Health Care Development Fund to be set up once the National Health Bill finally becomes law.

Following the merger with NPI, NHPCDA has initiated a number of institutional and capacity strengthening efforts. These will continue (drawing on support as necessary through other avenues). A key element of this ongoing capacity building is the enhancement of the Agency's zonal and state level capabilities in supporting and steering PHC strengthening at the LGA level. To complement the role and strengths of NPHCDA, and as part of helping build capacities to deliver on these activities, Family Health International Nigeria (FHI) and Institute for Human Virology Nigeria (IHVN) are co-SRs. These organizations will bring to bear their expertise in training (especially for ATM), supervision, mentoring and other core technical areas.

These HSS actions will be directly linked with the parallel SDAs proposed in the HIV/AIDS, TB and Malaria proposals. The HIV/AIDS, TB, ad Malaria activities include PMTCT and HCT (HIV/AIDS), TB DOTS and AFB microscopy (TB) and RDT and clinical management of malaria.

MAXIMUM ONE PAGE FOR EACH ACTION

(b) **Indicate below the planned outputs/outcomes** *(through a key phrase and not a detailed description)* that will be achieved on an annual basis from support for this HSS cross-cutting intervention during the proposal term. ➔ *Read the Round 8 Guidelines for further information.*

Year 1	Year 2	Year 3	Year 4	Year 5
PHC workers gaining upgraded technical, managerial and other essential skills	Upgraded and fully equipped PHC facilities in 10% of wards	Integrated supervision verifying that PHC workers are applying upgraded skills	Effective Ward Development Committees preparing ward health plans	Increased utilization of, and access to, quality PHC services

(c) **Describe below** other current and planned support for this action over the proposal term

*In the left hand column below, please identify the name of **other providers** of HSS strategic action support. In the other columns, please provide information on the type of outputs.*

Name of supporting stakeholder ↓	**Timeframe of support for HSS action**	**Level of financial support provided over proposal term** *(same currency as on face sheet of Proposal Form)*	**Expected outcomes from this support**
Government	2009-2011 : Medium Term Sector Strategy (updated annually, for next 3 years)	$240 million over 5 years (based on $142.3 million for PHC service strengthening in 2009-2011 MTSS)	Ward Minimum Health Care Package provided in 'functional' PHC facilities
Other Global Fund Grants (with HSS elements (*if applicable*)			
Other : GAVI HSS grant (approved 2008)	2008-2011	$32.5 million	Rehabilitated, re-equipped PHC facilities, with retrained staff
Other: World Bank HSDP II extension	2008-2010	$50 million (total project cost)	Rehabilitated, re-equipped PHC facilities, with retrained staff (in selected states)
Other: PATHS 2; DFID financed HSS and governance initiative	Q3, 2008 to Q3, 2014	$36 million	Improved planning, financing and management systems which support delivery of public health services in up to six States
Other: SPARC; DFID financed governance initiative	Q3, 2008 to Q3, 2014	Not yet agreed. Directly attributable financial support undecided at this stage.	Nigeria's own resources used efficiently and effectively to achieve MDGs (e.g. Increased and predictable State and LGA level allocations for health, education, and other priority LGA public services)
Other: PAVS; DFID financed voice and accountability initiative	Q3, 2008 to Q3, 2012	Not yet agreed. Directly attributable financial support undecided at this stage.	Nigeria's own resources used efficiently and effectively to achieve MDGs (e.g. Strengthened community voice for public service provision (including health) responsive to local and national priorities)
Other: *(identify*			
Other: *(identify)*			

Note: ***If relevant copy and paste this section for up to five 'HSS cross-cutting interventions' for which funding is requested in Round 8. Re-number each new box as 'Intervention 2', 'Intervention 3' etc.***
*****That is: separate out each major area of HSS cross-cutting support into a new table to ensure clarity about***

what is being requested *(e.g. Intervention 1: strengthening supply chain management of health products; Intervention 2: introducing an innovative health insurance framework targeting the poor; Intervention 3: strengthening diagnostic services at the rural and local level on a cross-functional disease basis to encourage the rationale, non-disease specific use of resources, etc).*

4B.2 Engagement of HSS Key Stakeholders in Proposal Development

(a) Briefly describe **which** and **how** important HSS stakeholders *(e.g., ministries of planning, finance etc)* have been involved in the identification and development of appropriate HSS cross-cutting interventions for this Round 8 proposal, **and how** coordination of the proposed HSS cross-cutting interventions has been ensured across the three diseases (and, where relevant, beyond).

The proposed health system strengthening SDAs (interventions) included in this proposal were agreed following consultations and discussions on priorities in May 2008, and reaffirmed at the CCM on 24-25th June. Participating in these discussions were representatives of the Departments of Health Planning Research and Statistics, Public Health (including the HIV/AIDS, TB and Malaria Programs), Food and Drugs in FMOH, and the National Primary Health Care Development Agency. The starting point for these consultations and discussions were a) the main HSS needs and gaps identified by the three ATM programs, and b) the national status of HSS – as expressed in national health policies and health sector reform strategies.

In targeting the HSS cross-cutting gaps most immediately relevant for improving ATM program performance, the selected SDAs are where there are both national policies and strategies and agreed strategic plans for implementing these policies and plans. (This does not yet apply to health financing – where there is a policy (revised in 2006), but not yet an implementation plan. For the remaining WHO HSS building block, "effective leadership and governance", the community level leadership and governance concerned are addressed in the Community System Strengthening SDA.

These detailed interventions have then been progressively refined by a HSS drafting team in association with key officials and others who will have the primary roles in leading and steering subsequent implementation. For NHMIS, this dialogue has been with Department of Health Planning Research and Statistics - with ongoing inputs from the Director, HPRS, and from the NHMIS Units. For Services, NHPHCDA have been continuously involved, and discussions have been held with a representative of the Committee on Biomedical Engineering. For supply chain management issues, the Food and Drugs Department, Department of Health Planning Research and Statistics, and Department of Public Health have all contributed extensively.

In the course of all these discussions, contributions have been received from :

- the proposal writing teams of HIV/AIDS, TB and Malaria
- the Directors of Health, Planning Research and Statistics, Food and Drugs, and Public Health in FMOH;
- officials in : the NHMIS unit and Human Resources unit in DHPRS; the NTBLP, NMCP, and HIV/AIDS Divisions in Public Health; Logistics Division in Food and Drugs; Federal Staff Hospital in Hospital Services (as a representative of the Medium Term Planning Committee on Biomedical Engineering); and the Budget division in Finance and accounts
- Deputy Director, PRS in NPHCDA
- CSOs working in the ATM domains
- WHO, USG, World Bank and DFID amongst development partners
- private sector bodies and foundations: HYGEIN, Packard Foundation
- consultants : Budgeting, Gender and HSS

A HSS presentation was made to the HIV/AIDS, TB and Malaria Round 8 drafting groups on 16th June. This highlighted key issues in relation to community level actions, laboratory services, and information systems. Further refined proposals have subsequently been shared with some of the key development partners – especially those already providing or are planning HSS support initiatives. This includes WHO, DFID, USAID, and World Bank.

Beyond this recent direct stakeholder participation, the proposals also draw very extensively on other HSS and ATM program debate and consultation over the past two years. The WMHCP was finalized in 2007 after some 18 months of dialogue, during which time there were 5 major stakeholders meetings with LGAs and States health officials, representatives of federal agencies, developmental partners and the private sector all having a number of opportunities to contribute. Other consultation was via the internet and some expert reviews. Final ratification of the WMHCP was by the National Council on Health (the highest policy body) in Nigeria in November 2007. This has ensured that the WMHCP is acceptable nationwide.

The Round 8 proposal also draws on the emerging experience now starting to be documented in some states and local governments. The Planned Preventive Maintenance approach extends a successful pilot initiative in Enugu. Building from this, the Technical Committee on Medium Term Plan for Biomedical Engineering Training is now

deliberating options for how the four Biomedical Engineering Centres can play an extended role in strengthening first-line maintenance at primary and secondary care levels. (Annex 7 Biomedical Engineering Trainining Committee minutes 17 June 2008, p3)

During, April and May 2008, the Federal Ministry of Health completed the annual updating of the Federal Health Medium Term Sector Strategy (MTSS). (The MTSS is a form of Medium Term Expenditure Framework.) This latest MTSS has been prepared by a Federal health Technical Working Group, comprising Planning Cell representatives from through-out the federal health system. A key part of the MTSS process is to prioritize all proposed federal health initiatives. This Round 8 proposal reflects the priorities articulated in the draft 2009-2011 MTSS.

(b) Has the CCM (or Sub-CCM) ensured that:

(i) the HSS cross-cutting interventions in this proposal do not repeat any request for funding under any of the specific disease components (section 4.6 of each disease)?; and ☑ Yes

(ii) the detailed work plan** **and the** 'Performance Framework'** (Attachment A) for this disease includes separate worksheets which clearly identify the HSS cross-cutting interventions by objective, SDA, and activity for the initial two years of the proposal? ☑ Yes

** *Applicants may prepare a separate **work plan** for the HSS cross-cutting interventions and a separate '**Performance Framework**' (Attachment A) if they prefer.*

4B.3 Strategy to mitigate initial unintended consequences

If there are some perceived initial disruptive consequences of the planned investment in any or all of the HSS cross-cutting interventions set out in section 4B.1 above *(e.g., human resource movement or loss for other services)*:

- What were the factors considered when deciding to proceed with the request for the financial support in any event?

What is the country's proposed strategy for mitigating these potential disruptive consequences?

One potentially serious unintended consequence is that this support might reduce the political and other pressures on Local Government Chairmen to ensure that PHC services are fully resourced and appropriately financed from the Local Government's own funds. In the past, some LGAs have diverted resources out of health to other political priorities following receipt of other health program inputs at LGA level. Equally, the opposite has also occurred i.e. where additional inputs have also been successful in other LGAs in establishing a stronger recognition of the value of health efforts and activities. In some cases, this has been followed by LGAs committing allocations where funding was not previously made available; one recent and directly relevant example of this is the decision by some LGAs in Kaduna state to use their own resources to pay for the overhead costs of integrated supervision – following the initiation of this process in the state.

In order to minimize the former (fungibility risk), and maximize the latter (demonstration potential), there will be ongoing advocacy with LGAs. In addition, the envisaged MOUs (see above) will serve as a means of mitigating this risk. Finally, some broader governance initiatives (e.g. the new DFID PAVS project are aimed at enhancing community pressures and accountability.

4B.1 Description of 'HSS cross-cutting intervention'

➔ ***Refer to the Round 8 Guidelines for information completing this section.***

Title: Intervention 2 ** *(Change number for each intervention)*	Strengthened national health commodity supply chain management systems
Beneficiary Diseases: *(e.g., HIV, tuberculosis, and malaria?)*	All
WHO "Building Block" category *(Refer to the Round 8 Guidelines)*	A well-functioning system for providing equitable access to quality essential pharmaceutical and health products and technologies;

(a) **Description of rationale for and linkages to improved/increased outcomes in respect of HIV, tuberculosis and/or malaria:**

Strengthening supply chain management – and, in particular, commodity storage and distribution - has featured in previous round proposals. Notwithstanding the actions currently being undertaken as part of Round 5 implementation, as well as with support from others, the supply chain management system is still not operating in a way which guarantees the availability of drugs and other commodities in facilities.

What is required – and proposed – is a concerted broad-based effort to implement the 2005 National Drug Policy (Annex 8). This policy highlights necessary areas for strengthening the operation of drug storage and drug distribution through-out Nigeria, in both public and private sectors. For the public sector (and some in the private sector), the policy highlights the need to reinforce and consolidate the respective roles and responsibilities for the national Central Medical Stores (CMS) and State Medical Stores (SMS), in order for these to operate in accordance with prescribed quality standards. For procurement and distribution, key principles are that all supplies procured for, and distributed to public facilities should be on the basis of expressed need, and that all drugs purchased at national or state levels should be procured into the respective CMS and SMS.

To date however, there has been no national plan for implementing this policy. Efforts to date – at either national or state levels – have typically been in the context of specific programs or initiatives rather than as part of a comprehensive national plan. This includes the limited support for improving the storage of TB drugs in the CMS and a number of zonal stores (as part of ongoing Round 5 implementation). Such 'disease-specific' measures are extremely unlikely however to yield collectively the overall system improvements which are needed to ensure the access to drugs and other health commodities which is essential if the national PHC is to be revitalized. (Where consistent drug availability at affordable prices has been assured, numbers using PHC facilities have increased substantially - sometimes by factors of three or more.) (Annex 9 PATHS Technical Brief : Strengthening Sustainable Drug Supply Systems, p3)

With WHO support, a comprehensive mapping of the entire supply chain management systems and processes has been completed. (Annex 10 Draft "Mapping Of Medicine Procurement And Supply Management In Nigeria", FMOH, WHO and EC.) On the basis of this draft report, some actions are already underway to strengthen the CMS; this includes establishing a web-based national inventory management system – linking programs, facilities and the CMS. Other recommended actions cover, upgrading zonal stores (as part of ultimately having a network of "CMS"), outsourcing distribution, and building appropriate mark-ups into commodity costs, to ensure the operating costs of procurement storage and distribution are properly financed. This proposal builds from this assessment and recommendations with the following measures.

a) reinvigorating the National Health Commodities Logistics Steering Committee – to co-ordinate all national drug logistics, procurement, storage and distribution. This Committee will oversee the finalization and implementation of specific strategic approaches developed to address key supply chain concerns.

b) establishing integrated commodity forecasting and quantification processes at national and state levels;

c) improving storage capacities at CMS and "zonal medical stores" – in line with the recommendations from the mapping report. (The zonal stores are upgraded state medical stores (SMS); these stores are already selected as part of the current TB program efforts.)

d) entering into additional outsourcing arrangements and contracts for the distribution of national procured commodities, including reproductive health commodities, as well as those for the ATM programs. These contracts will cover distribution down to LGAs and facilities, as well as the 'higher level' distribution between

CMS, zonal and state medical stores; and

e) strengthening the national medicines logistics information system – in a way which will enable this to be harmonized with the NHMIS, and ultimately integrated into the planned comprehensive national health monitoring and evaluation processes. (See below.)

These actions will be led, by the Department of Food and Drugs in the Federal Ministry of Health, which is charged with overseeing the implementation of the National Drug Policy, including the day-to-day stewardship responsibilities.

A key factor in proposing these measures is risk spreading, whilst also bringing about both efficiency and effectiveness gains – all with the ultimate aim of ensuring that drugs are constantly available at lower level stores and facilities. As part of mitigating risks, having more than one site able to act as a CMS will prevent any serious problems in the CMS in Lagos threatening the supply chain through-out the country. The strengthening of zonal stores in this proposal will allow such a strategy to be brought more quickly to fruition.

The distribution will be handled through a series of outsourcing arrangements and contracts, taking advantage of the diverse private sector distribution capabilities, and tailored to the specific needs and terrain in different parts of the country. (In some states and LGAs, this will require the use of boats as one means of transportation.)

The reinvigorated National Medicines Logistics Steering Committee will play an important role in bringing together all parties to co-ordinate and reinforce strategizing, planning and implementation across the supply chain management system as a whole. (A committee to do this is already in place for HIV/AIDS; what is required now is to broaden its scope of operation.) The Departments of Food and Drugs, Public Health, and Health Planning, Research and Statistics in the FMOH are all involved, along with the National Primary Health Development Agency (in establishing drug revolving funds at PHC facilities). At state level, the responsibilities are shared between the Pharmacy and Public/Primary Health departments in the SMOH. The Steering Committee will have the mandate to ensure that all these federal and state government actors will fulfil their respective roles and responsibilities.

In parallel, and with support from other sources, the Food and Drugs Department will benefit from additional capacity building. This is likely to be built around the clarification of both functional roles (in relation to supply chain management), and the links between those with different functional responsibilities. The subsequent rebuilding of capacities and systems will focus on the capabilities to discharge these functions, and to ensure links.

MAXIMUM ONE PAGE FOR EACH ACTION

(b) **Indicate below the planned outputs/outcomes** *(through a key phrase and not a detailed description)* that will be achieved on an annual basis from support for this HSS cross-cutting intervention during the proposal term. ➔ *Read the Round 8 Guidelines for further information.*

Year 1	Year 2	Year 3	Year 4	Year 5
Reinvigorated national logistics stewardship through National Logistics Steering Committee	Safe and efficient warehousing of nationally procured commodities at CMS system.	Cost-effective out-sourced distribution from CMS to SMS and LGA stores.	Comprehensive evidenced based quantification at national and state levels	Appropriate and adequate drug availability at all PHC public facilities

(c) **Describe below** other current and planned support for this action over the proposal term

*In the left hand column below, please identify the name of **other providers** of HSS strategic action support. In the other columns, please provide information on the type of outputs.*

Name of supporting stakeholder ⬇	**Timeframe of support for HSS action**	**Level of financial support provided over proposal term** *(same currency as on face sheet of Proposal Form)*	**Expected outcomes from this support**
Government	2009-2011 : Medium Term Sector Strategy (updated annually, for next 3 years)	$4 million over 5 years (based on $2.4 million for logistics strengthening in 2009-2011 MTSS) NB Other national	Effective national supply chain stewardship

		procurement, storage and distribution costs are currently subsumed within Disease Program budgets	
Other Global Fund Grants (with HSS elements (*if applicable*)			
Other : GAVI HSS grant (approved 2008)	2008-2011	$0.5 million	Harmonized Logistics system strategy and manual
Other: WHO	2008-2009 biennium	$1.5 million	Medicines and health commodities management information system Improved supply and management of ATM medicines
Other: SCMS, USG funded.	2008/2009	$0.3 million	Warehouse management System, capacity building, development of SOP manuals, provision of computers and software and internet connectivity
Other: PATHS 2; DFID financed HSS and governance initiative	Q3, 2008 to Q3, 2014	Total project cost of $82 million	Improved delivery of pro poor preventive and curative services, including affordable drugs in up to six States

Note: ***If relevant copy and paste this section for up to five 'HSS cross-cutting interventions' for which funding is requested in Round 8. Re-number each new box as 'Intervention 2', 'Intervention 3' etc. **That is: separate out each major area of HSS cross-cutting support into a new table to ensure clarity about what is being requested*** *(e.g. Intervention 1: strengthening supply chain management of health products; Intervention 2: introducing an innovative health insurance framework targeting the poor; Intervention 3: strengthening diagnostic services at the rural and local level on a cross-functional disease basis to encourage the rationale, non-disease specific use of resources, etc).*

4B.2 Engagement of HSS Key Stakeholders in Proposal Development

(a) Briefly describe **which** and **how** important HSS stakeholders *(e.g., ministries of planning, finance etc)* have been involved in the identification and development of appropriate HSS cross-cutting interventions for this Round 8 proposal, **and how** coordination of the proposed HSS cross-cutting interventions has been ensured across the three diseases (and, where relevant, beyond).

The overall process leading to this SDA is set out in section 4B.2 of the Services SDA above.

For supply chain management specifically, a joint meeting with representatives of the HIV/AIDS, TB and Malaria program, identified and agreed areas of common concern. This set the foundation for this proposal.

In addition, there was dialogue :

- extensively with Department of Food and Drugs, in FMOH;
- with WHO, who have been leading amongst UN agencies in providing technical support, and are at the forefront of efforts to implement the recommendations of the 2007 Mapping study.

- with the US Government (and the agencies implementing USG HIV/AIDS funded initiatives with commodities elements)
- with Crown Agents – who have been implementing the DFID funded Health Commodities Project (2005-2009)

(c) Has the CCM (or Sub-CCM) ensured that:

(ii) the HSS cross-cutting interventions in this proposal do not repeat any request for funding under any of the specific disease components (section 4.6 of each disease)?; and ☑ Yes

(iii) the detailed work plan** **and the** 'Performance Framework'** (Attachment A) for this disease includes separate worksheets which clearly identify the HSS cross-cutting interventions by objective, SDA, and activity for the initial two years of the proposal? ☑ Yes

** *Applicants may prepare a separate **work plan** for the HSS cross-cutting interventions and a separate '**Performance Framework**' (Attachment A) if they prefer.*

4B.3 Strategy to mitigate initial unintended consequences

If there are some perceived initial disruptive consequences of the planned investment in any or all of the HSS cross-cutting interventions set out in section 4B.1 above *(e.g., human resource movement or loss for other services)*:

- What were the factors considered when deciding to proceed with the request for the financial support in any event?

What is the country's proposed strategy for mitigating these potential disruptive consequences?

One potential risk concerns the integration of national health commodity procurement distribution and supply management efforts with the drug supply systems being operated at state level. A number of states are operating, and re-energising drug revolving funds (DRFs) in one form or another. DRFs are also being established in the PHCs being constructed and/or refurbished with NPHCDA funds. In line with the National Drug Policy, some of these DRFs center on institutionalizing facility based inventories, demand estimation, record keeping and financial management.

Care will be taken to ensure this DRF “demand led” or “expressed need” approach is meshed carefully with the higher-level aggregate commodity forecasting, procurement and distribution planned under the national programs (including those for HIV/AIDS, TB and Malaria) – to ensure consistent practice, and, more importantly, consistent availability of the entire range of drugs and supplies which PHCs should be stocking. In part, this will be addressed through state involvement in the Steering Committee.

4B.1 Description of 'HSS cross-cutting intervention'

➔ ***Refer to the Round 8 Guidelines for information completing this section.***

Title: Intervention 3 **	Strengthened health information and monitoring and evaluation systems
Beneficiary Diseases: *(e.g., HIV, tuberculosis, and malaria?)*	All
WHO "Building Block" category *(Refer to the Round 8 Guidelines)*	A well-functioning health information system that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health systems performance and health status.

(a) **Description of rationale for and linkages to improved/increased outcomes in respect of HIV, tuberculosis and/or malaria:**

The 2003 National Health Policy includes the goal of establishing "an effective National Health Management Information System (NHMIS) by all the governments of the Federation to be used as a management tool for informed decision-making at all levels". (Annex 11 NHMIS Policy p17) The policy also initiated the process of setting "minimum requirements" in terms of what is expected at each level of the system in terms of roles and responsibilities, and system inputs and processes. These latter have since been further refined, following the agreement at the 2007 Health Data Producers and Users (HDPU) to use District Health Information System (DHIS) software throughout the NHMIS, a detailed review of national health information systems in 2007, and most recently at the 2008 HDPU meeting. Annex 12 "Review of the Status of Federal/State Implementation of NHMIS", May 2008, pp10-11.)

This proposal sets out actions required to scale up the roll-out of the NHMIS at the Local Government, and primary health care facility and community levels. It is at these levels that there is the least information available – and, inevitably - the least information being used. Data collection and management is a huge problem in Nigeria and these actions are proposed to ensure a robust system that ensures that quality data is available at the right time to justify the requested investments from the ATMs and other public health programs.

The core of the proposal will be to strengthen basic NHMIS processes, whilst also ensuring that the requisite staff, equipment and infrastructure are in place in each of 185 LGAs. This will include LGA printing of NHMIS (and LMIS) forms and registers. Health Records Officers (HROs) will be recruited to work at the ward/facility level; the absence of a dedicated 'data officer' at this level has been highlighted as a major weakness. (Given the numbers of Medical Records Officers in Nigeria, less than 10% of PHC facilities currently have these staff (Annex 13 National Human Resources for Health Policy, p14). Consequently, it has been left to the main 'disease programs' to deploy some of their own staff time to take on facility level data collection and aggregation responsibilities

At the LGA level, other actions to be supported to strengthen NHMIS processes are: a) conducting monthly LGA PHC M&E meetings – both to collect and collate facility NHMIS returns, and to discuss performance and feedback; b) follow-up to facilities with poor performance in submitting data; c) quarterly Heath Data Consultative Committee meetings (when the monthly M&E meeting will be extended for one day); d) NHMIS software and other data management training (with the context of annual NHMIS capacity building plans); e) instituting mentoring processes; and f) establishing and institutionalizing data quality assurance processes (DQA) - including data validation through such as community services.

Given their importance, and because such meeting have already been initiated, supported, and proved effective, within the NMCP, provision has been made for the monthly PHC M&E meetings to be supported for all 774 LGAs in Nigeria, (thereby ensuring that all disease programs and not only malaria benefit from these meetings). Up to 10 private sector providers will be invited to participate in these meetings, so as to start the process of improving the capture NHMIS data from this key group. The proposed DQA actions

will also be extended nationally to all 774 LGAs.

At state and national levels, the proposed main inputs are for the State quarterly M&E HDCC meetings (where all LGAs will be represented), and the annual national Health Data Producers and Users meeting. This latter meeting was initiated in 2007 and repeated in 2008, and serves as the main means of sustaining political support for strengthened national health information systems, as well as providing feedback to data producers and users and developing strategies for better use of data. All state Commissioners (ministers) of Health are participating in these meetings.

The proposed integrated supervision by LGAs and States (described in the Services SDA above) will cover NHMIS as a key issue.

Alongside the acceleration of the NHMIS PHC/LGA level rollout, the second main thrust in this proposal is to develop a comprehensive "national health monitoring and evaluation framework". The aim is to one national integrated M&E platform and strategy, and thereby strengthen data availability and use in all aspects – service statistics, disease and epidemic surveillance, trends in health status, human resource and health financing, and such as logistics. This approach is needed not only to reinforce and broaden data availability and use, but also to ensure priorities are established and maintained – in line with the capacities of the system (thereby avoiding one health program over-burdening data collection at the expense of others).

These actions will consolidate the NHMIS as the "backbone" around which other PHC health information processes can be (re)built. The potential efficiency and sustainability gains from an integrated approach stem not only from having PHC health workers and LGA health staff dedicate an appropriate overall amount of time and effort to this key aspect of their work, but also from ensuring that training and capacity building achieve a balance between technical and basic 'personal transferable competencies'. For the latter, all programs will benefit from improved work planning, instilling aptitudes in rigorous data documentation, increased familiarity with computers, and strengthened report writing and presentation skills.

The strengthened NHMIS is also key in gaining an accurate and up-to-date assessment of trends in use across public health services as a whole. What data have been available suggest that many facilities, and especially those at primary care levels, have been only serving 10-20% of those in their respective catchment areas. If this is an accurate picture, it is vital to be able to document and track the reversing of this decline in PHC use, to show that confidence in public health care (not only HIV/AIDS, TB and malaria services but others as well) is being rebuilt.

Both the national NHMIS roll-out and the comprehensive M&E framework are essential as part of a wider effort which has just commenced to develop overall health sector plans and budgets – in the form of national and state health investment plans and/or medium term expenditure frameworks. In turn, these plans are equally essential as part of strengthening the political dialogue around health, and the articulation of national and state political agendas on which health is accorded a sufficiently high priority. This is underway in a small number of states, and increases in resource allocation and the monthly release of funds are following. In this way, investments in the ATM program can bring about wider resource mobilization and allocative efficiency gains, and then benefit from these as well.

(b) **Indicate below the planned outputs/outcomes** *(through a key phrase and not a detailed description)* that will be achieved on an annual basis from support for this HSS cross-cutting intervention during the proposal term. ➔ *Read the Round 8 Guidelines for further information.*

Year 1	Year 2	Year 3	Year 4	Year 5
Facilities reporting monthly to LGAs.	Monthly M&E meetings used for feedback and analysis in all LGAS	Data flow from LGA to state to national levels.	Production of HMIS reports at LGA, state, and national levels	Information use at LGA and state levels in health plans and budgets

(c) **Describe below** other current and planned support for this action over the proposal term

*In the left hand column below, please identify the name of **other providers** of HSS strategic action support. In the*

other columns, please provide information on the type of outputs.			
Name of supporting stakeholder ↓	**Timeframe of support for HSS action**	**Level of financial support provided over proposal term** *(same currency as on face sheet of Proposal Form)*	**Expected outcomes from this support**
Government	2009-2011 : Medium Term Sector Strategy (updated annually, for next 3 years)	$22 million over 5 years (based on $13m for NHMIS in 2009-2011 MTSS)	Well functioning National HMIS
Other Global Fund Grants (with HSS elements (*if applicable*)			
Other : GAVI HSS grant (approved 2008)	2008-2011	$3 million	Strengthened NHMIS for program monitoring
Other: World Bank HSDP II extension	2008-2010	$50 million total project cost	Strengthened NHMIS (including at LGA level)
Other: PATHS 2, DFID financed HSS and governance initiative	Q3, 2008 to Q3, 2014	$82 million	National HMIS framework functional and information used by FMOH for planning. Up to six States and their LGAs generate and use disaggregated HMIS data to plan and monitor services
Other: SPARC, DFID financed governance initiative	Q3, 2008 to Q3, 2014	Not yet agreed. Directly attributable financial support undecided at this stage.	Efficiency and effectiveness of selected state level governments' use of public resources is enhanced. (e.g. State and LG overall information systems strengthened and used – including by state planning and budget ministries)
Other: PAVS, DFID financed voice and accountability initiative	Q3, 2008 to Q3, 2014	Not yet agreed. Directly attributable financial support undecided at this stage.	Efficiency and effectiveness of selected state level governments' use of public resources is enhanced. (e.g. State and LGs more responsive and transparent in sharing public information)
Other: MEASURE, USAID M&E initiative	Ends 2009		Strengthen complementary M&E systems
Other:			
Other:			

ROUND 8 – HIV

Note: ***If relevant copy and paste this section for up to five 'HSS cross-cutting interventions' for which funding is requested in Round 8. Re-number each new box as 'Intervention 2', 'Intervention 3' etc. **That is: separate out each major area of HSS cross-cutting support into a new table to ensure clarity about what is being requested*** *(e.g. Intervention 1: strengthening supply chain management of health products; Intervention 2: introducing an innovative health insurance framework targeting the poor; Intervention 3: strengthening diagnostic services at the rural and local level on a cross-functional disease basis to encourage the rationale, non-disease specific use of resources, etc).*

4B.2 Engagement of HSS Key Stakeholders in Proposal Development

(a) Briefly describe **which** and **how** important HSS stakeholders *(e.g., ministries of planning, finance etc)* have been involved in the identification and development of appropriate HSS cross-cutting interventions for this Round 8 proposal, **and how** coordination of the proposed HSS cross-cutting interventions has been ensured across the three diseases (and, where relevant, beyond).

The overall process leading to this SDA is set out in section 4B.2 of the Services SDA above.

A joint meeting with representatives of the HIV/AIDS, TB and Malaria program, identified and agreed information system priorities of common concern.

For NHMIS, the annual HDPU meeting (the most recent of which was in May 2008), are proving effective in recording the year-on-year improvements to the information system (on a state-by-state basis), as well as discussing and agreeing key principles and priorities. In addition to state HMIS officers, representatives of the HIV/AIDS, TB and Malaria programs also participated. (Annex 12 "Review of the Status of Federal/State Implementation of NHMIS", May 2008)

The most recent Federal Health Data Consultative Committee (HDCC) meeting was held during 4-5 June 2008; this proposal accords with the priorities agreed at this meeting.

Finally, in the course of preparing the proposal, weekly updating discussions were held with the Director of Health Planning, Research and Statistics. The Health Research Officer, within the NHMIS unit has been a core member of the HSS drafting team.

(d) Has the CCM (or Sub-CCM) ensured that:

(iii) the HSS cross-cutting interventions in this proposal do not repeat any request for funding under any of the specific disease components (section 4.6 of each disease)?; and ☑ Yes

(iv) the detailed work plan** **and the** 'Performance Framework'** (Attachment A) for this disease includes separate worksheets which clearly identify the HSS cross-cutting interventions by objective, SDA, and activity for the initial two years of the proposal? ☑ Yes

** *Applicants may prepare a separate **work plan** for the HSS cross-cutting interventions and a separate '**Performance Framework**' (Attachment A) if they prefer.*

4B.3 Strategy to mitigate initial unintended consequences
If there are some perceived initial disruptive consequences of the planned investment in any or all of the HSS cross-cutting interventions set out in section 4B.1 above *(e.g., human resource movement or loss for other services)*: ▪ What were the factors considered when deciding to proceed with the request for the financial support in any event? What is the country's proposed strategy for mitigating these potential disruptive consequences?

OPTIONAL ADDITIONAL SECTION FOR ONE DISEASE IN ROUND 8 GLOBAL FUND PROPOSALS

Copy the material under this text box into the applicant's Round 8 proposal form after s.4.9.7 (for either HIV or Tuberculosis proposals) or after s.4.9.6 (Malaria proposals).

SECTION 4B CAN ONLY BE INCLUDED IN ONE DISEASE IN ROUND 8 and only if:

- *The applicant has identified gaps and constraints in the health system that have an impact on HIV, tuberculosis and malaria outcomes;*
- *The interventions required to respond to these gaps and constraints are 'cross-cutting' and benefit more than one of the three diseases;*
- *Section 4B is not also included in another disease in the Round 8 proposal;*
- *The applicant is requesting funding for disease interventions (e.g., provision of ARVs to people in need). That is, HSS cross-cutting interventions **ARE NOT** offering a HSS only component in Round 8; and*
- *The applicant also downloads 'Section 5B' from the Global Fund website and includes it **after s.5.5** in the same disease proposal **as the applicant has inserted this section 4B**.*

➔ ***Read the Round 8 Guidelines to consider including HSS cross-cutting interventions***

4B.1 Description of 'HSS cross-cutting intervention'

➔ ***Refer to the Round 8 Guidelines for information completing this section.***

Title: Intervention 4 *(Change number for each intervention)*	To strengthen capacity of core processes of the community based networks and community level committees to ensure the provision of an increased range and quality of services in scaled up ATM interventions
Beneficiary Diseases: *(e.g., HIV, tuberculosis, and malaria?)*	All
WHO "Building Block" category *(Refer to the Round 8 Guidelines)*	Effective leadership and governance to ensure strategic policy frameworks exist and are combined with effective oversight, coalition building ,the provision of appropriate regulations and incentives and accountability

(a) **Description of rationale for and linkages to improved/increased outcomes in respect of HIV, tuberculosis and/or malaria:**

The health system constraints in Nigeria have been identified in sections 4.3. in the HIV/AIDS, TB and Malaria proposals. Two mutually reinforcing cross-cutting HSS (CSS) interventions are proposed. These encompass measures to strengthen (i) The core processes of the CSO networks to help increase community access to, demand for, and utilization of health interventions (II) Strengthening and building partnerships at the community level through the integrated coordination of the Ward Health Development Committees by the CSO networks (in HIV/AIDS and Malaria) to enhance impact of scaling up of ATM interventions.

Civil society organizations serve as critical health delivery resources in communities. They create awareness, generate demand for services, disseminate information, advocate health- seeking behaviour, facilitate, commodity distribution; provide community home based care and generally act as linkages between the facilities and clients. The contribution of the HIV/AIDs CSO network especially, in the successes recorded in the (still ongoing) GF round 5 implementation has been documented. The malaria network is currently an implementing partner in phase two of the GF rounds 2 & 4 consolidated malaria grant.

Still many CSOs have limited technical, resource and operational capabilities. Often their community outreach activities are poorly linked to facility-based service providers. To address these gaps, GF round 8 shall adopt a dual track of strengthening institutional and community health systems while building synergies, reinforcing referrals and forging sustainable linkages between them.

The first CSS intervention in this proposal involves building the capacity of the ATM CSO networks shall be strengthened in management, technical and operational skills to generate demand for and provide services in key ATM interventions including HMM, LLITNs, Community Directed DOTS, Care and Support of PLWHAs, and orphans levels, BCC. (Annex 14; Guideline for CSOs role in Malaria) In addition, CSO/CBO capacity to collect and manage basic sex disaggregated data shall be strengthened;

More women's community networks shall be selected to address the differential impact of the 3 diseases on women and to enhance their care-giving roles. Women Networks shall be trained to generate demand and increase access to such as LLIN, PMCTC and care and support of PABA and PLHWA. In addition, CBOs shall be strengthened to intensify advocacy and social mobilization efforts, particularly on issues that violate the rights of women and PLHWA and to increase male involvement.

The proposed integration would cover trainings, sharing office space, and coordinating (where possible) of implementation of activities at the community levels – thereby saving huge costs in the process and broadening health seeking practices owned by communities

The second CSS intervention will strengthen and build partnerships at the community level through the integrated support to the coordination of the Ward Health Development Committees by the CSO networks (in HIV/AIDS,TB and Malaria) to enhance the impact of scaling up of ATM interventions.

Functionally, each Ward Health Development Committee is responsible amongst other things for the following:

- Identification of health and social needs of the Ward and planning solutions.
- Mobilization of resources (human and material)
- Supervision, monitoring and evaluation of health activities in the Ward
- Mobilization for community participation in health, and other health related programmes

- Liaison with Government, NGO and other partners in the implementation of health programmes

(Source: Ward Minimum Health Care Package, NPHCDA 2007)

The CSO networks will be supported to build requisite capacity and skills of the WHDC members, to enable them better articulate the activities required and ensure success in delivering their roles and responsibilities, identified above. This will include not only training in ATM interventions and response actions at community levels, providing quality service delivery platforms for ATM activities under GF round 8, but also support in effective committee and community processes.

Activities which include HMM, LLITNs, Community Directed DOTS, Care and Support of PLWHAs at the community levels, BCC, M&E and capture of basic community related data amongst others; planning and implementation, community mobilization for action, financial management e.t.c.

To implement this, all networks will receive refresher training to ensure common standards in the WHDC strengthening. In this, there will be opportunities to benefit from some of the member organizations positive experience in previous community health committee strengthening e.g (Ekulobia in Anambara State 2007 stigma reduction campaign by CISHAN). The WHDC strengthening actions will revitalize and activate 2000 of 9550 WHDC's over a five year period increasing functional wards by 20 % to a total of 50% % nationwide.

In all, over five years, 2,000 out of 9550 Ward Health Development Committees nationwide shall be activated and strengthened.

(b) **Indicate below the planned outputs/outcomes** *(through a key phrase and not a detailed description)* that will be achieved on an annual basis from support for this HSS cross-cutting intervention during the proposal term. ➔ *Read the Round 8 Guidelines for further information.*

Year 1	Year 2	Year 3	Year 4	Year 5
Technical and managerial capacities of the ATM CBO networks strengthened	500 revitalized/formed functional WHDC's coordinated by CBO/FBO's delivering ATM interventions and reporting	750 revitalized/formed WHDC's, bringing the total number of WHDC's coordinated by CBO's/FBO's delivering ATM interventions and reporting to 1250	Revitalized WHDC's	2000 WHDC's coordinated by CBO's/FBO's delivering ATM interventions and reporting.

(c) **Describe below** other current and planned support for this action over the proposal term

*In the left hand column below, please identify the name of **other providers** of HSS strategic action support. In the other columns, please provide information on the type of outputs.*

Name of supporting stakeholder ⬇	**Timeframe of support for HSS action**	**Level of financial support provided over proposal term** *(same currency as on face sheet of Proposal Form)*	**Expected outcomes from this support**
Government	2009 to 2013	3,300,000	Sustaining community participation
Other Global Fund Grants (with HSS elements (*if applicable*)			
Other: *GAVI-HSS Grant*	2008-2010	4,687,238	Strenghtening community participation and sustainance in 960 wards

Other: *(identify*

Other: *(identify)*

Note: ***If relevant copy and paste this section for up to five 'HSS cross-cutting interventions' for which funding is requested in Round 8. Re-number each new box as 'Intervention 2', 'Intervention 3' etc.***
*****That is: separate out each major area of HSS cross-cutting support into a new table to ensure clarity about what is being requested*** *(e.g. Intervention 1: strengthening supply chain management of health products; Intervention 2: introducing an innovative health insurance framework targeting the poor; Intervention 3: strengthening diagnostic services at the rural and local level on a cross-functional disease basis to encourage the rationale, non-disease specific use of resources, etc).*

4B.2 Engagement of HSS Key Stakeholders in Proposal Development

(a) Briefly describe **which** and **how** important HSS stakeholders *(e.g., ministries of planning, finance etc)* have been involved in the identification and development of appropriate HSS cross-cutting interventions for this Round 8 proposal, **and how** coordination of the proposed HSS cross-cutting interventions has been ensured across the three diseases (and, where relevant, beyond).

The proposed Community Systems Strengthening SDA (interventions) included in this proposal were ratified during the CCM meeting of the 24th and 25th of June 2008, following submission of plans and the draft proposals of the individual disease components (ATM) developed over the preceding 12weeks by the writing team in Malaria, HIV/AIDS and TB.

Over the 12 weeks various partners were involved in the process of distilling activities and service delivery vehicles that would best deliver the desired output and outcome for inclusion into this proposal.

Organisations, stakeholders and partners consulted include Government, Non Governmental Organisations, International NGO's, Multilateral and Bi lateral agencies, CBO/CSO networks amongst others.

Contributors to these sessions include:

National Malaria Control Programme (NMCP), National Agency for the Control of HIV/AIDSS (NACA), WHO, UNICEF, Society for Family Health (SFH), DFID, Malaria Consortium, Carter Foundation, Yakubu Gowon Centre (YGC) Department of Planning FMOH, Canadian Red Cross ,World Bank Booster programme, (Association of Civil Society Organisations in Malaria Immunization and Nutrition),PSI ,Malaria no More, Planned Parenthood Federation of Nigeria, Actionaid, NASCAP, ARFH, Federal Ministries of Education and Labour, HYGIEA, CISHAN, Family Health International, UNAIDS, UNDP, HALTAID, National Primary Healthcare Developement Agency (NPHCDA) NTBLP National TB and Leprosy Programme.

Following the CCM meeting of the 25th of June 2008, the CSO networks of CISHAN for HIVAIDS and ACOMIN for malaria with the ratification of the full CCM house recognized the opportunity to intergrate community and CSO/CBO capacity strengthening activities under round 8 as cost effective to the overall Country proposal .It was also seen as a means of avoiding duplication of activities.

(e) Has the CCM (or Sub-CCM) ensured that:

(iv) the HSS cross-cutting interventions in this proposal do not repeat any request for funding under any of the specific disease components (section 4.6 of each disease)?; and ☑ Yes

(v) the detailed work plan** **and the** 'Performance Framework'** (Attachment A) for this disease includes separate worksheets which clearly identify the HSS cross-cutting interventions by objective, SDA, and activity for the initial two years of the proposal? ☑ Yes

** *Applicants may prepare a separate **work plan** for the HSS cross-cutting interventions and a separate '**Performance Framework**' (Attachment A) if they prefer.*

4B.3 Strategy to mitigate initial unintended consequences

If there are some perceived initial disruptive consequences of the planned investment in any or all of the HSS cross-cutting interventions set out in section 4B.1 above *(e.g., human resource movement or loss for other services)*:

- What were the factors considered when deciding to proceed with the request for the financial support in any event?

What is the country's proposed strategy for mitigating these potential disruptive consequences?

The strengthened Ward Health Development Committees can also help in mitigating the fungibility risks highlighted under the Services Intervention/SDA above. These committees will help in bring local political and community pressures to bear – for appropriate LGA allocations for PHC.

Supporting documents submitted by applicant

SDA/Intervention	Document Description	Annex number
1	National Health Bill 2008	1
	Ward Minimum Health Care Package	2
	MDG workplan 2007	3
	FMOH 2009-2011 MTSS	4
	GAVI HSS Proposal 2007	5
	PATHS Technical Brief : Developing a Planned Preventive Maintenance Culture in Enugu	6
	Biomedical Engineering Trainining Committee minutes 17 June 2008, p3	7
2	National Drug Policy 2005	8
	PATHS Technical Brief : Strengthening Sustainable Drug Supply Systems, p3	9
	Draft “Mapping Of Medicine Procurement And Supply Management In Nigeria”, FMOH, WHO and EC.	10
3	NHMIS Policy p17	11
	Review of the Status of Federal/State Implementation of NHMIS”, May 2008, pp10-11	12
	National Human Resources for Health Policy, p14	13
4	Guideline for CSOs role in Malaria	14

ROUND 8 – HIV

5. FUNDING REQUEST

5.1. Financial gap analysis - HIV

➔ *Summary Information provided in the table below should be explained further in sections 5.1.1 – 5.1.3 below.*

Financial gap analysis *(same currency as identified on proposal coversheet)* **Note ➔ Adjust headings** (as necessary) **in tables from calendar years to financial years (e.g., FY ending 2007; etc) to align with national planning and fiscal periods**								
	Actual		**Planned**		**Estimated**			
	2006	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
HIV program funding needs to deliver comprehensive prevention, treatment and care and support services to target populations								
Line A ➔ Provide annual amounts	629,640,830	750,286,674	813,227,187	928,958,059	1,021,853,865	1,124,039,251	1,236,443,177	1,360,087,49
Line A.1 ➔ Total need over length of Round 8 Funding Request				*(combined total need over Round 8 proposal term)*				5,671,381,846
Current and future resources to meet financial need								
Domestic source **B1**: Loans and debt relief (*provide name of source*) Debt Relief and World Bank Loans	56,417,460	53,634,921	25,000,000	25,000,000	30,000,000	30,000,000	30,000,000	30,000,000
Domestic source **B2** National funding resources	36,372,117	25,490,227	82,958,064.67	82,958,066	82,958,067	82,958,068	82,958,069	82,958,070
Domestic source **B3** Private Sector contributions (national)				1,500,000	1,500,000	1,500,000	1,500,000	1,500,000

ROUND 8 – HIV

Financial gap analysis *(same currency as identified on proposal coversheet)* **Note ➔ Adjust headings** (as necessary) **in tables from calendar years to financial years (e.g., FY ending 2007; etc) to align with national planning and fiscal periods**								
	Actual		**Planned**		**Estimated**			
	2006	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
Total of Line B entries ➔ Total current & planned DOMESTIC (including debt relief) resources:	92,789,577	79,125,148	107,958,065	109,458,066	114,458,067	114,458,068	114,458,069	114,458,070
External source **C 1** (*provide source name*) United States Government	115,818,860	251,189,080	391,763,404	391,763,405	391,763,405	391,763,405	391,763,405	391,763,405
External source **C2** (*provide source name*) UN Country Team	-	879,084	4,362,205	4,798,425.50	5,234,640	5,670,866.50	5,670,867	5,670,867
External source **C2** (*provide source name*) UK Government (DfID)	123,820,340	132,600,430	136,163,500	76,950,000	100,000,000	100,000,000	100,000,000	100,000,000
External source **C2** (*provide source name*) CIDA	1,000,000	16,000	1,520,000	1,520,000	1,520,000	1,520,000	1,520,000	1,520,000
External source **C3** Private Sector contributions (International) Président Clinton Foundation	[redacted]	[redacted]	[redacted]	5,593,324.60	5,295,536.53	5,000,000	5,000,000	5,000,000
Total of Line C entries ➔ Total current & planned EXTERNAL (non-Global Fund grant) resources:	240,639,200	384,684,594	533,809,109	480,625,155	503,813,582	503,954,272	503,954,272	503,954,272

ROUND 8 – HIV

Financial gap analysis *(same currency as identified on proposal coversheet)* **Note ➔ Adjust headings** (as necessary) **in tables from calendar years to financial years (e.g., FY ending 2007; etc) to align with national planning and fiscal periods**								
	Actual		**Planned**		**Estimated**			
	2006	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
Line D: Annual value of all existing Global Fund grants for same disease: Include unsigned 'Phase 2' amounts as "planned" amounts in relevant years	2,436,000	23,916,574	39,133,103	39,133,103	39,133,103	39,133,103		
Line E ➔ Total current and planned resources (i.e. Line E = Line B total + Line C total + Lind D Total)	243,075,200	408,601,168	572,942,212	519,758,258	542,946,685	543,087,375	503,954,272	503,954,272
Calculation of gap in financial resources and summary of total funding requested in Round 8 *(to be supported by detailed budget)*								
Line F ➔ Total funding gap (i.e. Line F = Line A – Line E)	386,565,630	341,685,506	240,284,975	409,199,801	478,907,180	580,951,877	732,488,905	856,133,222
Line G = Round 8 HIV funding request *(same amount as requested in table 5.3 for this disease)*				**132,287,960**	**161,579,617**	**157,841,304**	**191,434,362**	**188,469,398**

ROUND 8 – HIV

Part H – 'Cost Sharing' calculation for Lower-middle income and Upper-middle income applicants	
In Round 8, the total maximum funding request for HIV in Line G is: *(a) For **Lower-Middle income countries**, an amount that results in the Global Fund's overall contribution (all grants) to the national program reaching not more than 65% of the national disease program funding needs over the proposal term; and* *(b) For **Upper-Middle income countries**, an amount that results in the Global Fund overall contribution (all grants) to the national program reaching not more than 35% of the national disease program funding needs over the proposal term.*	
Line H ➔ Cost Sharing calculation as a percentage (%) of overall funding from Global Fund **Cost sharing = (Total of Line D entries over 2009-2013 period + Line G Total) X 100** **Line A.1**	17.89%

5.1.1. Explanation of financial needs – LINE A in table 5.1

Explain how the annual amounts were:

- developed *(e.g., through costed national strategies, a Medium Term Expenditure Framework [MTEF], or other basis);* and
- budgeted in a way that ensures that government, non-government and community needs were included to ensure full implementation of country's HIV program strategies.

The estimates of the annual national needs were derived from the costed National Strategic Framework (NSF). The NSF is five-year multi-sectoral strategic plan developed in 2005 through a participatory and consultative process by all stakeholders to provide direction and guidance to the national HIV/AIDS response. The plan was costed in a participatory manner involving all stakeholders early 2006, based on the interventions in the strategic framework and the annual targets for the same period. These annual cost estimates are summarised in Line A of the financial dap analysis table 5.1 above. For the period 2010-2013 that is outside the period of the NSF but part of the Round 8 proposal duration, the annual cost was projected from the 2009 cost. The projections assumed that there will be an annual inflation at the rate of 5% as well as 5% increase in the annual financial needs arising from future expansion of treatment and other components. Hence annual amounts were projected based on an increase of 10% per year. These estimates might change in the future when a new strategic plan with new targets and changed scope of interventions is developed and costed.

The annual cost-estimates and projections were based on unit costs for HIV/AIDS interventions and were therefore restricted to costs necessary for the implementation of discrete HIV/AIDS interventions. Relevant Health-Sector Systems strengthening actions that are essential for HIV/AIDS service delivery such as human resources, health infrastructures etc were not included. For this reason, the cost estimates represent the lower end of the true financial needs for a comprehensive and holistic HIV/AIDS service delivery in the country.

5.1.2. Domestic funding – 'LINE B' entries in table 5.1

Explain the processes used in country to:

- prioritize domestic financial contributions to the national HIV program *(including HIPC [Heavily Indebted Poor Country] and other debt relief, and grant or loan funds that are contributed through the national budget)*; and
- ensure that domestic resources are utilized efficiently, transparently and equitably, to help implement treatment, prevention, care and support strategies at the national, sub-national and community levels.

National Planning frameworks are seeking to increase available financial and non financial resources to ensure effective, prevention and control of the diseases. The NACA receives direct funding from the Federation Account for HIV/AIDS interventions, thus ensuring continued Government commitment. In addition, all the Line Ministries also have the direct funding from the Federation account for HIV/AIDS and this has been growing progressively since 1998 till date.

The domestic sources of funding to the national programme were derived from the national budget. The figures here were calculated from the allocations to line ministries and parastatals in civil service that participate in the multi-sectoral response in line with the NSF. There is a significant increased budget allocation for HIV in 2008 as result of successful advocacy. In 2007, the FGoN committed $25,490,337million to HIV/AIDS. These funds were expended through the various ministries, parastatals and agencies for awareness creation, capacity building activities, community mobilization and building some service delivery centers or renovation of existing facilities in selected tertiary institutions. It is expected that the government will sustain the level of expenditure on HIV/AIDS control in subsequent years.

Nigeria is a beneficiary of the HIPC initiative which makes available US $ 17 billion for Health and other social development. In 2005 there was an agreement by group of eight (G8) developed democracies to write off over 17 billion US dollars of Nigeria's debt under the Highly Indebted Countries (HIPC) Initiative. Under the agreement, the Nigerian government committed itself to use the savings from debt relief on poverty eradication

in order to meet the Millennium Development Goals (MDGs). The funds arising from debt relief reflected in line B in table 5.1 for 2006 and 2007 were sourced from the JAAIDS report on *"Making Money Work for the People" (2008)*. Analysis of the allocation 853 million dollars of debt relief funds in 2006 revealed that only 4.3% was devoted to HIV programmes. The debt relief gains incorporated in two national budgets 2006 and 2007, was part of the reform programmes that established the national economic empowerment development strategy NEEDS. The last allocation of the funds was in 2007. The funds from this source for the future years are project from the 2006 and 2007 expenditure.

About US dollars 20 million annually is added to the debt relief funds for 2006 and 2007. These funds comprise of the 5 year 100 million US dollar loan from the World bank / IDA that ended in 2007. Subsequently, US $ 50 million has been approved for 2008 and 2009, and a US $ 150 million loan is to be negotiated in 2010 for 5 years. The amounts shown for the subsequent years assume that these funds will be approved and released.

A public private partnership exists to ensure increased availability of financial and non financial resources to support the National Response to prevention, treatment, care and control of the disease. Mobilization of funds from the domestic private sector for the HIV response has been increasing in recent years. While all information on private sector investment could not be obtained for this analysis, a few partners were able to provide some information. For instance, SHELL provided the information used in this forecast. The drop in budget allocation for this company from 2006 to 2007 is explained by the fact the company is engaged in development of its workplace policy in 2006 and from 2007 has been maintaining activities within and around its communities. It anticipated that more private interest will devote substantial funds to HIV in coming years. It is important to note that the Nigerian Business Coalition on HIV/AIDS (NIBUCCA) has been established to ensure increased participation and funding.

5.1.3. External funding *excluding Global Fund* – 'LINE C' entries in table 5.1

Explain any changes in contributions anticipated over the proposal term (*and the reason for any identified reductions in external resources over time).* Any current delays in accessing the external funding identified in table 5.1 should be explained (including the reason for the delay, and plans to resolve the issue(s)).

The external multilateral and bilateral development partners supporting the HIV/AIDS response in Nigeria comprise of mainly DfID, USG through PEPFAR, CIDA and the GFATM. Other development partners also support HIV/AIDS response through sectoral support especially through the support to Health Systems Strengthening activities.

Under the current Global Fund Round 5 grant, about 180 million US dollars was approved to expand programmes for HIV prevention, antiretroviral treatment and care and support for a 5 year period. Disbursement commenced in December 2007 and the support is slated to end in 2011. The projected annual cash flows are summarised in table 5.1. These resources end in 2011 which explains in the fall in the support from this source in 2011.

Nigeria is one of the fifteen PEPFAR focus countries. Current PEPFAR support is expected to end in 2009. However, with the recent approval of PEPFAR II, it is expected that funds will continue to be available from this source to continue to support HIV prevention, treatment, care and support throughout the period of the grant. However, the exact funding levels cannot be ascertained, but are expected to be higher. For purposes of this analysis, we projected future annual funding at the 2007 levels, allowing for inflation, but this might increase substantially.

CIDA has also been supporting the national HIV/AIDS response, but the funding dropped in 2007 due to closure of long term projects. However, the programme has been renewed in 2008. In the absence of future projections from this source, have maintained the level of funding from 2009 throughout the duration of the grant at the levels of 2008.

The DFID has been supporting the PSRHH for the past seven years ending in December 2008. A new programme is being negotiated and has been proposed to commence in 2010. There are indications that the level of funding would be similar to the PSRHH. It is therefore projected that approximately 100 million US dollars will continue to be available and expended annually from this source alone.

The joint UN country team funds the joint HIV/AIDS programme in the country which is proposed to last in 2011. The new joint programme is also under negotiation. In this funding gap analysis, it is assumed that the

level of support from this source will be maintained at approximately the same level for 2012 and 2013.

The President Clinton Foundation will maintain approximately the same funding level but the programme areas are yet to be determined. However, there will be a transition away from UNITAID. The support from this source for pediatric ART will end in 2010 and adult second-line ART will end in 2011.

5.2. Detailed Budget

Suggested steps in budget completion:

1. **Submit a detailed proposal budget *in Microsoft Excel format as a clearly numbered annex***. Wherever possible, use the same numbering for budget line items as the program description.

   - **FOR GUIDANCE ON THE LEVEL OF DETAIL REQUIRED** *(or to use a template if there is no existing in-country detailed budgeting framework)* **refer to the budget information available at the following link:** http://www.theglobalfund.org/en/apply/call8/single/#budget

2. Ensure the detailed budget is consistent with the detailed work plan of program activities.

3. From that detailed budget, **prepare a '*Summary by Objective and Service Delivery Area*'** (s.5.3.)

4. From the same detailed budget, **prepare a '*Summary by Cost Category*'** (s.5.4.)

5. Do not include any CCM or Sub-CCM operating costs in Round 8. This support is now available through a separate application for funding made direct to the Global Fund (and not funded through grant funds). The application is available at: http://www.theglobalfund.org/en/apply/mechanisms/guidelines/

5.3. Summary of detailed budget by objective and service delivery area

Objective Number	Service delivery area *(Use the same numbering as in program description in s.4.5.1.)*	Year 1	Year 2	Year 3	Year 4	Year 5	Total
1	PMTCT	1,886,872	1,782,646	3,185,825	5,211,552	5,206,499	**17,273,394**
1	Testing and Counseling	1,665,922	2,805,326	5,852,595	10,099,577	9,602,427	**30,025,847**
1	BCC - Mass media	1,282	657,456	570,673	814,281	593,728	**2,637,420**
1	BCC - community outreach and schools	2,263,132	3,025,253	4,084,814	7,834,517	3,494,397	**20,702,113**
1	Blood safety and universal precaution	103,195	192,057	279,819	544,776	333,056	**1,452,903**
2	Antiretroviral treatment (ARV) and monitoring	91,091,889	127,523,571	100,298,651	123,503,047	125,613,035	**568,030,193**
2	Prophylaxis and treatment for opportunistic infections	461,612	1,507,802	1,248,519	10,026,768	10,467,809	**23,712,510**
2	TB/HIV	92,981	1,591,887	152,959	237,854	57,764	**2,133,445**
3	Support for orphans and vulnerable children	807,356	2,056,942	3,703,135	6,162,506	5,819,229	**18,549,168**
3	Care and support for the chronically ill	537,675	1,326,105	2,309,456	5,810,032	5,733,652	**15,716,920**
4	Policy development including workplace policy	272,779	484,414	392,773	611,809	540,245	**2,302,020**
5	HSS: Information system	10,581,977	505,016	16,494,136	665,145	265,751	**28,512,025**
5	Programme management and Administration cost	22,521,288	18,121,142	19,267,949	19,912,498	20,741,806	**100,564,683**
		132,287,960	**161,579,617**	**157,841,304**	**191,434,362**	**188,469,398**	**831,612,641**

5.4. Summary of detailed budget by cost category *(Summary information in this table should be further explained in sections 5.4.1 – 5.4.3 below.)*

ROUND 8 – HIV

Avoid using the "other" category unless necessary – read the Round 8 Guidelines.	*(same currency as on cover sheet of Proposal Form)*					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Human resources	9,061,750	9,146,475	9,571,537	10,015,090	10,512,257	**48,307,109**
Technical and Management Assistance	879,520	5,829,818	5,620,070	8,954,338	9,136,493	**30,420,239**
Training	2,941,644	3,845,377	20,466,691	6,518,740	1,146,969	**34,919,421**
Health products and health equipment	2,409,370	2,711,787	4,505,144	6,400,974	6,489,570	**22,516,845**
Pharmaceutical products (medicines)	52,990,502	73,577,153	96,866,468	124,826,566	128,414,714	**476,675,403**
Procurement and supply management costs	36,649,866	51,392,944	385,109	2,568,297	2,636,334	**93,632,550**
Infrastructure and other equipment	5,572,355	878,605	1,270,171	1,261,098	633,483	**9,615,712**
Communication Materials	761,736	1,501,086	1,921,715	4,454,554	3,837,613	**12,476,704**
Monitoring & Evaluation	12,252,356	1,422,658	2,724,762	5,169,843	5,232,772	**26,802,391**
Living Support to Clients/Target Populations	1,532,244	3,649,822	6,174,507	12,009,183	10,908,233	**34,273,989**
Planning and administration	3,348,710	4,036,011	4,604,246	5,375,927	5,601,021	**22,965,915**
Overheads	3,887,907	3,587,881	3,730,884	3,879,752	3,919,939	**19,006,363**
Other: *(Use to meet national budget planning categories, if required)*	0	0	0	0	0	**0**
Round 8 HIV funding request (*Should be the same annual totals as table 5.2*)	**132,287,960**	**161,579,617**	**157,841,304**	**191,434,362**	**188,469,398**	**831,612,641**

Avoid using the "other" category unless necessary – read the Round 8 Guidelines.	*(same currency as on cover sheet of Proposal Form*

5.4.1. Overall budget context

Briefly explain any significant variations in cost categories by year, or significant five year totals for those categories.

HALF PAGE MAXIMUM There is a significant change in the annual cost for living support to clients/target populations as in year 1 is devoted to systems set up for implementation of the Round 8 proposal. As the implementation rolls out in more clusters more clients are reached. The community efforts of the civil society shall be reaching more clients directly through the home based care, direct support to OVCs, and support groups.

The costs for Pharmaceutical products (Medicines) accounts for 57% of the total cost of this proposal. This consists of the costs of antiretroviral therapy, medicines for OIs, family planning commodities and CTX (adults and pediatrics). The target of the proposal earlier explained informed the huge budget for the products. It is to ensure that all service delivery sites do not experience stock out during the 5 year duration. Upon the expiration of Round 5 in Years 4 and 5, significant increases are foreseen as Round 8 take over the treatment of more clients (PMTCT, ARV and OIs. Accordingly, there is a significant increase in the cost of pharmaceutical products (medicine) in these two years. Procurement of most pharmaceutical products shall be undertaken in years 1 and 2 hence the increased cost of procurement and supply management costs. This reduces significantly from $51,392,944 in year 2 to $2,636,334 by year 5.

Training cost over the 5 years varied significantly as the implementation rolled out in the clusters. This follows the pattern of implementation as there is an expansion into 250 additional clusters. The Monitoring and Evaluation costs and communication materials follow the same implementation plan and thus reflect the expansion in states as well as the closure of Round 5. M&E cost in year 1 is highest as majority of systems building activities essential for programme implementation shall be undertaken in this year

5.4.2. Human resources

In cases where '*human resources*' represents an important share of the budget, summarize: (i) the basis for the budget calculation over the initial two years; (ii) the method of calculating the anticipated costs over years three to five; and (iii) to what extent human resources spending will strengthen service delivery.

(Useful information to support the assumptions to be set out in the detailed budget includes: a list of the proposed positions that is consistent with assumptions on hours, salary etc included in the detailed budget; and the proportion (in percentage terms) of time that will be allocated to the work under this proposal.

➔ *Attach supporting information as a clearly named and numbered annex*

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Human resources in this budget constitute 5% of the total costs. The details of the human resources envisaged for the implementation is included in the PR and SR Personnel and Admin folder in the budget. Each of full time staff proposed in this plan shall be comply with the national working hours and schedules. There are some contract staff envisaged for the implementation of some activities as the project expands in the states. In addition, 2% inflationary rate has been factored into the salaries in subsequent years after year 1. It is envisaged that as project expands both the PR and SR shall be required to employ more staff in years 3 and 4 for performance

Clarified section 5.4.3

5.4.3. Other large expenditure items

If other 'cost categories' represent important amounts in the summary in table 5.4, (i) explain the basis for the budget calculation of those amounts. Also explain how this contribution is important to implementation of the national HIV program.

➔ *Attach supporting information as a clearly named and numbered annex*

N.A as 'other cost categories' row has zero budget.

5.5. Funding requests in the context of a common funding mechanism

In this section, **common funding mechanism** refers to situations where all funding is contributed into a common fund for distribution to implementing partners.

Do not complete this section if the country pools, for example, procurement efforts, but all other funding is managed separately.

5.5.1. Operational status of common funding mechanism
Briefly summarize the main features of the common funding mechanism, including the fund's name, objectives, governance structure and key partners. ➔ *Attach, as clearly named and numbered annexes to your proposal, the memorandum of understanding, joint Monitoring and Evaluation procedures, the latest annual review, accountability procedures, list of key partners, etc.*
Not Applicable
5.5.2. Measuring performance
How often is program performance measured by the common funding mechanism? Explain whether program performance influences financial contributions to the common fund.
Not Applicable
5.5.3 Additionality of Global Fund request
Explain how the funding requested in this proposal (*if approved*) will contribute to the achievement of outputs and outcomes that would not otherwise have been supported by resources currently or planned to be available to the common funding mechanism. *If the focus of the common fund is broader than the HIV program, applicants must explain the process by which they will ensure that funds requested will contribute towards achieving impact on HIV outcomes during the proposal term*.
Not Applicable

5B. FUNDING REQUEST – HSS CROSS-CUTTING INTERVENTIONS

OPTIONAL ADDITIONAL SECTION FOR ONE DISEASE IN ROUND 8 GLOBAL FUND PROPOSALS

Copy sections 5B.1 to 5B.4 inclusive below into the applicant's Round 8 proposal form after section.5.5 in the **same disease proposal** as the applicant included section 4B (once only, in one disease only).

SECTION 5B CAN ONLY BE INCLUDED IN ONE DISEASE IN ROUND 8 and only if:

- *The applicant has identified gaps and constraints in the health system that have an impact on HIV, tuberculosis and malaria outcomes;*
- *The interventions required to respond to these gaps and constraints are 'cross-cutting' and benefit more than one of the three diseases;*
- *Section 4B is included in same disease proposal as the applicant is to copy this material; and*
- *The Applicant has not included s.4B or s.5B in any other disease in the Round 8 proposal.*

5B.1 Detailed Budget

Steps in budget completion:

1. **Submit a detailed budget of the HSS cross-cutting interventions *in Microsoft Excel format*** using the same numbering for budget line items as in the description of HSS cross-cutting interventions in section 4B.1.

   - **The detailed budget must be submitted as a clearly numbered annex**. *The HSS cross-cutting interventions may be prepared as a separate Excel worksheet of the disease budget, or a separate file (Excel workbook) at the applicant's election.*

   - **For guidance on the level of detail required** *(or to use a template if there is no existing in-country detailed budgeting framework)* **refer to the detailed budget guidance in section 5.1 of the Round 8 Guidelines.**
     (i.e., same instructions as for the disease budget preparation)

2. From that detailed budget, **prepare a '*Summary by Objective and Service Delivery Area*'** (section 5B.2).
   (*Note – 'SDAs' for the purpose of HSS cross-cutting interventions are **not** the same as the SDAs for the diseases. Refer to s.5B.2 of the Round 8 Guidelines for more information).*

3. From the same detailed budget, **prepare a '*Summary by Cost Category*'** (section 5B.3); and

4. **Ensure the** detailed budget **is consistent with** the detailed workplan for HSS cross-cutting interventions, **and the** 'Performance Framework' for HSS cross-cutting interventions *(Attachment A).*

➔ ***READ THE ROUND 8 GUIDELINES FOR MORE INFORMATION***

5B.2 Summary of detailed budget for HSS cross-cutting interventions by objective and service delivery area

Table 5B.2 – Summary of detailed budget by objective and service delivery area

		Budget breakdown by SDA					
Objective Number	**Service delivery area** *(Use the same numbering as the detailed work plan for HSS cross-cutting interventions)*	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
1	Strengthened basic health service systems	11,532,794	10,823,080	13,842,607	14,567,863	6,387,939	**57,154,283**
2	Strengthened national health commodity supply chain management systems	12,027,025	1,518,484	1,594,408	1,618,063	1,698,967	**18,456,947**
3	Strengthened health information and monitoring and evaluation systems	11,053,653	11,359,725	13,074,746	14,487,698	14,907,563	**64,883,385**
4	Strengthened capacities of community based networks and community level health and development committees	8,206,517	6,624,850	6,944,133	7,127,192	6,017,364	34,920,056
	Use "Add Extra Row Below" from "Table" menu in Microsoft Word menu bar to add as many additional rows as required to ensure consistent with the 'Performance Framework'						
Total funds requested from Global Fund for HSS cross-cutting interventions *(i.e., total for all the interventions described on a programmatic basis in s.4B.1, where included in Round 8)*		**42,819,989**	**30,326,139**	**35,455,894**	**37,800,816**	**29,011,833**	**175,414,671**

ROUND 8 – HIV

5B.3 Summary of detailed budget by cost category

Summary information provided in the table below should be supplemented with additional detail in section 5B.4 below.

Table 5B.3 – Summary of detailed budget by cost category

Avoid using the "other" category unless necessary – read the Round 8 Guidelines.	**Breakdown by cost category** *(same currency as selected by Applicant on face sheet of the Proposal Form)*					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Human resources	2,483,001.00	3,210,228.00	4,162,278.00	5,201,507.00	5,810,652.00	20,867,666.00
Technical and Management Assistance	3,770,744.00	3,083,175.00	3,160,398.00	3,410,148.00	3,027,288.00	16,451,753.00
Training	9,548,650.00	3,437,775.00	4,253,471.00	3,943,780.00	1,938,114.00	23,121,790.00
Health products and health equipment	2,136,752.00	3,589,744.00	4,711,538.00	4,947,115.00	2,077,788.00	17,462,937.00
Pharmaceutical products (medicines)	0	0	0	0	0	-
Procurement and supply management costs	1,355,897.00	1,423,693.00	1,494,877.00	1,569,621.00	1,648,102.00	7,492,190.00
Infrastructure and other equipment	15,039,437.00	6,181,616.00	7,915,223.00	8,482,632.00	3,751,574.00	41,370,482.00
Communication Materials	0	0	0	0	0	-
Monitoring & Evaluation	7,436,324.00	8,298,265.00	8,601,384.00	9,031,452.00	9,483,027.00	42,850,452.00
Living Support to Clients/Target Populations	0	0	0	0	0	-
Planning and administration	617,502.00	648,377.00	680,796.00	714,835.00	750,577.00	3,412,087.00
Overheads	431,682.00	453,266.00	475,929.00	499,726.00	524,711.00	2,385,314.00
Other: *(To be further defined to meet national budget planning categories)*	-	-	-	-	-	-
Total funds requested from Global Fund for HSS cross-cutting interventions (s.4B.1)	42,819,989.00	30,326,139.00	35,455,894.00	37,800,816.00	29,011,833.00	175,414,671.00

5B.4.1 Briefly explain any significant variations in cost categories by year, or significant five year totals for those categories.

Apart from medical store refurbishment, and a number of the CSO network strengthening activities in year 1, the majority of the proposed activities are either phased (for the refurbishment and re-equipping of the PHC facilities), or will continue through the 5 year period (e.g. the monthly LGA M&E meetings).

The main 'large expenditure' items proposed in the HSS budget are :

- $32.9 million to cover the cost of the monthly M&E meetings in 774 LGAs through-out the 5 years. However, the cost of a single LGA meeting is only $641. The equivalent quarterly meetings at the state level will cost another $7.3 million.
- $21.8 million and $17.5 million for refurbishing and re-equipping 925 PHC facilities (this include laboratory equipment). The per facility unit costs are based on current and projected contracts for equivalent activities.
- $10 million for external DQA visits to PHC facilities – again through-out all 774 LGAs. This is new activity, but costed on the basis of 2 facilities being assessed per LGA per year.
- $6.9 million for zonal store refurbishment, and $7.4 million for the distribution contracts from these stores to LGA and facility level.
- $5.5 million for the monthly Ward Health Development Committees

5B.4.2 Human resources

In cases where '*human resources*' represents an important share of the budget, summarize: (i) how these amounts have been budgeted in respect of the first two years; and (ii) to what extent human resources spending will strengthen health systems' capacity at the client/target population level.

(Useful information to support the assumptions to be set out in the detailed budget includes: a list of the proposed positions that is consistent with assumptions on hours, salary etc included in the detailed budget; and the proportion (in percentage terms) of time that will be allocated to the work under this proposal.

➔ *Attach such information as a numbered annex to the proposal, and indicate the annex number in the checklist at the end of this section.)*

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The main human resource elements in this proposal are (i) to recruit 925 Health Records Officers to work at the PHC facility and ward levels, and (ii) to staff of the CSO networks at national and state levels.

The HROs will be recruited and deployed in line with the phased refurbishment of PHCs; the HR budgets reflect this phasing. The roles and responsibilities of the HROs are broadly similar to those of the Community Health Extension Workers (CHEW), and the proposed salary and benefits (at Naira 28,000 per month) are in line with this. The absence of a facility staff member with dedicated data management responsibilities is resulting in both key information systems work not being completed, and the work of other front-line health providers being distorted. Over the lifespan of this support there will be ongoing dialogue with LGAs and the respective state Local Government Service Commissions (as the employing body for LG staff) to ensure that the HROs are absorbed onto the LG payroll. In addition, this commitment (to take over the staff) will be emphasized in agreeing the MOUs with LGAs.

For the CSO staff, the rates of remuneration are standardised in line with the respective HR policies of the CBO Networks. The proposed Resource Centres will serve as a means of generating CBO and network income, to enable the staff costs to be covered beyond the period of GFATM funding.

5B.4.3. Other large expenditure items

If other 'cost categories' represent important amounts in the summary in table 5.4, (i) explain the basis for the budget calculation of those amounts. Also explain how this contribution is important to implementation of the national disease program.

➔ *Attach supporting information as clearly named and numbered annex.*

Applying for funding for HSS cross-cutting interventions is optional in Round 8

SECTION 5B CAN ONLY BE INCLUDED IN ***ONE DISEASE*** *IN ROUND 8 and only if this disease includes the applicant's programmatic description of HSS cross-cutting interventions in s.4B.*

Read the Round 8 Guidelines to consider including HSS cross-cutting interventions **ownload 'Section 5B' from the Global Fund website here if the applicant intends to apply for 'Health systems strengthening cross-cutting interventions'** ('HSS cross-cutting interventions') ***in Round 8 and has completed section 4B and included that section in the HIV proposal sections.***

Section	Document description	Annex Number
	FMoH – 2007-2009 Medium Term Health Sector Strategic Plan	4.1.1
	National HIV/AIDS Strategic Framework 2005-2009	4.1.2
	National Human Resource for Health Policy	4.1.3
	Joint Mid Term Review of National Strategic Framework 2005-2007 Report	4.1.4
	National Human Resource for Health Plan	4.1.8
	Nigerian Health Management Information System Policy	4.1.5
	National Education Sector HIV/AIDS Strategic Plan 2006-2010	4.1.6
	Mainstreaming Gender Equality into National Response to HIV and AIDS	4.1.7
	National Policy on HIV & AIDS for the Education Sector in Nigeria	4.1.8
	National Economic Empowerment and Development Strategy	4.1.9
	FMoH: National Scale up Strategy for HIV Counseling and Testing in Nigeria	4.1.10
	Nigerian Health Review 2007 Primary Health Care in Nigeria: 30years after Alma Ata	4.1.11
	Federal Republic of Nigeria ; 2006 Population Census	4.2.1
	FMoH : National HIV/Syphilis Sero-prevalence Survey 2005	4.2.2
	NNRIMS Operational Plan	4.8.1
	National M & E Plan: Systems Strengthening Assessment Report	4.8.3
	List of Sub Recipients, sectors represented and roles in this proposal	4.9.2
	Costed NSF 2005-9	5.1.1

Attachment A - HIV Performance Framework

Program Details

Country:	NIGERIA
Disease:	HIV/AIDS
Proposal ID:	

Program Goal, impact and outcome indicators

	Goals
1	To reduce HIV/AIDS incidence and provide equitable prevention, care, treatment and support while mitigating its impact among women, children and other vulnerable groups and the general population in Nigeria.
2	
3	
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5	

Impact and outcome Indicators	Indicator	Baseline			Targets					Comments*
		value	Year	Source	Year 1	Year 2	Year 3	Year 4	Year 5	
impact	HIV prevalence in the general population (15 - 49)	4.4	2005	ANC Sentinel Survey FMOH 2005	4	3.9	3.8	3.7	3.6	Information collected from antenatal sentinel surveillance surveys every two years
impact	% of young women and men aged 15-24 who are HIV infected	4.3 (women)	2005	ANC Sentinel Survey FMOH 2005	3.9	3.7	3.4	3.1	2.8	Rate given here is only for women. Based on FMOH 2005 HIV sentinel report, The report gives 4.2% for the married women 15-24 age group. The Extraporation is based on the constant average annual rate of decline of 7% percentage points in the between years 2001, 2003 & 2005.
impact	% of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	94.6	2007	ICAP Programme Record	95	95.25	95.5	95.75	96	The indicator perfomance is such that only minimal annual improvements are envisaged. Will be obtained from cohort analysis of ART clients annually
impact	% of infants born to HIV infected mothers who are HIV infected		2006	ANC Sentinel Survey FMOH 2005						The projection available in the report are up to year 2010. An extra polation was done for the subsequent years
impact	% of children under age 18 who are orphans	10.8	2005	UNICEF- Children on the brink, UNFPA State of Nig Popn 2005	10.6 (0-14yrs)	10.56	10.52	10.48	10.44	The value refer to%of children 0-14years, - UNICEF estimate (UNFPA Nigeria State of Nigerian Population, 2005). Projections assumed / used constant annual rate of decline
outcome	% of women and men aged 15-49 who have had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse	**56.4**	2005	NARHS 2005	56.4	59.4	62.4	65.4	68.4	Value given here from NARHS 2005 is for sex with non marital partner. A weighted average of ages 15-49 was 56.4 and 55.9 for 15-64. A 3 percentage point increase was use in projection based on the NARHS report which indicated that 3% had just started using condom.
outcome	% of never married young men and women aged 15-24 who have never had sex	**37.8**	2003	DHS/DHS+ (Demographic and Health Survey 2003)	40.3	40.8	41.3	41.8	42.3	The value refers to those that had never had sex without specifying whether they were married or not. An annual increment on 0.5 percentage points were used for the projection since 2003.

* please specify source of measurement for indicator in case different to baseline source

Program Objectives, Service Delivery Areas and Indicators

Objective Number	Objective description	Comments
1	1. To scale up HIV prevention services among children and adults in Nigeria	
2	2. To Scale up chronic HIV/AIDS treatment among adults and children in Nigeria	
3	3. To scale-up care and support services for PLWHA, orphans and vulnerable children	
4	4. To Create Supportive Environment to Deliver Comprehensive HIV/AIDS Services	
5	5. To enhance the management and coordination of the multi-sectoral response at National, state, Local Government and Community levels	
6		
7		
8		
9		
10		
11		
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13		
14		
15		

Attachment A - HIV Performance Framework

Program Details

Country:	NIGERIA
Disease:	HIV/AIDS
Proposal ID:	

Objective / Indicator Number (e.g.: 1.1, 1.2)	Service Delivery Area	Indicator	Baseline (if applicable)			Targets for year 1 and year 2				Annual targets for years 3, 4, and 5			Directly tied (Y/N)	Baselines included in targets (Y/N)	Targets cumulative (Y-over program term/Y-cumulative annually/N-not cumulative)	DTF: Name of PR responsible for implementation of the corresponding activity	Comments, methods and frequency of data collection
			Value	Year	Source	6 months	12 months	18 months	24 months	Year 3	Year 4	Year 5					
1.1	PMTCT	Number of pregnant women tested and received their test results	270,107	2,007	HMIS	0	75,000	195,000	390,000	690,000	1,332,000	1,332,000	Y	N	Y - cumulative annually	NACA	Reported monthly through the routine reporting system
1.2	PMTCT	Number of HIV-infected pregnant women who receive a complete course antiretroviral prophylaxis to reduce the risk of mother-to-child transmission	12,278	2,007	HMIS	0	2,640	6,864	13,728	24,288	46,886	46,886	Y	N	Y - over program term	NACA	Reported monthly through the routine reporting system
1.3	PMTCT	No (and %). of facilities providing PMTCT services for pregnant women (& with HIV/RH intergrated Services)	74	2007	HMIS	0	125 (0.5%)	160 (0.7%)	325 (1.4%)	575 (2.5%)	1110 (4.8%)	1110 (4.8%)	Y	N	Y - over program term	NACA	Reported monthly through the routine reporting system
1.4	Testing and Counseling	No. of individuals who are counselled, tested for HIV and received their test results	753,391	2007	HMIS	0	307200	643200	1286400	2126400	4634400	4634400	Y	N	Y - cumulative annually	NACA & PPFN	Reported monthly through the routine reporting system
1.5	Testing and Counseling	No of Sites providing HIV /RH counselling and testing service	442	2007	HMIS	0	125	160	325	575	1480	1480	Y	N	Y - over program term	NACA & PPFN	Reported monthly through the routine reporting system
1.6	Blood safety and universal precaution	No. of facilities with staff trained in universal precautions for infection control and having infection control committees	0	2008	HMIS	0	125	160	325	575	1480	1480	Y	N	Y - over program term	NACA	Reported biannualy through programme report
1.7	BCC - Mass media	No. of HIV & AIDS IEC material brodcasted or distributed (radio and television programmams/ news papers per year	0	2008	Administrative records	0	0	3042	6084	8112	8112	8112	Y	N	Y - over program term	NACA & PPFN	Reported biannualy through programme report
1.8	BCC - community outreach	No. of young people reached with life skills-based HIV/AIDS education in schools	0	2008	Reports (Programme reports)	0	300000		480000	600000	840000		Y	N	Y - cumulative annually	CISHAN	Reported biannualy through programme report
1.9	BCC - community outreach and schools	No. of young people out-of-school reached by HIV/AIDS prevention programmes	0	2008	Reports (Programme reports)	0					296000	296000	Y	N	Y - cumulative annually	CISHAN	Reported biannualy through programme report
2.1	Antiretroviral treatment and monitoring	No. of sites collecting DBS samples for Early Infant HIV diagnosis	0	2008	HMIS	0	2112	5491	10982	19430	37509	37509	Y	N	Y - over program term	NACA	Reported Quarterly through programme report
2.2	Antiretroviral treatment and monitoring	No. of children aged 0-14 years receiving ART services	0	2008	HMIS	0	3524	3830	7660	12409	16361	18569	Y	Y	Y - over program term	NACA	Reported monthly through the routine reporting system
2.3	Prophylaxis and treatment for opportunistic infections	No. of people living with HIV receiving co-trimozaxole during the reporting period	0	2008	HMIS	0	6600	17160	34320	60720	156288	156288	Y	N	Y - cumulative annually	NACA	Reported monthly through the routine reporting system
2.4	TB/HIV	No. of people with HIV receiving HIV treatment and care services who were screened for TB symptoms.	0	2008	Patient records	0	2,819.00	3,064.00	6,128.00	9,927.00	107,097.00	144,312.00	Y	N	Y - over program term	NACA	Reported monthly through the routine reporting system
3.1	Support for orphans and vulnerable children	No. of OVCs aged 0-17 years that receive external support including education	0	2008	Administrative records	0	1250	1625	3250	5750	9250	9250	Y	N	Y - over program term	CISHAN	Reported Quarterly through Administrative record
3.2	Care and support for chronicall ill	No. of PLWHA receiving home-based care and support	0	2008	Administrative records	0	7500	10000	19500	34500	55500	55500	Y	N	Y - over program term	CISHAN	Reported Quarterly through Administrative record
3.3	Care and support for the chronically ill	No. of CBOs and NGOs receiving support to provide home-based care	0	2008	Administrative records	0	25	32	65	115	185	185	Y	N	Y - over program term	CISHAN	Reported Quarterly through Administrative record
4.1	Policy development including workplace policy	No. of small and medium term enterprises with active workplace-based HIV/AIDS programmes	0	2008	Administrative records	0	0	25	50	100	150	200	Y	N	Y - over program term	PPFN	Reported Quarterly through Administrative record
5.1	HSS: Information system	Percentage of Health facilities submitting timely reports reports according to national guidelines	0	2008	Administrative records	0	125	160	325	575	1110	1110	Y	N	Y - over program term	NACA	Reported Quarterly through Administrative record
5.2	HSS: Leadership and Governance	Number of organisations strengthened in program management and coordination	0	2008	Administrative records	0	10	10	15	20	20	20	Y	N	Y - over program term	NACA	Reported Quarterly through Administrative record

Attachment A - HIV Performance Framework

Program Details

Country:	Nigeria
Disease:	
Proposal ID:	

Program Goal, impact and outcome indicators

	Goals
1	To Increase Use of, and Public Confidence in, the Minimum Package of Health Care Provided through the National PHC System
2	
3	
4	
5	

Impact and outcome Indicators	Indicator	Baseline			Targets					Comments*
		value	Year	Source	Year 1	Year 2	Year 3	Year 4	Year 5	
outcome	Ward Minimum Health Care Package available in 925 Wards in Nigeria (10% of Wards) by 2013	missing value	2007	missing value	125	325	575	825	925	End of project report
outcome	50% of GF supported LGAs using data in preparation of annual health operational plans	missing value	2007	missing value	12	32	57	82	92	End of project report
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* please specify source of measurement for indicator in case different to baseline source

Program Objectives, Service Delivery Areas and Indicators

Objective Number	Objective description	Comments
1	To increase the number of PHC facilities providing the Ward Minimum Health Care Package, towards achieving the National Target of 50% by 2013	
2	To have appropriate and adequate drug availability at all public PHC facilities	
3	To Increase data capture and use of PHC Information at the LGA and State Levels	
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Attachment A - HIV Performance Framework

Program Details

Country:	Nigeria
Disease:	
Proposal ID:	

Objective / Indicator Number (e.g.: 1.1, 1.2)	Service Delivery Area	Indicator	Baseline (if applicable)			Targets for year 1 and year 2				Annual targets for years 3, 4, and 5			Directly tied (Y/N)	Baselines included in targets (Y/N)	Targets cumulative (Y-over program term/Y-cumulative annually/N-not cumulative)	DTF: Name of PR responsible for implementation of the corresponding activity	Comments, methods and frequency of data collection
			Value	Year	Source	6 months	12 months	18 months	24 months	Year 3	Year 4	Year 5					
1.1	HSS: Service delivery	1.1 Number of facilities refurbished, equipped and providing services	1030	2007	HERFON PHC Assessment 2007.	61	125	225	325	575	825	925	Y	N	Y - cumulative annually	missing value	Quartely/yearly PR reports
1.2	HSS: Service delivery	1.2 Number of health workers trained on integrated service delivery package	5	2020	PATHS/Enugu State Government-PPM Initiative	366	750	1350	1950	3450	4950	5550	Y	N	Y - over program term	missing value	Quartely/yearly PR reports
1.3	HSS: Service delivery	1.3 Number of facilities that have recieved supportive supervision in the past 12 months (90%)	missing value	2020	missing value	54	112	202	292	517	742	832	Y	N	Y - over program term	missing value	Yearly Facility Supervision Reports
1.4	HSS: Service delivery	1.4 Number of LGAs that have a PPM program established	missing value	2020	missing value	12	25	45	65	115	165	185	Y	N	Y - over program term	missing value	Quarterly LMIS reports
2.1	HSS: Medical Products, vaccines and technology	2.1 Number of GF supported facilities reporting stock out of ATM, RH and MCH commodities (5% or less)	missing value	2020	missing value	3	6	11	16	28	41	46	Y	N	Y - over program term	missing value	Biannual stores reports
3.1	HSS: Information system	3.1 Number of GF supported health facilities that report data on key indicators to the national level within 30 days after the end of each quarter (90%)	missing value	2020	missing value	54	112	202	292	517	742	832	Y	N	Y - over program term	missing value	Quarterly HMIS Reports
4.1	HSS: Community Strengthening	4.1 Number of Ward Health Development Committees mobilising community participation in health and supported by CSOs(90%)	missing value	2020	missing value	225	450	789	1125	1575	1800	0	Y	N	Y - over program term	missing value	
	Please Select…	4.2 Number of CSOs trained on integrated ATM issues and intervention	missing value	2020	missing value	115	230	529	828	1058	1518	1700	Y	N	Y - over program term	missing value	