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

PROPOSAL FORM – ROUND 9
(SINGLE COUNTRY APPLICANTS)

Clarified section 1

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 9 Guidelines)*	LOW INCOME		
Applicant Type	☒ ccm	☐ Sub-CCM	☐ Non-CCM

Round 9 Proposal Element(s):			
Disease	**Title**	**Does this disease include cross-cutting Health Systems Strengthening interventions in part 4B? *(include in one disease only)***	**Is this a 're-submit' of the same disease proposal not recommended in Round 8?**
HIV[1]	Scaling-up gender sensitive HIV/AIDS prevention, treatment, and care and support interventions for adults and children in Nigeria.	NO	YES
Tuberculosis[1]	Further DOTS expansion while addressing MDR-TB prevention and Control	NO	YES
Malaria			

[1] 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/

If this is a Round 8 proposal being re-submitted, have the TRP Review Form comments been clearly addressed in s.4.5.2?	☒ Yes	☐ No
Are there major new objectives compared to the Round 8 proposal that is being re-submitted? If yes, please provide a summary of the changes in the box below by each disease re-submission and section number.	☐ Yes	☒ No
INSERT TEXT – maximum one page		

Currency	☒ USD	or	☐ EURO

Deadline for submission of proposals: **12 noon, Local Geneva Time, Monday 1 June 2009**

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 9:

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 9. Refer to the Round 9 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 9 Guidelines fully before completing a Round 9 proposal. Applicants should continually refer to these Guidelines as they answer each section in the proposal form. All other Round 9 Documents are available here.

A number of recent Global Fund Board decisions have been reflected in the Proposal Form. The *Round 9 Guidelines* explain these decisions in the order they apply to this Proposal Form. Information on these decisions is available at:
http://www.theglobalfund.org/documents/board/16/GF-BM16-Decisions_en.pdf.

Since Round 7, efforts have been made to simplify the structure and remove duplication in the Proposal Form. The Round 9 Guidelines therefore contain the **majority of instructions** and examples that will assist in the completion of the form.

1. FUNDING SUMMARY AND CONTACT DETAILS

Clarified section 1.1

1.1. Funding summary

Disease	Total funds requested over proposal term					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
HIV	25,783,005	36,197,491	64,372,670	97,262,426	117,404,316	341,019,908
Tuberculosis	8,937,024	22,578,136	32,524,897	34,947,901	14,344,143	113,332,101
Malaria						
HSS cross-cutting interventions section 4B and 5B within *[insert name of the one disease which includes s.4B. and s.5B. only if relevant]*						
					Total Round 9 Funding Request ➔:	**454,352,009**

1.2. Contact details

	Primary contact	Secondary contact
Name	JEROME MAFENI	BELLO FATAI WOLE
Title	Chairman, CCM Nigeria	Executive Secretary
Organization	ENHANSE Project/Futures Group International	COUNTRY COORDINATING MECHANISM (CCM), NIGERIA
Mailing address	50 HAILE SELASSIE STREET, ASOKORO, PMB 533, ABUJA, NIGERIA	4TH FLOOR, (ABIA HOUSE) ORJI UZOR KALU HOUSE, PLOT 979, 1ST AVENUE CENTRAL BUSINESS DISTRICT, MAITAMA ABUJA.
Telephone	234-803-7001609	234-806-0093229
Fax	234-7066873254	
E-mail address	jmafeni@futuresgroup.com	fwbello@yahoo.com
Alternate e-mail address	jmafeni@gmail.com	fwbello@ccmnigeria.org

1.3. List of Abbreviations and Acronyms used by the Applicant

Acronym/ Abbreviation	Meaning
AIDS	Acquired Immune Deficiency Syndrome
ARFH	Association for Reproductive and Family Health
ART	Anti-Retroviral Therapy
ARVs	Anti-Retroviral Drugs
BCC	Behavioral Change Communication
CBOs	Community-Based Organizations
CCM	Country Coordinating Mechanism
CiSHAN	Civil Society for HIV/AIDS in Nigeria
CPT	Cotrimoxazole Preventive Therapy
DFID	Department for International Development
FBOs	Faith-Based Organizations
FHI	Family Health International
FLHE	Family Life and HIV Education
FMOE	Federal Ministry of Education
FMOH	Federal Ministry of Health
FMOWA& SD	Federal Ministry of Women Affairs and Social Development
FSWs	Female Sex Workers
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSS	Health System Strengthening
IBBSS	Integrated Behavioral and Biological Sentinel Survey
IDUs	Injecting Drug Users
LGAs	Local Government Areas
M&E	Monitoring and Evaluation
MARPs	Most-at-Risk Populations
MDGs	Millennium Development Goals
MSM	Men Who Have Sex With Men
NACA	National Agency for the Control of AIDS
NARHS	National AIDS and Reproductive Health Survey
NGOs	Non-Governmental Organizations
NHSS	National HIV Sentinel Survey
NIBUCAA	Nigerian Business Coalition Against AIDS
NPA	National Plan of Action
NSF	National Strategic Framework
NSS	National Sentinel Survey
OIs	Opportunistic Infections
OR	Operational Research
OVC	Orphans and Vulnerable Children
PEP	Post Exposure Prophylaxis
PEPFAR	U.S.President's Emergency Plan For AIDS Relief
PHC	Primary Health Care
PLWHAs	People Living With HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PPFN	Planned Parenthood Federation of Nigeria
PRs	Principal Recipients
SACA	State Agency for AIDS Control/State Action Committee on AIDS
SFH	Society for Family Health
SMOH	State Ministry of Health
SRH	Sexual and Reproductive Health
SRs	Sub-Recipients
STIs	Sexually Transmitted Infection
TB	Tuberculosis

UNAIDS	UN Joint Program on AIDS
WHO	World Health Organization

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 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

Clarified section 2.1.1

2.1.1. Membership summary

Sector Representation		Number of members
☒	Academic/educational sector	2
☒	Government	5
☒	Non-government organizations (NGOs)/community-based organizations	11
☒	People living with the diseases	1
☒	People representing key affected populations[2]	1
☒	Private sector	1
☒	Faith-based organizations	2
☒	Multilateral and bilateral development partners in country	4
☒	Other *(International NGOs):*	0
	Total Number of Members: *(Number must equal number of members in 'Attachment C'[3])*	27

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	☒ Yes

[2] Please use the Round 9 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/9/CP_Pol_R9_AttachmentC_en.xls

(b)	Is there continuing active membership of people living with and/or affected by the diseases.	☐ No	☒ 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 substantial knowledge and in depth experience in health systems development and strengthening. Many CCM members from the multilateral and bi-lateral partners (WHO, UNDP.UNAIDS, USAID, DFID, CIDA etc) have significant health system experience both in Nigeria and other countries and frequently bring this to inform discussions on issues of the Nigerian health system and this impact on the three diseases. Some CCM members especially from the government and NGO sectors have expert knowledge, skills, and understanding of the Nigeria health system and how the system impacts on programs and outcomes of the three diseases. Some CCM members are health system experts and/or work on the three diseases in the country. The CCM therefore has substantial capacity and experience on how health system issues impact on HIV/AIDS, TB and Malaria programs and outcomes.

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 issues and as a result eight (8) females represent different constituencies on the CCM Board. A couple of members are gender experts professionally and many have significant knowledge, expertise, and skills on gender mainstreaming not only for the three diseases but in many other areas of development both in Nigeria and in other countries. Therefore the capacity and experience of the CCM in gender issues is substantial.

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 (NSFs) for HIV/AIDS, Malaria and Tuberculosis) which are multi-sectoral in nature and from which the GFATM Nigeria proposals are derived. The Resource Mobilization Committee (RMC) of the CCM Nigeria is chaired by WHO and has representation from the 3 disease programs, multilateral and bilateral organizations, line ministries represented on the CCM, the Civil Society Organizations (CSOs), 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.	
☒ Applied for funding in Round 7 and/or Round 8 **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 7 **or** was determined non-compliant with the minimum eligibility requirements when last applied.	➔ ***First, go to 'Attachment D' and complete.*** ➔ ***Then also complete sections 2.2.5 to 2.2.8 below*** *(Do not complete sections 2.2.2 to 2.2.4)*

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 Mobilization 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

(SEE ANNEX4 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, Organizations 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 review, 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 15th 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.	Minutes of the 18th CCM Meeting (Annex 1, GF R9 Proposal)

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 formulate and present findings, reports, and recommendations to the CCM Nigeria for 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 9 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 organizations 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 3 of Round 8 attachment) meeting and the CCM finally shortlisted 12 organizations for verification purpose after which 9 of the organizations 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	Minutes of the

members decided on the Principal Recipient(s) for each disease.	15th CCM Meeting (Annex 5, GF R8 Proposal)

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 Society for HIV/AIDS in Nigeria	HIV/AIDS	CSO
Association for Reproductive and Family Health	TB	NGO
CHAN-MEDI-PHARM	TB	NGO

*** Choose a 'sector' from the possible options that are included in this Proposal Form 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.
ONE PAGE MAXIMUM

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***
		☐ No ➔*go to s.2.2.8.*
(b)	**If yes, attach** the plan for the management of actual and potential conflicts of interest.	☐ **Yes** ***[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

Proposal checklist - Section 1 and 2

Section 2: Eligibility		List Annex Name and Number
CCM and Sub-CCM applicants		
2.2.2(a)	Comprehensive documentation on **processes** used to invite submissions for possible integration into the proposal (if different processes used for each disease, attach as separate annexes).	☒Copy of Advert (Annex 1, Round 8 GF Proposal)
2.2.2(b)	Comprehensive documentation on **processes** used to review submissions for possible integration into the proposal (if different processes used for each disease, attach as separate annexes).	☒List and areas of interventions (Annex 2, GF Round 8 Proposal)
2.2.2(c)	Comprehensive documentation on **processes** used to ensure the input of a broad range of stakeholders in the proposal development process	☒Minutes and list of attendance (Annex 3, GF Round 8 Proposal)
2.2.3(a)	Comprehensive documentation on processes to oversee grant implementation by the CCM (or Sub-CCM).	☒CCM Nigeria Governance Manual (Annex 2, GF Round 9)
2.2.3(b)	Comprehensive documentation on processes used to ensure the input of a broad range of stakeholders in grant oversight process.	☒ CCM Nigeria Governance Manual (Annex 2, GF Round 9)
2.2.4(a)	Comprehensive documentation on processes used to select and nominate the Principal Recipient (such as the minutes of the CCM meeting at which the PR(s) was/were nominated). If different processes used for each disease, then explain.	☒Minutes of 15th CCM meeting (Annex 5, GF Round 8 Proposal)
2.2.7	Documented procedures for the management of potential Conflicts of Interest between the Principal Recipient(s) and the Chair or Vice Chair of the Coordinating Mechanism	☒ CCM Constitution (Annex 3 Round 9)
2.2.8	Minutes of the meeting at which the proposal was developed and CCM (or Sub-CCM) endorsed.	☒22nd CCM Nigeria Meeting Minutes Annex 4 Round 9)
2.2.8	Endorsement of the proposal by all CCM (or Sub-CCM) members.	**Attachment C to the Proposal Form**
Other documents relevant to sections 1 and 2 attached by applicant: *(add extra rows to this section of the table as required to ensure that documents directly relevant are attached)*		

ROUND 9 – HIV

3. PROPOSAL SUMMARY

3.1 Duration of Proposal	Planned Start Date	To
Month and year: *(up to 5 years)*	January 2010	December 2014

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 9 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 9 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/9/CP_PoI_R9_FAQ_GrantConsolidation_en.pdf

(b) If yes, which grants are planned to be consolidated with the Round 9 proposal after Board approval? *(List the relevant grant number(s))*	

3.3 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 2010, 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 on aid effectiveness.

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

3.4 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

3.5 Summary of Round 9 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$341,019,908 million from the Global Fund under its Round 9 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 9 the gap in access and coverage of HIV services to rural communties will be bridged by further decentralizing HIV/AIDS prevention, care and support services to the PHC and community levels, while expanding ART services through establishing 194 new ART sites in secondary health facilities. 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 (PLWHAs) and orphans and vulnerable children (OVC).
4. To create a supportive environment for delivery of comprehensive gender sensitive HIV/AIDS services
5. To enhance the management and coordination of HIV/AIDS programs in the country

The approved GF Round 8 Health System Strengthening (HSS) grant will strengthen 925 PHC facilities to deliver an integrated essential package of services including HIV/AIDS, tuberculosis, malaria, STIs, OIs and SRH, in keeping with the current government of Nigeria initiative. The implementation of HCT, PMTCT, Opportunistic Infection Diagnosis and Management will be done in these strengthened PHC facilities, leading to the following results:

About **4.04 million** pregnant women will receive HIV counseling and testing (**HCT**) out of whom **185,886** (4.6%) HIV positive women will receive a full course of ARV prophylaxis to prevent mother to child transmission of HIV and their HIV-exposed babies will undergo tests for early infant diagnosis (**EID**) of HIV. About **8.6 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 HCT services; 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 targeting 80 million individuals, whilst about **4,848,000** million students will receive Family Life and HIV Education (**FLHE**) through curricular and co-curricular activities. Over the 5-years of the proposal, **345,200** most-at-risk-populations (**MARPs) -** female sex workers (FSWs), men who sex with men (MSM), and injecting drug users (IDUs) - will be reached with HIV/SRH services.

About **90,025** new people living with HIV/AIDS (**78,872 adults** and **11,153 children**) children will receive anti-retroviral treatment (**ART**) , more than **582,660** people including those co-infected with TB will receive Cotrimoxazole Preventive Therapy (**CPT**) whilst other opportunistic infections diagnosis, treatment and prevention services will be provided to PLWHAs; NGOs, CBOs and FBOs will be empowered to care for some **86,250** PLWHAs and **28,800** OVC (including children infected with HIV) who will receive a basic package of support that includes educational, health, and nutrition support. Two hundred (**200**) small and medium enterprises (**SMEs**) will be supported to implement workplace policies and interventions that will benefit **360,000** workers.

The National Agency for Control of AIDS (NACA), Planned Parenthood Federation of Nigeria (PPFN) and the Civil Society for HIV/AIDS in Nigeria (CiSHAN) has been selected as PRs. In addition, **18**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 program, building on achievements made through Round 5 funding and benefiting from lessons from programs supported by other partners in order to reduce overlaps and increase efficiencies. The GF Round 8 HSS grant will be critical to achieving the targets set in this proposal, which will increase Nigeria's chances of meeting the Millennium Development Goals (MDGs) especially as they relate to halting the spread of HIV and AIDS and the Universal Access targets by 2015.

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 (NSF) for HIV/AIDS (2005-09) and 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, and orphans and vulnerable children (OVC). Line Minstries and states have developed their Sectoral and State Strategic Plans in line with the NSF. The plan towards the development of the NSF II(2010-2015) has commenced, with the participatory development and consensus of the National Targets for the period. The targets were population needs derived and on the principles of attaining the Universal access by 2015 as well as the Millenium development Goals by same year. The national strategies are:

Prevention: This encompasses 1. Behavior change for reducing high risk sex behaviors; 2. Prevention of mother-to-child transmission (PMTCT); 3. HIV counseling and testing (HCT), 4. Prevention of HIV transmssion in the health setting including blood safety, universal precautions, and post exposure prophylaxis (PEP), 5. Prompt and effective treatment of STIs and condom use programming. Unprotected high risk sex, mother to child transmission, and blood borne transmission are the main modes for the spread of HIV whilst STIs facilitate the transmission of HIV. The strategies, jointly and severally, are expected to prevent the spread of HIV.

Treatment: This encompasses: 1. Treatment for AIDS with anti-retrovirals (adults & children), 2. Treatment of opportunistic infections and 3. TB/HIV co-infection interventions. AIDS is an important cause of death especially in adults and increasingly in children. With severely compromised immune system from the HIV infection, AIDS patients die from opportunistic infections (OIs)of which TB is a prime example. Additionally, HIV and TB mutually facilitate co-infection and disease progression. Effective treatment of AIDS and OIs including TB is expected to reduce mortality.

Care and support: This includes home/community based care and palliative care. About 3 million people living with HIV/AIDS (PLWHAs) need care and support including psychological, health, social, spiritual, and economic support to reduce the impact of the disease. These services are provided mainly by CBOs, NGOs, FBOs, and private providers aligned with and in the context of the National Strategic Framework and guidelines. The expected outcome is to improve the quality of life of PLWHAs, their families, and communities.

Reduce the impact of HIV/AIDS on OVC: HIV/AIDS increases children's psychosocial, health, economic and other vulnerabilities. About a quarter of Nigeria's estimated 17.5 million orphans are AIDS orphans. The National Plan of Action (NAP) on OVC (2006-2010) was developed to guide interventions targeted at OVC. It recommends seven priority areas of service for OVC care and suppport: health, education, nutrition, protection, psychosocial, economic strengthening/household care and shelter. Implemented by a multisectoral approach coordinated by the Federal Minisitry of Women Affairs and Social Development, the Plan aims to reach at least 25% of orphans with these services by 2010. Most of these activities are implemented by CBOs, NGOs, and FBOs.

Increase knowledge of HIV/AIDS among students in basic and secondary schools: The Federal Ministry of Education (FMoE) developed a HIV/AIDS Policy in 2005, which in turn, informed the the development of the National Education Sector HIV/AIDS Strategic Plan (2006-2010) with 4 objectives, namely: 1. Promote awareness on HIV and AIDS and other STIs, 2. Develop strategies and interventions that support behavior 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. The expected outcome of this strategy is to prevent HIV infection as well as inculcate constructive responses on HIV/AIDS issues in students in basic and secondary schools.

Strategic Information: The health sector undertakes HIV/AIDS and STI sentinel surveillance, population surveys (NARHS) and special surveys (IBBSS, HIV Drug Resistance Monitoring).Data and information on the magnitude

and situation of PLWHAs from appropriate operational researches, surveys and disease surveillance will inform the design and implementation of effective care and support programs. The expected outcome of this strategy will inform the design and implementation of national response strategies.

(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 or Round 8 proposal when the document was last submitted, and the Global Fund will obtain this document from our 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
☒ National Health Sector Development/Strategic Plan	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	

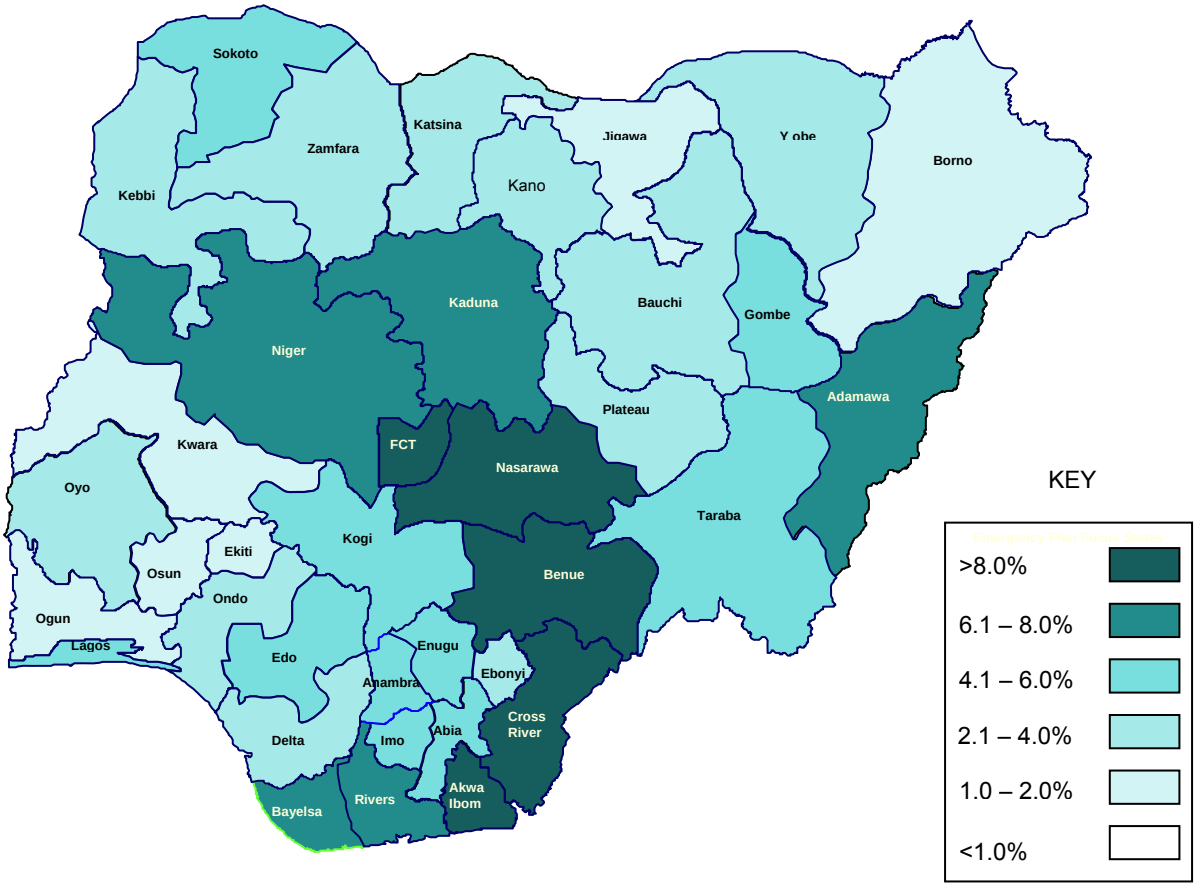
4.2 Epidemiological Background

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***

The National HIV Sentinel Survey (NHSS) 2008 revealed a national HIV prevalence of 4.6%. The prevalence varied by state ranging from 1% to 10.6%. The prevalence was generally higher in urban than rural areas except in 9 states and the FCT. It increased with age group up to 25-29 years after which it then declined. It was higher among singles than married and higher among women with primary and secondary education.

Figure 1: HIV prevalence by states (NHSS 2008)



(b) **Size of population group(s)** *(If national data is disaggregated differently then type over the categories proposed)*			
Population Groups	**Population Size**	**Source of Data**	**Year of Estimate**
Total country population (all ages)	157,141,288	National Population Council (NPC) 1991 Analysis*	2009
Women ≥ 25 years	29,277,352	NPC 1991 Analysis	2009
Women 19 – 24 years	6,850,779 (20-24yrs)	NPC 1991 Analysis	2009
Women 15 – 18 years	6,713,266 (15-19yrs)	NPC 1991 Analysis	2009
Men ≥ 25 years	28,378,666	NPC 1991 Analysis	2009
Men 19 – 24 years	6,738,847 (20-24yrs)	NPC 1991 Analysis	2009
Men 15 – 18 years	6,956,710 (15-19yrs)	NPC 1991 Analysis	2009
Girls 0 – 14 years	34,186,857	NPC 1991 Analysis	2009
Boys 0 – 14 years	35,435,882	NPC 1991 Analysis	2009
Other **: Women 25-49	21,456,503	NPC 1991 Analysis	2009
Other **: Men 25-64	26,011,810	NPC 1991 Analysis	2009
Other **: **Refer to the Round 9 Guidelines for other possible groups			

*The last census for which data was disaggregated by age was in 1991. The last census data in 2006 is not officially released yet.

4.2.2 HIV epidemiology of target population(s) *(If national data is disaggregated differently then type other the categories suggested)*			
Population Groups	**Estimated Number**	**Source of Data**	**Year of Estimate**
Number of people living with HIV *(all ages)*	2.95 Million	National AIDS and Reproductive Health Survey (NARHS) 2007/ANC 2008 EPP	2008
Women living with HIV 25 -49 yrs	1,025,621	NARHS data set 2007/NPC 1991 Analysis	2009
Women living with HIV 19 – 24 years	308,285 (20-24yrs)	NARHS 2007/NPC 1991 Analysis	2009

4.2.2 HIV epidemiology of target population(s)

(If national data is disaggregated differently then type other the categories suggested)

Population Groups	Estimated Number	Source of Data	Year of Estimate
Women living with HIV 15 – 18 years	87,272 (15-19yrs)	NARHS 2007/NPC 1991 Analysis	2009
Pregnant women living with HIV	289,140	NSS 2008 (ANC)/NPC 1991	2009
Men living with HIV 25 - 64	1,069,085	NARHS 2007/NPC 1991 Analysis	2009
Men living with HIV 19 – 24 years	128,038 (20-24yrs)	NARHS 2007/NPC 1991 Analysis	2009
Men living with HIV 15 – 18 years	146,091 (15-19yrs)	NARHS 2007/NPC 1991 Analysis	2009
Girls (0 – 14 years) living with HIV			
Boys (0 – 14 years) living with HIV			
Other**: **Refer to the Round 9 Guidelines for other possible groups*			
Other**: Women with HIV ≥ 25			
Other**: Men with HIV ≥ 25			[*use "Tab" key to add extra rows if needed*]

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[1] 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 which could limit the expected outcomes of the strategies listed in section 4.1 and therefore increase the existing gaps in the delivery of services to target populations. The main weaknesses are:
i) *Inadequate resources:* The national strategies for HIV/AIDS prevention, treatment, care and support are limited by inadequate resources and inefficiencies in resource mobilization, allocation, and management. Although the

[1] Please refer back to the definition in s.2 and found in the Round 9 Guidelines.

national HIV/AIDS program has developed national scale-up plans and targets, and attracted significant resources, substantial programmatic and financial gaps remain. Consequently, the national strategies listed above have not been fully implemented.

ii) *Inadequate HIV prevention*: Coverage of HIV prevention services are still low: only 14.4% of adults in the country have ever tested for HIV, and only 11% of pregnant women currently have access to 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 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 such as female sex workers (FSWs), men who have sex with men (MSM) and injecting drug users (IDUs). These weaknesses reduce the achievements of the prevention outcomes.

iii) *Inadequate dissemination of treatment, care and support guidelines*: To achieve rapid scale-up of HIV/AIDS prevention, treatment and care services, national frameworks, standard operating procedures (SOPs), 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. These weaknesses constrain the achievement of national targets.

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

v) *Inadequate attention to socio-cultural and economic drivers of HIV/AIDS epidemic*: 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. The national response also inadequately addresses poverty issues that drive many people including FSWs to high risk behaviors that expose them to contracting and transmitting HIV. Inability to adequately address the socio-economic drivers of the epidemic constraints the achievement of Federal Minisitry of Women Affairs and Social Development the national outcomes.

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 organizational and human capacity and systems at these two levels. Private sector to complement the national response remains largely under-tapped.

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.

x) *Inadequate coverage of TB/HIV collaborative activities:* Only 500 out of a total of 2,724 DOTS centers were implementing TB/HIV collaborative activities by end of 2008. Staff in both the TB and HIV/AIDS programmes have not been trained in infection control measures while INH prophylaxis among HIV positive individuals is still in pilot phase.

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 national HIV response has enjoyed a number of achievements. However, there are deficiencies within the health sector that have posed challenges to achieving Universal Access. Some of those weaknesses are systemic, cutting across all disease programs, whereas other weaknesses are unique to HIV service delivery and outcomes. The majority of these deficiencies are being addressed under the auspices of different donor projects.

(I) Areas for Improvement in the General Health System

1. Incomplete decentralization of services: The Government and its partners have ensured that primary health care facilities (PHCs) are distributed throughout the country; however, these facilities offer a limited package of services. In contrast, most secondary- and tertiary-level facilities are still concentrated in urban areas.
2. Challenges with continuity of care: There is tremendous potential to strengthen referral linkages between different levels of health care, as well as between the public and private sectors in areas of synergy.
3. Human resource constraints: As with other low-resource settings, Nigeria's health system is characterized by staff shortages—particularly in rural areas and at lower levels of care—underscoring the need for improved human resource development/management to address issues such as staff recruitment, deployment, remuneration, and incentives/disincentives for staff retention and high-quality performance.
4. Health physical infrastructure that needs to be refurbished/upgraded: Nigeria has numerous health facilities at different levels. However, some of those facilities are in need of refurbishment and functioning equipment.
5. Insufficient resources (human, financial, systems) to support Quality Assurance/Quality Improvement: There is a need for a coherent system that addresses various dimensions of quality of care in both the pubic and private health sectors, including but not limited to supportive supervision of staff.
6. Gaps related to procurement and supply chain management: There is a recognized need to streamline and strengthen procurement and supply chain management in the country. The parallel systems that currently exist limits efficiency, effectiveness, and sustainability.
7. Less-than-optimal knowledge management: In the interest of evidence-informed action, the Government and its partners have prioritized deficiencies along the pathway from routine data production to data use (e.g., capacity gaps among data management staff at sub-national and service delivery levels; improved IT infrastructure to support timely, efficient, and high-quality collation, storage, analysis, and feedback).

(II) Areas for Improvement Specifically Related to HIV Service Delivery

1. Systematic approach to service integration: In the interest of reducing missed opportunities to link beneficiaries with services that improve their quality of life and survival, there is a need for a more systematic approach to mainstreaming HIV in the health sector. This Round 9 proposal outlines activities to transition from a vertical HIV approach to an integrated approach that builds on synergies between HIV and other key service delivery areas such as TB control and sexual and reproductive health (e.g., STI services, family planning).

2. Positioning HIV counseling and testing (HCT) as an entry point: One of the biggest challenges has been the limited availability, and consequently limited coverage, of HCT services in the country. Increased access to HCT, as an entry point, will increase access to HIV treatment, care and support, and reproductive health services, as well as support behavior change efforts aimed at preventing the spread of infections.

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.

ONE PAGE MAXIMUM

(I) Creating a framework and policy tools to guide Health Systems Strengthening

The Federal Government of Nigeria and its partners have formulated policies and strategies to address weaknesses and gaps within the health system. The National Health Policy articulates priorities, linking them to broader health goals and impacts. The Federal Government of Nigeria has also established the Health Sector Reform Program (HSRP), which provides a framework to guide the entire health system, not just the government sector. The HSRP prioritizes health stewardship, national-level health management, partnerships and collaboration (including community involvement) as critical pillars to be strengthened within the health system. Coupled with government programs and mechanisms such as the National Health Insurance Scheme, the HSRP aims to improve health access and quality, and ultimately reduce disease burden and mortality. The Health Sector Strategic Plan (HSSP) for HIV and AIDS in Nigeria 2005-2009 is the vehicle for the delivery of he outcomes of the HSRP, vis-à-vis HIV/AIDS.

(II) Addressing the foundational aspects of health service delivery

Over the last four years, the FMoH and State Ministries of Health have been implementing the Health Systems Development Project (HSDP II), which is supported by the World Bank. The HSDP II focuses on both institutional and individual capacity development at all levels of the health system, in support of health-sector strategic development and reform initiatives. A $12.6 million World Bank loan under HSDP II is allocated to strengthen the national health management information system (HMIS). The DFID-supported Partnership for Transforming Health Systems (PATH 1) ended last year and has been replaced by a US$36 million 5-year PATH 2 with a focus on 6 states aiming to improve planning, financing and management systems for supporting public health service delivery. In addition, the approved Round 8 HSS component directs additional resources to address crosscutting gaps within the health system. The following are anticipated outcomes of the GF Round 8 HSS support grant: (1) improved physical infrastructure in 925 target primary health care facilities (PHCs), (2) increased technical and managerial capacity of PHC workers, (3) continuous quality improvement via integrated supportive supervision, (4) better availability and distribution of essential drugs, equipment, and supplies in response to demand, and (5) robust and reliable routine health information that is used nationally and sub-nationally to make decisions that maximize access, quality, and impact in the health sector.

Finally, Nigeria is a beneficiary of the 3-year (2008-2010) US$45 million GAVI grant for strengthening the health system and repositions it to deliver effective, efficient and sustainable health services. The **General objective** is to develop the Ward Health System in 960 wards to deliver PHC services based on minimum health care package by 2010. **Specific objectives** include: 1. re-vitalization of the Ward Development Committees in the selected 960 wards, 2. Rehabilitation and equipping 960 health facilities (one facility per ward) to deliver PHC minimum health package, 3. Training and retraining PHC workers in those 960 wards on managerial capacity and technical skills for integrated service delivery by 2010, 4. Strengthening the NHMIS for program monitoring and management in 100 LGAs by 2010 and 5. Strengthening the logistics system and infrastructure at the National/State/LGA/Ward levels by the end of 2010. The scope of the activities will cover 960 wards (10% of total wards in the country) which will be selected by a combination of high performing wards (low proportion of un- immunized children) and low performing wards (high proportion of un- immunized children). The expected result will in the targeted wards be: improved access to and utilization of PHC services, increased technical and managerial capacity of PHC workers, improved data management and use for planning, program monitoring and decision making and a unified effective and efficient health commodity procurement and distribution system established.

(III) Benefits reaped in terms of HIV service delivery

Although the HIV epidemic is being addressed in Nigeria through a multi-sectoral approach, the health system remains at the cornerstone of the national response. There is clear link between improved health-sector performance and improved HIV- and AIDS-related outcomes. Efforts on the part of the Government and its development partners have provided the framework for action. All the above measures to strengthen the health system in Nigeria have yoielded some positive results. The 1st phase of the GF 5 HIV/AIDS grant was suucessfully implemented resulting in the recent approval by the GFATM Secretariat for its phase 2 extension. The implementation of the Phase 2 malaria grant is likewise demonstrating improvement in the health system as a result of the above cited investments. The GF Round 8 HSS grant will help to operationalize the national vision with respect to health system strengthening, and it establishes a solid foundation for enhanced service delivery related to HIV.

With a stronger foundation for the general health system, it will then be possible to pursue the service expansion and quality improvement strategies outlined in this Round 9 HIV proposal.

4.4 Round 9 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.4.2.2 and 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: 1	Prevention of Mother to Child Transmission (PMTCT)	Historical		Current		Country targets			
Indicator name	No of pregnant women accessing PMTCT services	2007	2008	2009	2010	2011	2012	2013	2014
A: Country target *(from annual plans where these exist)*		605,875	605,875	1,203,351	1,857,616	2,547,658	3,275,652	4,043,202	4,851,978
B: Extent of need already planned to be met under other programs		270,107	605875	605,875	605,875	605,875	605,875	605,875	605,875
C: Expected annual gap in achieving plans		335,768	0	597,476	1,251,741	1,941,783	2,669,777	3,437,327	4,246,103
D: Round 9 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			**75,000**	**390,000**	**912,000**	**1,332,000**	**1,332,000**

Priority No: 2	HIV Counseling and Testing	Historical		Current		Country targets			
Indicator name	Number of people counseled, tested, and received results	2007	2008	2009	2010	2011	2012	2013	2014
A: Country target *(from annual plans where these exist)*		753,391	1,640,000	1,980,000	3,992,595	7,985,191	11,977,786	15,970,381	19,962,977
B: Extent of need already planned to be met under other programs		453, 599	1,635, 852	1,968,000	2,500,000	3,000,000	3,500,000	4,000,000	4,500,000
C: Expected annual gap in achieving plans		299,792	4,140	12,000	1.492.595	4,985,191	8,497,786	11, 970,.381	15,462,977
D: Round 9 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			**182,160**	**767,520**	**2,070,720**	**2,776,320**	**2,776,320**

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Priority No:3	Anti-Retroviral Therapy (ART)	Historical		Current		Country targets			
Indicator name	No of AIDS patients receiving anti-retroviral treatment (ART)	2007	2008	2009	2010	2011	2012	2013	2014
A: Country target *(from annual plans where these exist)*		224,995	249,988	385408	539,815	694,223	848,630	1,003,038	1,157,445
B: Extent of need already planned to be met under other programs		145,078	231,079	288,849	372,134	383,460	408,591	604,639	872,431
C: Expected annual gap in achieving plans		67,425	18,909	35,270	167681	310,763	440,039	398,399	285,014
D: Round 9 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			**1,883**	**10,020**	**31,588**	**60,807**	**90,025**

Priority No: 4	Behavior Change Communication	Historical		Current		Country targets			
Indicator name	No. of students receiving Family Life & HIV Education (FLHE)	2007	2008	2009	2010	2011	2012	2013	2014
A: Country target *(from annual plans where these exist)*		78,400	120,000	8,992,000	11,572,000	14,410,000	17,531,800	20,965,780	26,631,847
B: Extent of need already planned to be met under other programs		1,200,000	1,300,000	1,350,000	1,600,000	1,780,000	1,850,000	2,200,000	2,400,000
C: Expected annual gap in achieving plans		(1,121,600)	(1,180,000)	7,642,000	9,972,000	12,630,000	15,681,800	18,765,780	24,231,847
D: Round 9 proposal contribution to total need		*(i.e., can be equal to or less than full gap)*			**768,000**	**1,536,000**	**2,304,000**	**3,744,000**	**4,848,000**

* Pilot phase of FLHE

ROUND 9 – HIV

Priority No: 5	Orphans and Vulnerable Children (OVC)	Historical		Current		Country targets			
Indicator name	No. of OVC receiving care and support (5% to be reached)	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target *(from annual plans where these exist)*		868,977	912,900	939,742	948,158	975,275	1,003,168	1,031,859	1,091,725
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	166,000
C: Expected annual gap in achieving plans		798,977	818,900	821,742	806,158	809,275	837,168	865,859	925,725
D: Round 9 proposal contribution to total need		*(i.e., can be equal to or less than full gap)*			**1,300**	**4,500**	**10,300**	**19,500**	**28,800**

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

4.5 Implementation strategy

4.5.1. Round 9 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), activities and indicator in the 'Performance Framework' (Attachment A). The Global Fund recommends that the work plan and budget follow this same order.*

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 9 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 9. The applicant will need to decide which disease to include s.4B (but only once). ➔ Refer to the Round 9 Guidelines (s.4.5.1.) for information on this choice.*

BETWEEN 4 to 8 PAGES

The National population-based targets for each program priority areas were developed through a participatory and consultative process led by NACA and involving all stakeholders including government, UN agencies, and civil society in January 2009. The process for setting the targets upheld the national commitment to achieve Universal Access Targets and Millennium Development Goals (MDGs) by 2015. The finalized National HIV/AIDS Targets (**see Annex 5)** will be incorporated in the National HIV/AIDS Strategic Framework II for the period 2010-2015. They have been applied in determining the programmatic gap, the reduction of which this proposal will contribute.

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 PLWHAs and OVC
iv. To create a supportive environment for delivery of comprehensive gender sensitive HIV/AIDS services
v. To enhance the management and coordination of HIV/AIDS programs

Thirteen (13) Service Delivery Areas (SDAs) and corresponding activities are detailed below under each of the five objectives. Three principal recipients (PRs) have been selected to coordinate these objectives and the SDAs based on core competence, experience, and capacity. The 3 PRs are National Agency for the Control of AIDS (NACA), the Civil Society for HIV/AIDS in Nigeria (CiSHAN), and the Planned Parenthood Federation of Nigeria (PPFN). Eighteen (18) sub-recipients (SRs) from public, NGO, and the private sectors have similarly been selected along the same criteria.

i) Objective 1: To scale-up gender sensitive HIV prevention services for children and adults.

The activities under the SDAs listed below will address the issue of low coverage for HIV prevention services as well as improve integration of SRH and HIV services at PHC level.

***SDA 1 - Prevention: PMTCT**:*

Linkages: This SDA is Priority # 1 – Prevention of mother to child transmission of HIV and addresses weaknesses identified in section 4.3.1 (ii) and (vi), and also (iii), (iv), (vii) and (ix).

Background: The national PMTCT coverage is only 11%; this is very low relative to the national target of Universal Access of 80% by 2015. Major support for HCT services is provided by the government, PEPFAR, and GFATM through its Found 5 HIV and Round 8 HSS grants. The GF Round 8 HSS grant in particular will provide integrated training in and harmonize Standard Operating Procedures (SOPs) for HIV/SRH services including PMTCT, SRH, TB, and Malaria to health workers in the 925 PHC facilities supported by the grant. Under the Round 8 HSS grant, 925 PHC public facilities will be refurbished and 4,625 staff trained to offer integrated services including PMTCT.

Aim: This SDA seeks to contribute to achieving the national target by increasing access to PMTCT services from 11% to 80% among pregnant women attending ante-natal clinics (ANC) in the 925 PHC facilities being supported under the Round 8 HSS grant and at the 185 PHC facilities supported under the GF Round 5 HIV grant when this expires in 2011. The target population for PMTCT services are pregnant women and babies born to HIV+ mothers.

The main activities include:

Advocacy activities will be undertaken in all the states and LGAs including those receiving GF Round 5 HIV and Round 8 HSS grants which will target key gatekeepers such as state governors, LGA chairmen, and other highly placed political leaders and their spouses to mobilize political commitment for scaling up PMTCT interventions as well as all other services including integrated maternal, newborn and child health (IMNCH) services.

Service provision: All pregnant women attending ANC clinics at all participating facilities will be offered HCT services. DHL will be contracted to continue to transport dried blood spots (DBS) collected from babies born to HIV+ mothers to and return the test results from the 6 zonal laboratories for Early Infant Diagnosis (EID) of HIV by the Polymerase Chain Reaction (PCR) technique. Each facility is expected to provide PMTCT services to 1,200 pregnant women per year. In the last 3 years of this proposal, the 185 PMTCT sites presently supported under GF Round 5 HIV grant will be taken over and supported under this proposal. All HIV+ pregnant women and babies born to HIV positive mothers will receive ARV prophylaxis. *Complementary activities*: The BCC interventions (SDA 3) contained in this proposal including community-based and other information, education, communication (IEC) and social mobilisation activities to generate demand for healthcare services will reinforce the PMTCT interventions.

Roll-out plan and outcomes: The PMTCT services will be rolled-out as shown in **Table 1.** Cumulatively, **4,041,000** pregnant women will be counselled, tested for HIV, and receive their results and **185,886** babies born to HIV positive mothers will be tested for HIV over the 5-years grant period. All HIV+ pregnant women and babies born to HIV positive mothers will receive ARV prophylaxis.

Table 1: PMTCT Roll-Out Plan 2010-2014

Indicator	2010	2011	2012	2013	2014	Total
No. of new PMTCT sites (GF R8 grant)	125	200	250	350		925
No. PMTCT sites carried over from GF R5 grant			185			185
Total no. of health facilities providing PMTC services	125	325	760	1110	1110	1100
Staff trained (GF R8 HSS grant) to provide integrated PHC services including PMTCT	625	1,000	1,250	1,750	0	4,625
No. of pregnant women counseled, tested & received results	**75,000**	**390,000**	**912,000**	**1,332,000**	**1,332,000**	**4,041,000**
Number pregnant women who will test HIV positive *(4.6% HIV prevalence rate in ANC clinics)*	3,450	17940	41952	61272	61272	185,886
No HIV exposed babies (i.e. Babies born to HIV+ mothers) for early infant diagnosis (EID) of HIV	**3,450**	**17,940**	**41,952**	**61,272**	**61,272**	**185,886**

PR and SRs: NACA is the PR. The SRs are Institute of Human Virology of Nigeria (IHVN), Family Health International Global HIV/AIDS Initiative Nigeria (FHI/GHAIN), FMOH (HIV/AIDS Division), APIN and HYGEIA.

SDA 2: HIV Prevention: HIV Counseling and Testing (HCT):

Linkages: This SDA is Priority # 2 – HIV Counseling and Testing and addresses weaknesses identified in section 4.3.1 (ii) and also (iii), (iv), (vi), (vii) and (ix).

Background: HCT is an essential entry point to prevention, treatment, care, support and other HIV/AIDS program activities. However, according to the National HIV/AIDS and Reproductive Health Survey (NARHS, 2007), only about 14.4% of Nigerians have ever been tested for HIV. The national target is to reach the universal target of at least 80% of sexually adults with HCT services. Presently, HCT services in Nigeria are provided by a number of service providers including the government, NGOs, FBOs and the private sector, with support from development partners including PEPFAR and the GFATM. As at December 2008, only 897 sites provide HCT services countrywide; this number is very inadequate. Some of the HCT sites are supported by the GF Round 5 HIV grant, which at its expiry in 2012 would have supported the establishment of a total of 555 sites. The GF Round 8 HSS grant (2009-2013) will support the strengthening of 925 PHC facilities that will provide integrated services including HCT. Accordingly, the national target to establish 12,630 *new sites* phased over 5 years (2010 – 2015) aims to improve coverage and increase access to HCT services. Other plans include the establishment of 74 mobile HCT teams (2 per state x 37 states) to deliver services and involving FBOs health infrastructure to deliver services.

Aim: This SDA seeks to scale-up HCT services to a total of about **8.6 million** people in 185 clusters covering 37 states of Nigeria over 5 years.

HCT service provision: HCT services will be provided in participating public PHC facilities, mobile outreach, and at FBO sites. ***PHC facility*** level services will increase access especially in rural communities. It is expected that each of the participating PHC sites will provide services to 1,440 clients annually based on the assumption that each site will be able to counsel and test a minimum of 6 clients a day for 20 days a month, and 12 months a year. Cumulatively, the PHC facility sites will provide HCT services for **6,447,600** clients in 5 years. Despite these efforts many people do not have access to services at fixed facilities: these include youths out of school, hard-to-reach

communities, and people who for various reasons are unable to visit the fixed health facilities. ***Mobile HCT*** services can improve access to these individuals and communities. The grant arising from this proposal will provide support for 12 mobile teams, each manned by a team of six (6) staff to provide services targeted at individuals and hard-to-reach communities in the 37 states. Each member of the mobile team will be able to counsel and test an average of (10) ten persons per day, three (3) days a week for fifty two (52) weeks a year. Cumulatively the mobile teams will provide **505,440** people with HCT services over 5 years. HIV tests kits, reagents and other consumables will be procured and distributed to the mobile HCT teams for the outreach work. The delivery of HCT services 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 organizations (FBOs)*** offering HCT services. Two (2) FBO facilities will be established in each of the 185 clusters providing HIV/AIDS services countrywide. Thus a total of 370 FBO sites (to offer HCT to 120 clients per month per site) will provide HCT services to **1,620,000** clients in five years. The grant will support FBO facility assessment and selection, infrastructural upgrades, training for at least 3 persons per FBO (not covered under GF Round 8 HSS grant) 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. This grant will also support the 555 sites established and functioning from the HIV Round 5 by 2012, in order to attain the targets. The HCT services will be based on the national serial testing algorithm.
Ensuring quality of services: The grant support facilitative supervision and HCT quality assurance, whereby PHC facilities will participate in one annual external quality assurance (EQA) program. There will be periodic visits by the counselor-tester supervisors, 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.
Roll-out plan and outcome: HCT services will be rolled out as shown in **Table 2.** The grant will enable **8,573,040** people in Nigeria to be counseled and tested for HIV and receive the test results over the 5 years duration of the grant.

Table 2: HCT Roll-out Plan 2010-2014

	2010	**2011**	**2012**	**2013**	**2014**	**Total**
No. of *new* HCT sites from GF R8 HSS grant (integrated sites)	125	200	250	350	0	925
Carry over comprehensive HCT sites from GF R5 HIV grant			555			555
Total HCT sites (cumulative)	**125**	**325**	**1,130**	**1,480**	**1,480**	**1,480**
No. of staff trained (GF R8 HSS grant)	625	1,000	1,250	1,750	0	4,625
No. people counseled., tested, & received results in integrated HCT sites (1440 clients/site)	***90000***	***468000***	***1627200***	***2131200***	***2131200***	***6,447,600***
No. of mobile teams	12	12	12	12	12	12
No. of people counseled, tested, & received results in mobile outreach HCT sites	56160	***112320***	***112320***	***112320***	***112320***	***505,440***
No. FBO HCT sites	50	130	230	370	370	370
No. of people counseled, tested, and received results from FBO sites	***36,000***	***187,200***	***33,1200***	***532,800***	***532,800***	***1,620,000***
Total no. of people counseled, tested, and received results from all HCT sites	**182,160**	**767,520**	**2,070,720**	**2,776,320**	**2,776,320**	**8,573,040**
No. Expected to be HIV positive (4.6%)	**8,379**	**35,306**	**75,253**	**127,711**	**127,711**	**394,360**

PR and SRs: The PR is Planned Parenthood Federation of Nigeria (PPFN). The SRs are FHI/GHAIN and SFH.

SDA 3*:* HIV Prevention – BCC Mass Media.
Linkages: This SDA relates to all 5 Priority areas and addresses the last 8 weaknesses identified in section 4.3.1.
Background: Over the past decade, the media has contributed immensely to shaping public opinion and knowledge of HIV and AIDS. The National HIV and AIDS and Reproductive Health Survey (NARHS 2007) revealed the public acceptability of the mass media in the following order of preference: radio (90%), television (81%) and print media (74%). Half of the population surveyed reported daily use of radio while only a quarter of the population reported use of TV on a daily basis. An in-depth assessment of the communication situation in the country carried out during the revision of the National BCC Strategy, revealed major gaps in grass-roots communication. Linguistic, cultural and other access related barriers were found to limit the "reach" and "impact of media messages". It was found that use of local languages and community involvement in message and media material development greatly increases probability of reaching the audiences. The Operational Plan of the National HIV and AIDS BCC Strategy (2009-2014) provides for the development of national level multi-media, and multi targeted campaign based on identified priority audiences and thematic areas.
Aim: To use the mass media to reach at least 80 million people with information on and generate demand for HIV/AIDS prevention, treatment, care & support services over the proposal period of 5 years.

Activities: Thus, this proposal will support the participatory development, production and airing of **TV and radio spots** in the four main languages: Hausa, Yoruba, Igbo and Pidgin English. This campaign will run simultaneously at national and state levels, and will be monitored and evaluated every two years by an appointed media firm. It is planned that 4 TV and radio spots will be aired per week reaching an audience of at least 80 million people over the proposal period. The **capacity of media personnel** in HIV communication program production and mainstreaming will be enhanced through training and hands on mentoring.
Expected outcomes: Expected outcomes of these activities include increased knowledge of HIV/AIDS, reduced HIV related stigma and discrimination, increased adoption and maintenance of HIV prevention behaviors, and increased awareness of and demand for HIV/AIDS and SRH services.
PR and SRs: The PR is NACA. The SRs are BBC World Service Trust (BBCWST), Journalists Against AIDS (JAAIDS), and SFH.

SDA 4: HIV Prevention - Community Outreach:
Linkages: Relates to all 5 Priority areas & addresses last 8 weaknesses of HIV program identified in section 4.3.1
Background: Community outreach programs are important in meeting the HIV prevention and SRH needs of people especially those living in hard-to-reach communities and out-of-school youths. The HIV/SRH prevention information and services needs of hard-to-reach communities and youth out-of-school are often the focus of CBOs and NGOs activities; however these CBOs and NGOs are often very poorly resourced. The government's Family Life and HIV Education (FLHE) and the National Youth Service Corps (NYSC) Peer Education Training (PET) programs provide HIV/AIDS prevention knowledge and information to youths-in-school in the country; however, these programs are not reaching a large number of schools. This proposal seeks to improve access to quality HIV/AIDS and SRH information and services through community outreach strategies and expansion of the FLHE and NYSC PET programs.
The PR is Civil Society for HIV/AIDS in Nigeria. (CiSHAN).

Youth-out-of-school and hard-to-reach populations
Activities: Community mobilization strategies including peer education, dialogue, rallies, campaigns, and access to prevention commodities will be used for the community outreach program. This proposal seeks create the necessary environment for out of school youths within their community to build knowledge and peer influence to embrace and sustain positive preventive behavior. This will be done by deploying the DFID funded and tested Peer Education Plus (PEP+) Module within an identified community amongst particular peer group. The group will teach their peers in HIV prevention and build necessary skills over a nine month period. This peer group will thereafter be empowered to form a CBO which then takes forward several activities and initiatives necessary for behavior maintenance. The CBO will also expand its activities to surrounding communities in order to expand behavior change amongst this group in Nigeria. One of such youth initiated CBO will be supported by this grant in each of the 185 clusters of the operation of this grant.(one CBO from each of the 5 clusters in each of the 37 states of the country) The Outreach activities of the CBOs will be supported. Each of the 185 CBOs will carry out ten (10) outreaches every year reaching 300 people for HCT per CBO per outreach; thus a total of 3,000 people will be reached by each CBO per year. A total of 555,000 people will be reached per year and 2,775,000 over the five year project period.
PR and SRs: The PR is CiSHAN. The SR is SFH
Youth-in-school: Family Life and Health Education (FLHE)
Activities: The Government's FLHE program is currently being implemented in basic and senior secondary schools with plans to expand it to tertiary institutions in the country. This proposal seeks to contribute to the Ministry of Education's effort to scale-up the FLHE program to all basic and secondary schools. It will support the expansion of the pool of Master Trainers of the FLHE program by **370** spread across all states equally (10/state) by the end of grant period in 2014 through a series of 10-day residential training workshops. The Master Trainers will be expected to train **160 teachers per year** (total of **24,240** 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 per year over the 5years of the program. Cumulatively a total of **4,848,000** students will be reached through the scale up and ***roll out of the FLHE program*** (**Annex 9A)**. Refresher training will 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 will be purchased and distributed to the Master Trainers and teachers. A total of 37 Project Management Committees (PMCs) will be established (1 PMC per state) to coordinate and advocate for public support for FLHE implementation at the state level. The PMC activities will be supported under this grant.
PR and SRs: The PR is CiSHAN. The SRs are Federal Ministry of Education (FMOE) and ActionHealth Inc.
Youth-in-school: National Youth Service Corps (NYSC) Peer Education training (PET) program
Activities: The NYSC PET program receives support from the GF Round 5 HIV grant and runs out in 2011, which

is the beginning of the third year of this Round 9 proposal. The GF Round 5 HIV grant has strengthened behavior change among youths and supported anti-AIDS extracurricular activities amongst in-school youths as a complement to the FLHE curriculum implementation. This proposal seeks GF support to continue the NYSC peer education program in the last 3 years (2012 -2014) of this proposal. Fifty **(50)** NYSC members will be trained as Peer Educators Trainers (PETs) on HIV/SRH in each of the two batches of NYSC Orientation programs per year in 37 State camps in 2012 to 2014 (**11,100** in the 3 years). This will increase the national pool of knowledgeable personnel to complement the implementation of the FLHE in secondary school. From the pool of trained NYSC peer educators, 10 will be selected in each state and posted to 5 secondary schools in each of the 185 clusters in the country on annual basis. Each of the trained NYSC PETs will be expected to select, train and mentor **40** secondary school students as peer educators (PEs) during the service year. The young people mentored in turn will reach **20** student colleagues each with HIV/AIDS information. Thus the NYSC PETs will train a total of **44,400** PEs in the 5 years of the grant who in turn will mentor **888,000** students. Cumulatively **2775** schools will benefit from the NYSC PETs program including the establishment of anti-AIDS clubs in the schools. Each of the PEs mentored by the NYSC PETs will be provided with IEC materials to aid their work. Transport of NYSC PETs for quarterly review meetings at state level will be supported. The NYSC State Schedule Officers will perform oversight functions of M & E on the post camp activities of PETs through unscheduled visits to PETs with resources from the government and its partners outside the Global Fund. The monthly meetings at the LGA level and the quarterly project review meetings at the State level are key measures to ensure quality of services.
Roll out plan and outcomes: Cumulatively 888,000 students in 2775 secondary schools in 37 states will be reached with FLHE information and education in **3** years. **Annex 9B of Round 9** shows the roll-out plan for this SDA.
PR and SRs: The PR is CiSHAN. The SRs are National Youth Service Corps (NYSC) and ARFH.

Most-at-risk populations (MARPs)
Linkages: This SDA is linked to Priorities 1, 2, 3 and 4 and address the weaknesses identified in section 4.3.1 (v) especially as well as to all the others.
Background: MARPs include female sex workers (FSWs), men who have sex with men (MSM), and injecting drug users (IDUs). The number of MARPs in Nigeria is unknown. However, triangulation evaluations of studies including the IBBSS 2007, The Population Council, and the Modes of HIV Transmission (MOT) study commissioned by NACA in 2008, estimated the number of MARPs at about one million **(Table 3).** Based on MOT study report, the majority of MARPs are believed to be FSWs, followed by MSM, and then IDUs. HIV prevalence levels among MARPs are 34% in FSWs, 13.5% in MSM, and 5.6% in IDUs. MARPs contribute markedly in fuelling up the epidemic in Nigeria. Key challenges facing MARPs include: marked levels of stigma, unfriendly legal/policy environment; inadequate financial resource allocation as well as limited numbers of CSO/CBOs to address MARPs related health needs. Key CSOs providing HIV/SRH services to MARPs include Alliance Right Nigeria (ARN) & Nigeria Network of Sex Workers Project (NSWP) working under CiSHAN. A limited number of CSOs work under the National Drug Law Enforcement Agency (NDLEA) with a focus on drugs demand reduction and address both HIV/AIDS and drug use. However, all these services are under-funded and are under-utilized.

Table 3: MARPs Gap Analysis.

		Historical		Current		Country targets			
Indicator name	*Estimated no. of MARPs*	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Conservative estimates of no. of MARPs*		953,392	981,943	1,010,815	1,040,265	1,070,016	1,100,619	1,132,097	1,164,475
B: Extent of need already planned to be met under other programs**		12,000	18,000	27,000	40,500	60,750	91,125	136,688	205,032
C: Expected annual gap		941,392	963,943	983,815	999,765	1,009,266	1,009,494	995,409	959,443
D: Round 9 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			14,000	32,500	60,750	97,500	140,450

**Estimates based on triangulation evaluation on available studies including IBBSS 2007, Mode of Transmission-NACA etc.*
***Estimates based on planned targets by the few NGOs/CBOs including SFH targeting MARPs (mainly FSWs) with HIV/SRH services,*
Aim: To reach a total of 680,400 MARPs including those in hard-to-reach locations (e.g. prisons) with HIV/SRH prevention, treatment, care and support services in 5 years.
Activities: This proposal seeks GF support to increase access to quality services for HIV/SRH prevention, treatment, care and support and impact mitigation for MARPs by aiming to increase the number of MARPs accessing provider-friendly quality HIV/SRH services annually. This will be realized through proper and effective information sharing; enhanced access to medical products (including condoms (male and female), lubricants, and oral contraceptives through training of PEs; support for MARPs-focused CBOs/NGOs, and support for mobile outreach teams targeting MARPs.
The following **strategies** are proposed:
i) Conduct MARPs **population size estimation** to improve demand and utilization of services. This will be done

through providing technical assistance to ensure inclusion of MARPs issues in the IBBSS scheduled for 2011.

ii) Sensitize gatekeepers on MARPs related challenges and intensify BCC peer driven interventions (PDI) carried out by **trained peer educators** (PEs) targeted at MARPs to improve behavior modifications to reduce risks of HIV and generate demand for services including HCT. Toll free **hotlines** will be installed and managed by trained staff to provide information and advice for MARPs.

iii) Increase access by MARPs to HIV prevention **medical products** including **male & female condoms,** water-based **lubricants** and SRH services.

iv) Build capacity for **FBOs/CBOs** to provide quality provider-friendly HIV/SRH services to MARPs through **facility- based and mobile outreach services.**

v) Customize the WHO-TREATNET package as key line of care and treatment for MARPs with the technical support of the UN joint team.

vi) Improve **referral systems** for MARPs: All the 194 *new* sites that will provide ART in this proposal will be used as referral centers with ***3 trained staff*** *designated to provide MARPs-friendly services*.

vii) Monitoring and evaluation of the designed interventions to ensure access and quality services for MARPs.

Other BCC strategies including efforts to reduce stigma and discrimination outlined in SDA 3 will complement HIV prevention activities specifically targeting MARPs. **Table 4** shows the rollout plan for MARPs activities for the years 2010-2014 during which a total of **345,200** MARPs countrywide will be reached with targeted HIV/SRH services including medical products. Within the 5 years, it is expected **617 trained PEs** will reach ***137,700 MARPs*** (40% of total MARPs); **63 trained CBOs/FBOs** will reach ***124,500*** (36% of total MARPs); while the **63** trained outreach teams will reach ***83,000 (***24% of total MARPs) at the end of the grant.

Table 4: Roll-Out Plan 2010-2014 for MARPs

	2010	2011	2012	2013	2014	TOTAL
Annual no. of PEs to be trained	40	60	120	180	217	617
Annual no. of PE trainings to be held (40 PE/training)	1	2	3	5	5	16
Annual no. of new PEs providing services	40	60	120	180	217	617
Cumulative no. of PEs providing services	40	100	220	400	617	
No. of MARPS reached by peer educators (100/PE)	***4,000***	***10,000***	***22,000***	***40,000***	***61,700***	***137,700***
No. of CBOs/NGOs to be trained	8	10	13	15	17	63
Cumulative no. of CBs/NGOs providing services	8	18	31	46	63	
No. of MARPS reached by CBOs/NGOs (750/CBO)	***6,000***	***13,500***	***23,250***	***34,500***	***47,250***	***124,500***
No. of Outreach teams trained	8	10	13	15	17	
Cumulative no. of Outreach teams	8	18	31	46	63	
No. of MARPs reached by mobile teams (500/team)	***4,000***	***9,000***	***15,500***	***23,000***	***31,500***	***83,000***
NO. OF MARPS REACHED	**14,000**	**32,500**	**60,750**	**97,500**	**140,450**	**345,200**
Cumulative Total of MARPS reached (all services)	**14,000**	**46,500**	**107,250**	**204,750**	**345,200**	

PRs and SRs: The PR is CiSHAN and the SRs are SFH and National AIDS Research Network (NARN).

SDA 5 – SRH/HIV Integration

Linkages: This SDA is linked to Priority #s 1, 2 & 3 and addresses program weaknesses identified in section 4.3.1 (vi) in particular as well as (ii).

Background: SRH problems remain the leading causes of ill health and death of people of reproductive age in Nigeria. Therefore, integration of SRH/HIV is focused on offering HCT, family planning (FP), prevention and management of sexually transmitted infections (STIs) services within the same facilities and during same service hours. The rationale is that the clients seeking HIV related services and those seeking SRH services share many common needs and concerns which make service integration appropriate. Sexually active populations are fertile while a significant proportion is also exposed to the risks of STIs and HIV. All HIV and SRH services at PHC level should be integrated and all HIV services at stand-alone service delivery points should offer RH and STI services and vice versa. 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. Out of the 56% of sexually active population (approximately 82 million from the 2009 projected population figures, National Population Commission), based on the current national contraceptive prevalence rate (9%, NARHS, 2007), STI target population of 7% of sexually active population that exhibit symptoms of STI, between 2010 and 2015, over 7 million persons will require protection against unintended pregnancies; they will also need STI prevention and

treatment services. This approach also promotes dual protection amongst HIV-negative clients accessing HCT. HCT provides a unique advantage to ensure that there is no missed opportunity as HIV positive clients will be counselled to use contraceptive methods.
Aim: To provide integrated SRH and HIV services in **925 PHC** facilities supported by the GF Round 8 HSS grant.
Activities: Since this is an integrated service, targets for facilities are based on computed HCT targets which suffice as the entry point for other reproductive health services (STIs and FP). These targets and roll out plan are shown in **Annex 9C** and are the basis of the request to **procure FP commodities and STI drugs** for integrating FP and STI into HIV services. For FP services, the current 9% contraceptive prevalence rate is used in providing projections. FP commodities and STI drugs will be procured and made readily available at these PHC sites to ensure that consenting HIV positive women and men can access dual protection, and clients with reported STIs are properly diagnosed and treated. This will therefore require the availability of basic STI drugs and oral contraceptive pills, injectable, intra- uterine contraceptives devices (IUCD), and condoms which are the basic family planning methods that can be dispensed at the PHC facility level. These commodities will be made available for initiation at the HCT service points. All training programs including development and distribution of manuals have been addressed in GF Round 8 HSS grant.
PR and SRs: The PR is PPFN. The SR is Association for Reproductive and Family Health (ARFH).

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

The activities and services under this objective complement the GF 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 among the185 facilities presently supported under Round 5 grant to deliver pediatric treatment and care services. In addition, all the 185 adult ART sites will be supported in the 3rd, 4th and 5th years of this proposal after the Round 5 grant ends in 2011. Resources will be specifically dedicated to pediatric 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 pediatric treatment to date compared to adult ART. The following SDAs with corresponding activities will be supported to achieve this objective. The activities under the SDAs below will contribute to addressing the quality of care for patients and the low coverage of children receiving ART services.

SDA 6: Anti-Retroviral Treatment (ART) and Monitoring.
Linkages: This SDA is Priority # 3. Its activities address HIV program weakness identified under section 4.3.1 (i), (iii), (iv) (vii) and (ix).
Background: Based on the National Strategic Framework (NSF) for HIV/AIDS 2005-2009, the national HIV Scale-up Plan (2005-2009) commits to providing ART to 1 million PLWHAs by 2009. The National HIV Targets document developed by the GON and its development partners to inform the development of a successor NSF 2010-2014, commits to providing ART for 1.3 million PLWHAs by 2014. However, by December 2008 there were only 231,000 PLWHAs on ART in the country. Thus, a huge unmet need for ART exists and requires intensified scaling-up of the ART program in the country. The achievement of the national HIV ART targets requires contributions from the government, (National and States), development partners and the GFATM. To increase access to services, the ART program plans to establish 2,700 additional sites between 2010 and 2015. The new sites will be located in secondary health facilities. It is intended that the PHC facilities will serve as refill centers for clients on ART, thus reducing the client burden on the secondary facilities.
Aim: To provide anti-retroviral treatment **(ART)** for **90,025 PLWHAs** (78,872adults and 11,153children**)** by 2014.
Key activities: This proposal will support a total of 90,025 **newly eligible PLWHAs** on ART generated from the HCT services supported under SDA 2 of this proposal. To provide services to the new eligible PLWHAs on ART will require establishing **194 new secondary ART sites.** In order to identify the new sites for strengthening, a total of 585 secondary facilities will be assessed. The outcome of the site assessment will be the development of a strengthening plan to address the identified gaps. During this assessment, potential ART team members for training will be identified. A total of **1,365 health personnel (seven per site) will be trained** using the nationally adapted IMAI package that is being used in training ART teams including those supported under the GF Round 5 HIV grant. Eighty persons will be trained in each workshop lasting for 14 days. A total of 17 trainings are envisaged during the proposal period. This proposal will support the updating and the reproduction of existing (IMAI) training materials which will be used for the training, as well as the DSA, transport, and venue costs. After the training, **supervision** of the service provision will be undertaken by multidisciplinary teams made up of relevant stakeholders. Additionally, the trained teams will benefit from **clinical mentoring** by senior ART experts according to the National Mentoring ART guidelines. Each facility will be visited twice a year by an ART expert with each visit lasting 4days in order to strengthen the clinical skills of the trained providers. A total of 390 mentoring visits will occur during the duration of the proposal. **Table 5** shows the **Roll-Out Plan** for this SDA.

Table 5: Adult and Children Roll-Out ART Plan for 2010-2014.

	2010	2011	2012	2013	2014	Total
Number of Health workers to be trained	65	141	309	400	450	1365
Number of trainings(80per/training for 14days)	1	2	4	5	6	18
Mentoring Visits(2visits/yr/facility for 4days)	56	120	264	342	386	1168
Number of facilities to be assessed	28	60	132	171	193	584
Number of new facilities to be established (selected from among those assessed in ratio of 3:1)	9	20	44	57	64	194
No. adults who had HIV test (from HCT)	***182,160***	***767,520***	***2,070,720***	***2,776,320***	***2,776,320***	***8,573,040***
No of adults assumed HIV positive (4.6%)	8,379	35,306	95,253	127,711	127,711	394,360
No of adults who require ART (20% of HIV +)	1,676	7,061	19,051	25,542	25,542	78,872
Cumulative total adults who require ART	**1,676**	**8,737**	**27,788**	**53,330**	**78,872**	
No of children to have EID test (from PMTCT)	***3,450***	***17,940***	***41,952***	***61,272***	***61,272***	***185,886***
No. of children testing HIV+ from EID tests (30%)	1,035	5,382	12,586	18,382	18,382	55,767
No. of children requiring ART treatment (20% of HIV+)	207	1,076	2,517	3,676	3,676	11,152
Cumulative total children requiring ART	**207**	**1,283**	**3,801**	**7,477**	**11,153**	
Grand total (adults + children) on ART for GF R9	**1,883**	**10,020**	**31,588**	**60,807**	**90,025**	
1st Line ARVs (Adults) – 90% total adults	**1,508**	**7,863**	**25,009**	**47,997**	**70,985**	
2nd line ARVs (Adults) – 10% total adults	**168**	**874**	**2,779**	**5,333**	**7,887**	
1st Line ARVs (Children) – 90% total children	**186**	**1,155**	**3,420**	**6,729**	**10,038**	
2nd line ARVs (Children) – 10% total children	**21**	**128**	**381**	**748**	**1,115**	

PR and SRs: The PR is NACA. The SRs are FHI/GHAIN, IHVN, FMOH/HIV Division, and HYGEIA

SDA 7: Prophylaxis and Treatment of Opportunistic Infections (OIs)

Linkages: This SDA is linked to Priority # 3 and addresses weaknesses identified in section 4.3.1 (i), and also (ii), (iii), (iv), (vii) and (ix).

Background: The targets for Opportunistic Infection prevention using Cotrimoxazole prophylactic therapy (CPT) are set on assumptions based on the national guidelines for use of ARVs (2008) which are consistent with the WHO guideline for Cotrimoxazole prophylaxis (2006). According to these guidelines, CPT for children should be administered to all those that are HIV exposed starting at six months of age and continued until HIV status is determined. It will be stopped among those that test negative for HIV, while it is continued among those that test positive for HIV until the age of five years. Children who are HIV positive at the age of one year or older should be placed on CPT until the age of five years, when a decision to discontinue will be similar to adults. Among adults, CPT is recommended to those in clinical stage 3 or 4, or those with CD4 counts <350cells/ml. Discontinuation is on the basis of demonstrated immunological stability (CD4>350cell/ml) after being on art for 1 year or longer. Based on this the targets **(Table 6)** are then calculated as follows:

- 50% of the adult positive HCT clients will fulfil the criteria for Cotrimoxazole prophylaxis;
- 50% of the positive ANC clients will fulfil the criteria for Cotrimoxazole prophylaxis;
- All the HIV positive patients on DOTS will fulfil the criteria for Cotrimoxazole prophylaxis;
- All infants born to HIV positive mothers captured through PMTCT services will be eligible for CPT.

Table 6: Targets for children and adults to receive CPT

	2010	2011	2012	2013	2014	TOTAL
# of pregnant women attending ANC who test HIV Positive	3,450	17940	41952	61272	61272	**185,886**
# of pregnant women eligible for CPT (30%)	1725	8970	20976	30636	30636	**92,943**
CPT Adults from HCT services	4,190	17,653	47,627	63,855	63,855	**197,180**
CPT for HIV exposed babies	3450	17940	41952	61272	61272	**185,886**

CPT for HIV co-infected with TB	11,790	15833	20 752	25 917	32359	**106,651**
TOTAL ON CPT	**24,605**	**78,336**	**152,507**	**217,035**	**249,394**	**582,660**

PR and SRs: The PR is NACA. The SRs are FHI/GHAIN, IHVN, FMOH/HIV. Div. and HYGEIA.

SDA 8 - TB/HIV Collaborative Activities.

Linkages: This SDA is linked to Priority # 3 and addresses weaknesses identified in section 4.3.1 (i), (vi) and also (ii), (iii), (iv), (vii), (ix) and (x).

Background: It is estimated that 27% of new TB cases in Nigeria are also infected with HIV and less than 15% of the expected TB cases among PLWHAs are being detected (WHO Global TB Report for 2009). There is a need for intensified case finding, as well as stronger collaboration between HIV and TB programs to ensure that co-infected individuals receive the necessary TB and HIV treatment services. Under the approved Round 8 HSS component, health care workers will be trained in TB/HIV co-management as part of integrated training. Remaining TB/HIV gaps are being addressed in both this Round 9 HIV proposal and the Round 9 TB proposal.

Key activities: The **Round 9 TB proposal covers**: (1) TB/HIV working group meetings; (2) DOTS expansion to ART sites; (3) HCT expansion (excluding HIV rapid test kit procurement) to new 1,65*0 DOTS* centers; (4) Training of medical officers on TB/HIV co-management, 3Is ((Intensified Case Finding, TB Infection Control and Isoniazid Preventive Therapy [IPT]), and interpretation of chest X-Rays; training of general healthcare workers on TB/HIV co-management and 3Is. Training of state TB and HIV program managers on TB/HV co-management; (5) CPT for **32,359** co-infected patients while they are being treated for TB; and (6) procurement of IPT for PLWHAs with latent TB infection; 7) joint supervision by TB and HIV teams at the state and facility levels; 8) support for 100 ART sites to develop, implement, and strengthen facility-based TB infection control plans; and printing and dissemination of national guidelines and SOPs for TB infection control; 9)subsidize x-ray services for PLWHAs being worked up for IPT.

This **Round 9 HIV Proposal** will address the following aspects of TB/HIV integration: (1) screening of all PLWHAs enrolled in HIV treatment for symptoms of TB and, for suspected co-infected persons, linkages to the TB program to ensure timely diagnosis and TB treatment; (2) procurement of HIV rapid test kits for use in DOTS centers annually as shown in Table 7; (3) procurement and provision of CPT to co-infected patients annually as shown in Table 7; (4) procurement and provision of ART to co-infected patients identified by the TB program annually as shown in Table 7; and (5) TB/HIV co-management/promotion of treatment adherence at the community level (under the auspices of home-based and community-based care and support). Projections for the HCT, ART, and opportunistic infection SDAs of this Round 9 HIV proposal account for additional requirements of HIV rapid test kits, ARVs, and Co-trimoxazole as a result of improved TB/HIV integration. **Table 7** shows the 5-year **Roll-Out Plan** for this SDA.

PRs and SRs: TB/HIV activities described in this proposal will be undertaken by NACA as the PR and Sub-recipients (SRs) are the Federal Ministry of Health (HIV. Div), Family Health International/Global HIV/AIDS Initiative Nigeria (FHI/GHAIN), Institute for Human Virology in Nigeria (IHVN) and HYGEIA. Implementation of TB/HIV collaborative activities will require coordination and collaboration between the PRs and SRs of the Round 9 HIV proposal and those of the Round 9 TB proposal. Notably, a number of institutions (e.g., Federal Ministry of Health, Association of Reproductive and Family Health, Institute for Human Virology, Family Health International) are PRs or SRs in both the Round 9 HIV proposal and Round 9 TB proposal. Global Fund resources will facilitate these agencies to pursue holistic approaches to addressing the problem of TB/HIV co-morbidity in this country.

Table 7: TB/HIV Collaborative Activities Rollout Plan 2010-2014

	2010	2011	2012	2013	2014
No. of DOTS centers to receive HIV rapid test kits	1500	2000	2750	3200	3,650
No. of TB/HIV **co-infected patients to receive CPT after completing TB treatment** at DOTS centers (targets aligned with annual targets for co-infected patients supported under R-9 TB Proposal)	11,790	15,833	20,752	25,917	32,359
No. of TB/HIV **co-infected patients to receive ART** (targets aligned with annual targets for co-infected patients supported under R-9 TB Proposal)	11,790	15,833	20,752	25,917	32,359
No. of **PLWHA enrolled in HIV treatment** who will be **screened for TB** symptoms (targets aligned with ART targets in this R-9 HIV proposal)	1,883	10,020	31,588	60,807	90,025

iii) Objective 3: To scale up gender sensitive care and support services for PLWHA and OVC

The activities in the SDAs below will address the poor access to care and support services in the rural areas by making services closer to rural communities and the problems of limited number and under-funded CBOs/FBOs working at community level. This objective will be achieved through the implementation of the following activities under each SDA below:

SDA 9: Care and support for the chronically ill.

Linkages: This SDA is linked to Priority #3 & 5 and addresses weaknesses identified in section 4.3.1 (i), and also (iii), (iv), (vii) and (ix).

Background: Presently, it is estimated that there are about 3 million people infected with HIV; 20% of this figure are AIDS patients, many of whom will be chronically ill and in need of HBC. The GF Round 5 HIV grant supports 2 CBOs to provide HBC in each of the 185 clusters providing HIV/AIDS prevention, treatment, care and support services nationwide. The number of chronically ill PLWHAs who need care and support is growing every day. Many more CBOs and PLWHAs support groups (SGs) are needed to provide quality care and support to the chronically ill. SGs comprise PLWHAs and provide psychological, experiential mentoring, morale, companionship, and fellowship support to each other and to other PLWHAs and their families.

Aim: This proposal seeks GF support to provide care and support to **86,250** chronically ill PLWHAs over 5 years.

Key Activities: **Capacity building for CBOs and SGs**: This proposal seeks GF support to build the capacity of three (3) additional **CBOs/FBOs** to provide HBC services within each of the 185 clusters. This will bring the number of CBOs providing HBC to 5 per cluster. 3 new ones to be supported by Rd 9 while the 2 from Round 5 will find alternate resources from Government to continue their work after 2011. Key activities to be carried out include CBOs/FBOs capacity to meet the health, education, legal protection, nutrition, economic strengthening and psychosocial support needs of PLWHAs using existing curriculum developed under GF R5 grant. Following training, the CBOs/FBOs will be provided with HBC kits, financial resources (grants) and M & E tools. Advocacy and sensitization to communities is vital to enhance participation, impact, ownership and sustainability. This will be done through community outreaches, IEC materials and radio/TV messages. A total number of **555** new CBOs/FBOs (3 CBOs x 185 clusters) will be targeted for support. The CBOs/FBOs supported in GF Round 5 will be taken over and supported by the government and its partners. The trained CBOs/FBOs will provide HBC services to ***51,750*** PLWHAs in five years. In addition to the CBOs/FBOs, two (2) **PLWHAs Support Groups** (SGs) 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 SGs will absorb the emerging PLWHAs and catalyze the formation of additional groups, and will also support treatment and drug adherence. A total number of **370 support groups** will be created. The SGs (370 in all) will serve ***11,100*** PLWHAs. These activities will be implemented mainly by NGOs/FBOs, who are member organizations of CiSHAN, and registered SGs from the Network of People Living with HIV/AIDS in Nigeria (NEPWHAN). CiSHAN the grant PR. The total number of PLWHAs to be reached both by CBOs and SGs with quality HBC and support for treatment and drug adherence services is **86,250 PLWHAs.** The 5-year **Roll Out Plan** for this SDA is shown in **Annex 9D.**

PR and SRs: The PR is CiSHAN. The SRs are ARFH and Network for People Living with HIV/AIDS in Nigeria (NEPWHAN).

SDA 10: Support for Orphans and Vulnerable Children (OVC).

Linkages: This is Priority #5 and addresses weaknesses identified in section 4.3.1 (i), and also (iii), (iv), (vii) & (ix).

Background: Nigeria has a high burden of orphans and vulnerable children (OVC); a quarter of the estimated 17.5million orphans are HIV orphans. HIV positive children, especially those who are orphans and/or have developed AIDS, are among the most vulnerable children. The HIV prevalence rate in pregnant women is 4.4% and breastfeeding is almost universal; thus the risk of mother-to-child transmission of HIV is high. Current estimates indicate that about 10% (295,000) of the 2.95 million PLWHAs in Nigeria are children under 18 years of age. Under SDA 6 of this proposal, it is planned to provide ARVs treatment to nearly 26,000 children by 2014. The Federal Ministry of Women Affairs and Social Development is the national body responsible for OVC issues including coordination. The State Ministries of Women Affairs and Social Development perform the same function at the state level. The OVC National Plan of Action (NPA) stipulates the standards of practice for OVC programming. Government programs that benefit children including OVC include free primary schooling, free basic healthcare services including immunizations, and school feeding programs in selected states. Much of the federal government funding for OVC comes from monies realized from the Debt Relief Fund. Significant support for OVC programs is also provided by PEPFAR and UNICEF. The GF Round 5 HIV grant is also providing support for OVC care and support with a focus on education and health. It has also enabled the country to develop the national

curriculum for training (those providing services to OVCs) and the national guidelines (for selecting OVCs who require support). The major OVC service providers include the Ministry of Women Affairs and Social Development (MoWA&SD), FBOs, CBOs and NGOs.
Aim: This proposal seeks to provide educational, health, nutritional, legal, psychosocial care and support services for **28,800 OVC who are HIV positive** over the proposal period.
Key Activities: The strategies will include **advocacy** meetings with stakeholders in communities around the clusters of operation to sensitize community leaders and members on the plight of OVC especially those children infected with HIV and urge communities to play key roles in caring for OVC. The funding will support **capacity building including training** for key government staff and select CBOs/FBOs providing support to OVCs. OVC desk officers at Federal and State FMOWA and OVC Steering Committees and technical working groups at state level will be trained and resourced to effectively coordinate, supervise, monitor, and report on OVC activities. CBOs and FBOs will be selected, trained, and supported to provide care and support to meet the needs of these children in line with the stipulations of the NPA. Training of CBOs will include the identification and treatment of malnutrition in children. Trained CBOs and FBOs will provide care and support to the OVC with a focus on **education, health, nutrition, protection, and psychosocial** support that are consistent with the NPA requirements. Basic primary education is free and so is basic healthcare at public facilities. Support for education includes school uniforms and stationery, support for health includes cost for basic additional needs not provided free of charge in public health facilities; and nutrition support includes food supplements and ready-to-use therapeutic foods (RUTFs). Support to CBOs and FBOs in the proposal includes funding to enable them meet the cost of providing services, technical assistance to ensure services are provided that meet NPA requirements, and supportive supervision and monitoring visits to ensure quality of care and services.

Table 8: Roll Out Plan for OVC 2010-2014

	2010	2011	2012	2013	2014	Total
Training of Federal & State OVC desk officers (5 federal; 145 for all 37 states = 150 people)	**30**	**30**	**30**	**30**	**30**	**150**
No. CBOs to be trained each year	13	32	58	92	93	288
Cumulative no. of CBOs & FBOs	13	45	103	195	288	
Cumulative no. of HIV+ children reached with support (100 OVC/CBO or FBO)	**1,300**	**4,500**	**10,300**	**19,500**	**28,800**	
NPA Recommendation: Education support N20,000/OVC/yr (shown in US$/OVC/yr)	142.85	142.85	142.85	142.85	142.85	
NPA Recommendation: Healthcare support N5,000/OVC/yr (shown in US$/OVC/yr)	35.71	35.71	35.71	35.71	35.71	
NPA Recommendation: Nutrition support N36,000/OVC/yr (shown in US$/OVC/yr)	257.14	257.14	257.14	257.14	257.14	

Roll out plans and outcomes: Cumulatively, 1250 HIV positive OVCs will be reached with care and support services for education, health, nutritional, legal, and psychosocial support in 2010; 4,500 in 2011; 10,250 in 2012; 19,500 in 2013; and 28,750 in 2014. (**See Table 8 – Roll Out Plan for OVC 2010-2014).**
PR and SRs: The PR is CiSHAN. The SRs are Federal Ministry of Women Affairs (FMOWA&SD), and ARFH.

iv) Objective 4: To Create Supportive Environment to Deliver Comprehensive HIV/AIDS Services
The activities identified in the SDA below will address the weakness associated with the under-utilization of the potential involvement of the private sector to contribute to the national response. The following services and activities will be delivered under this objective:

SDA 11: Policy Development including Workplace Policy.
Linkages: This SDA is linked to Priority #s 1, 2, & 3 and addresses weaknesses identified in section 4.3.1 (i), (ii) and also (iii), (iv), (vii) and (ix).
Background: The majority of PLWHAs are in their productive age working in the private-for-profit sector. Workplace HIV/AIDS programs are strategic in providing HIV/AIDS prevention, treatment, and care and support services for this population segment as part of the national response through public-private partnership approaches. Many of the publicly quoted companies are coalition members of the Nigerian Business Coalition Against AIDS (NIBUCAA), a coalition committed to fighting HIV/AIDS in the workplace. Its members have domesticated the National HIV Workplace Policy and are providing HIV/AIDS services to their workforce. The small and medium enterprises (SMEs) particularly those that are not members of NIBUCAA are having greater challenges in

domesticating the national workplace policy. Under the GF Round 5 grant, some of the 170 SMEs in 17 states (out of 37) of the federation targeted for support to domesticate the HIV/AIDS workplace policy have successfully done so. SMEs in the remaining 20 states have not benefitted from the assistance and are keen to domesticate the policy in their enterprises.

Aim: This proposal seeks GF funding to provide support for the domestication of the national policy in two hundred **(200)** SMEs in 20 states in 5 years.

Key Activities: The main activities that this grant will support will include **advocacy** meetings with the managers of 200 selected SMEs to create awareness and sensitize them about HIV in the workplace and provide technical support for them to domesticate the National HIV Workplace policy by developing and implementing their own HIV workplace policies over the 5 years period of this proposal. To enhance HIV prevention behavior change in the workplace, the grant from this proposal will support **peer educators training** for the participating SMEs. One hundred (100) peer educators (PEs) will be trained on HIV/AIDS in the workplace; each PE will mentor at least 10 workers every month through formal and informal education sessions The PEs will receive refresher training every 2 years. The peer educator trainers will serve as mentors to the PEs 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. It is expected the PEs will reach a total of **360,000** workers with HIV/AIDS information and education in 200 SMEs in 20 states in 5 years under this proposal. The grant will also provide **support for the meaningful involvement of PLWHAs (MIPA) in the workplace**. Forty **(40)** PLWHAs from within the SMEs will be recruited and trained as MIPA officers. These MIPA officers will work with the SMEs to sensitize workers about HIV/AIDS and reduce the stigma and discrimination surrounding the disease. The grant from this proposal will support the training and salaries of the MIPA officers throughout the 5 years duration of the proposal. It is expected the SMEs will sustain the salaries of the MIPA staff after the project ends. The **Roll-Out Plan** is shown in **Annex 9E.**

PR and SRs: The PR is PPFN. The SRs are Federal Ministry of Labor and Productivity, SFH and the Nigerian Business Coalition Against AIDS (NIBUCAA).

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

The activities under the SDAs below will address the weaknesses of inefficiencies in resource allocation and management and need for improved strategic information for program design and implementation. The service delivery areas and activities that will be supported to achieve the above objective are as follows:

SDA 12: Strengthening Program Management and Administration.

Linkages: This SDA is linked to all 5 Priorities and addresses *all* the weaknesses identified in section 4.3.1 especially (i) and (viii).

Background: There are 3 PRs for this grant: NACA, CiSHAN, and PPFN. All three PRs have significant experience in managing complex HIV/AIDS and SRH programs. NACA is a PR in the GF Round 5 HIV grant. CiSHAN and PPFN are key SRs for the implementation of the GF Round 5 HIV grant in the country. This grant has always received an A rating. Management of the Round 9 grant will draw from the experience of the implementation of the Round 5 grant.

Aim: To ensure a successful program implementation through strengthening and enhancing program management and administration of the GF Round 9 HIV grant.

PRs and SRs: 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&SD), Federal Ministry of Education, Federal Ministry of Youth Development, and the National Youth Service Corps (NYSC). Others include NGOs and FBOs.

Capacity development: In the first and second quarter of grant signing, the three PRs will be involved in grant activation activities such as finalizing negotiations (with GFTAM, government, partners, etc), recruitment, training, advocacy and other preparatory work. Memoranda of Understanding (MOUs) will be signed after negotiations with SRs. 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 program. Such training will be outsourced to capable institutions within the country.

Program coordination, monitoring, and quality assurance: This proposal will support forums for program 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. 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.

Health sector coordiantion: 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 a day-to-day basis. The task teams provide expert support to the FMOH for the development, implementation and coordination of the relevant program areas. Activities in the states and LGAs are routinely coordinated through the State Ministries of Health with the State AIDS Coordinators as managers.

SDA 13: Strategic Information (SI) and Program M&E:

Linkages: This SDA is linked to all 5 Priorities and addresses all 9 weaknesses identified in section 4.3.1.

Aim: To provide robust quality strategic information for policy formulation and guidelines development; program design, implementation, and review; and for program reporting.

Background: The approved Round 8 HSS focuses on an array of activities aimed at strengthening routine data collection and use at the primary health care (PHC) level, as well as targeted knowledge management activities at National, Zonal, State, LGA, and PHC levels within the health sector. This Round 9 proposal extends activities to include the secondary and tertiary care levels in the health sector, and it broadens strategic information strengthening efforts to include non-health sectors involved in the national HIV response. The National Health Management Information System (HMIS), which is the focus of the approved Round 8 HSS component, forms the backbone of the Nigerian National Response Information Management System (NNRIMS).

Key activities: Proposed Round 9 activities include: (1) development and costing of a new National M&E Operational Plan (NOP); (2) procurement of necessary IT infrastructure (for entities and service delivery points not covered in the Round 8 HSS project) to facilitate data management, reporting, and use; (3) integration of pre-existing IT platforms (e.g. LHPMIP/DHIS) with the broader NNRIMS database in all 37 states; (4) printing of routine monitoring forms for use at secondary and tertiary-level health facilities, as well as at non-health sector service delivery points; (5) capacity development in 27 of the 37 states (which will entail training, field supervision, and on-going mentoring in the areas of data quality assurance and data use); (6) multi-sectoral knowledge management at the national, zonal, state, and LGA levels, which will entail the development of dissemination products (e.g., Research Briefs) and processes (e.g., data triangulation exercises) that facilitate the interpretation and use of data for local decision making; (7) improved monitoring of the quality of program implementation/service delivery (as part of a broader Quality Assurance/Quality Control strategy); (8) increasing the availability of data on population impact, TB/HIV, STIs, and most-at-risk population groups (MARPs); (9) inter-sectoral M&E coordination and technical direction at National (NACA)/FMOH, sectoral, State (SACA)/SMOH, and LGA levels and (10) conducting Operational Research activities.

PR: The PR is NACA.

4.5.2. Re-submission of Round 8 (or Round 7) 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 8 (or, Round 7, if that was the last application applied for and not recommended for funding).

TWO PAGES MAXIMUM

TRP Comment 1: *The proposed program is very ambitious with very high targets (e.g. 1,332,000 women screened for HIV in antenatal clinics, 14,000,000 adults tested for HIV, 438,569 people on ART in year 5). Although these targets may be justified, the TRP believes that a proposal to reach such targets should be accompanied by a detailed phased implementation plan showing clearly how this program will be rolled out.*

Response to TRP comment 1: Some of the targets have been revised downwards (HCT-from 14,000,000 to 8,573,040 and AR from 438,569 to 90,025). In terms of absolute numbers the proposal still seems to be ambitious. However, when looked at in terms of service coverage improvement, the contribution is modest. For example, the coverage of PMTCT services will be improved from the current 11% (n=605,875) to 23%

(n=1,332,000) while that for HCT will be improved from 14.4% (n=10,080,000) in 2008 to 27% (n=18,653,040). In this proposal, the workplan contains more elaborated activities with timing when they will be implemented throughout the proposal period. Furthermore, Section 4.1.1 provides a detailed description of the strategies to be used and a roll-out plan in tabular form for key Service Delivery Areas. Roll-out plans in tabular form for some of the SDAs are not included in Section 5.1.1 but attached as **Annex 9.**

TRP Comment 2: *Although the proposal states that it addresses the integration of HIV and tuberculosis programming; there are very few activities and practically no budget to support the integration of HIV and tuberculosis care at the clinical or the programmatic level. There are also no links to the proposal for tuberculosis programming submitted to the Global Fund in Round 8. The TRP considers this a missed opportunity for a necessary initiative to remove the barriers that still exist between tuberculosis and HIV programs.*

Response to TRP comment 2: This proposal has increased the TB/HIV collaborative activities to be conducted (see work plan and Section 4.1.1 SDA 8 below. The same activities appear in both the HIV and the TB proposals with indications on where the budget for each activity will be allocated. These activities include:

- Production and printing of TB/HIV manuals, registers and reporting forms
- Strengthen capacity of heath care workers to provide quality and comprehensive care for persons co-infected with TB/HIV (active TB case finding, TB infection control & IPT)
- Undertake clinical screening of all HIV positive individuals for TB symptoms,
- Provide Cotrimoxazole prophylaxis to patients dually infected with TB and HIV.
- Procure HIV test kits for DOTS sites
- Train DOTS providers in HIV testing

There is a budget of US$313,678 budgeted for collaborative TB/HIV activities in the HIV proposal.

TRP Comment 3: *The budget lacks transparency in some areas where lump sums are budgeted for infrastructure projects or "family planning commodities".*

Response to TRP comment 3: The budget for this proposal is detailed with all the items quantified and budgeted for using unit costs. A separate service Delivery Area (SDA) 5: RH/STI/HIV integration has been created with a list of all the needed commodities listed and budgeted for each year. There is no budget for infrastructure in this proposal, since this will be undertaken by the HSS Round 8 grant (See attachment B).

TRP Comment 4: *Strategies are lacking to assure quality of interventions, and the M&E system does not address this issue of quality.*

Response to TRP comment 4: In this proposal, each of the key SDA has planned to institute mentoring of trained service providers as a strategy for providing practical training to the service providers, and ensuring that providers provide services according to the national guidelines. Experienced/senior personnel for each SDA will visit and work with HIV/AIDS service provider teams twice a week for each facility lasting five days. The approved HSS Round 8 grant has planned to conduct monthly data quality assurance meetings in each state. This proposal will contribute to the conduct of Operational Research (OR) on issues pertaining to 5 SDAs. Service quality issues will be the focus of some of OR to be conducted. Finally, Section 4.1.1 SDA 12 Strategic Information, has elaborated on activities for data quality assurance. This proposal contains quality indicators (**see attachment A**) as follows:

- Impact: percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy;
- HCT Indicator 1.4: Number of new service outlets providing counseling and testing according to national standards;
- ART Indicator 2.2: Percentage of people starting antiretroviral therapy who picked up all prescribed antiretroviral drugs on time; and
- Strategic Information Indicator 5.1: Percentage of supported service delivery points with timely and complete reports of routine HIV data in the last 12 months.

TRP Comment 5: *Clear strategies for targeting difficult to reach populations such as sex workers, men who have sex with men, and injecting drug users are not provided.*

Response to TRP comment 5:

This proposal contains clear strategies for reaching Female Sex Workers, Intravenous Drug Users and Men who have Sex with Men. The strategies are elaborated under Section 4.1.1 SDA 4: Prevention: Mass Media and Community Outreach. There are about 35 activities in the workplan targeting most at risk populations

with a budget of approximately US$8.4million (see work plan and budget).

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 9 program draws important lessons from previous program implementation, especially the ongoing Round 5 grant that is currently in second year of implementation, as well as other ongoing programs 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 9 proposal. The key lesson that will have implications on this round 9 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 program accountability. The Round 9 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 programs 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 programs 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 9 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 programs will be enhanced. These will leverage resources across programs to enhance implementation of the Round 9 proposal.

3. *Leveraging resources to enhance program roll-out*: There was no upgrade of infrastructure in Round 5 proposal which constrained program 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 9 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 9 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 9 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 program

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 9 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 program 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 9 program 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 9 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 9 proposal will increase the number of community groups providing such services within the clusters. For the OVC program, 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 9.

13. *Multiple PRs:* Having multiple PRs in the Round 5 grant was vital in rapidly rolling out program 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 9 proposal will draw on this experience. Activities in the Round 9 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 program 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 9 proposal will specifically target children age 0-14 years. Also, in order to expand access to counseling services, the proposed HCT in the Round 9 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 M&E system.

Strengthening of the Health Management Information System is provided for under the cross-cutting category because it supports malaria and tuberculosis programs 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 levels 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 2 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 programs in the same locations, the PRs and SRs leading this activity under the HIV/AIDS component will work with their malaria and tuberculosis program 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 any 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 or Round 8 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.

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The design of the Round 9 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 9. 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 9 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 9 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 9. 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 9 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) of the Round 9 proposal will further strengthen patient monitoring and management and provides early diagnosis for exposed infants.
This proposal fills the gap in the national program and the ongoing Round 5 grant. Some of the identified gaps include:

- GF Round 5 HIV grant supports ART centers in 185 secondary and tertiary facilities. The strengthening of the 925 PHCs under the GF Round 8 HSS grant to scale up HCT services will generate an increasing number of PLWHAs who will require ART. This proposal seeks support to the establishment of 194 additional ART centers to ensure an adequate number of treatment sites are available to treat the increased number of patients.

- 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 9 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 one of the main focus of the Round 9 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 9 that are in dire need of educational, health, nutritional, legal and psychosocial support.

- 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.

- The Round 5 grant and the Round 9 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 programs 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 9 proposal will bridge the gap between supply of services and the demand for the services.

- The GF Round 8 HSS grant provides for strengthening integrated services at 925 PHC facilities through infrastructure upgrades, provision of equipment and supplies, and training of healthcare workers. The GF Round 9 proposal seeks support for the procurement of HIV test kits to enable these facilities to provide HCT services.

- Currently, PPFN, one of the proposed PR, is implementing Round 5 project as a sub-Recipient in HCT 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 GF Round 5 HIV and Round 8

HSS grants thus increasing service utilization and effective use of personnel. It also adopts the principle of private public partnership.

4.6.2. Links to non-Global Fund sourced support

Describe any 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.

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There are other HIV/AIDS programs supported from other sources. The major programs are supported with funding mainly from the Federal Government of Nigeria, PEPFAR, the President Clinton Foundation, DFID, etc. All these programs 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 programs 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 program arising from approval of this proposal, linkages will be established with the various programs. The major programs include:

- USG/PEPFAR project provides ART to about 200,000 clients across the nation; this grant when approved, will strengthen the existing linkages with PEPFAR supported program and other partners involved in treatment and leverage resources, expertise and experiences.

- USG/PEPFAR 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 programs, 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 9 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 USG funded projects such as the PSRHH by SFH and BBCWST etc are also implementing similar programs. 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 9 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 programs, 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 9 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 USG/PEPFAR and DFID. Funds will be leveraged from the Round 9 grant to strengthen weak components of the activities.

Clarified section 4.6.3 (b)

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 9 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.)*

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The national HIV response does not have a framework of co-investment schemes with the private sector; however, the private sector undertakes activities that support the national response. Following the establishment of the Nigerian Business Coalition Against AIDS (NIBUCAA), the involvement of the private sector in the HIV/AIDS national response has been encouraging. NIBUCAA has about 40 members. The vast majority of members are multi-national companies (MNCs); they have workplace policies and support HIV/AIDS interventions. The MNCs include Lafarge, Nigerian Breweries PLC, Nestle, Chevron Nigeria Ltd, Total, Coca-Cola Company, Julius Berger, and Guinness Nigeria. However, an excessively large number of private sector firms and institutions especially small and medium enterprises (SMEs) are presently not members of NIBUCAA but are involved in the fight against HIV/AIDS. These include banks and telecommunication companies. ECOBANK, in partnership with NACA, supports Youth Friendly Centers (YFCs) in about 10 universities across the country that train volunteers to provide HIV/AIDS information and education and counseling and testing to the community members and make referrals for further care. The MTN Foundation in partnership with NACA supports YFCs in tertiary institutions, PE training in secondary schools, an economic empowerment program with a focus on PLWHAs especially women, and a touch screen program using 12 machines strategically located throughout the country that provides voice interactive HIV/AIDS prevention messages in three Nigerian languages and Pidgin English. CELTEL (now Zain) supports 20 toll free lines for HIV/AIDS information and counseling and regularly disseminates HIV prevention and BCC messages by SMS to all its subscribers on regular basis. The toll free lines are managed by personnel trained by YET, an HIV/AIDS-focused NGO which also provides technical oversight. The program that will arise from this proposal will deepen partnership with private-sector initiatives and leverage the investments made therein.

(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)?)* ➔	**Young People in Tertiary Institutions and working Population.**

Contribution Value (in USD)

Refer to the Round 9 Guidelines for examples

Organization Name	**Contribution Description** *(in words)*	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
ECOBANK	Youth friendly centers in 7 Universities						449,356
MTN	Workplace policy, peer education in schools; IEC materials; HCT civil works, lab equipment, furniture; HIV interactive touch screen; PMTCT & Universal Basic Precaution; Support for PLWHAs; Youth-friendly centers capacity building; National Awareness (TV and Radio) etc.						3,120,504
ZAIN	SMS messages; Tool free lines; Billboards; E1 transmission						4,985,378

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*.

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The proposed activities in this proposal are based on the priorities of the NSF 1(2005-2009) and address the gaps anticipated in achieving the agreed national targets for the NSF2 (2010-2015). The cluster model approach initiated in Round 5 will be expanded under the Round 9 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. The health system strengthening activities contained in the GF Round 8 HSS grant will result in strengthened institutions and community entities in order to support not only the HIV response but also other health sector interventions beyond the duration of the proposal. Activities contained in this proposal will further strengthen the capacity of public and private institutions to serve the country beyond the duration of the project period.

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.

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 result in a more effective utilization of resources, minimize wastage and maximizing the intended outcomes.

The joint mid-term review of the NSF revealed 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 2009.

The National Health Bill (2008) which is in its final stages of enactment, specifies the establishment a Fund to be known as the National Primary Health Care Development Fund that will be financed from (a) the consolidated fund of the Federation, an amount not less than two per cent of its value; (b) grants by international donor partners; and (c) funds from any other source to finance the following: (a) 50% of the fund shall be used for the provision of basic minimum package of health services to all citizens, in primary health care facilities through the National Health Insurance Scheme (NHIS); (b) 25 per cent of the fund shall be used to provide essential drugs for primary healthcare; (c) 15 per cent of the fund shall be used for the provision and maintenance of facilities, equipment and transport for primary healthcare; and (d) 10 per cent of the fund shall be used for the development of Human Resources for Primary Health Care.
The actualisation of the National Health Bill will contribute to sustaining the gains of this proposal which will mostly be implemented using the PHC facilities.

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.

ONE PAGE MAXIMUM

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 which is in turn linked to the National Economic Empowerment and Development Strategy (NEEDS 1). Of the NSF four priorities namely: (1) Reforming Government and Institutions, (2) Growing the private sector and (3) Implementing a social charter (4). Value Re-Orientation, HIV/AIDS response falls under the third priority, because it is acknowledged as a major threat to productivity and the economy. Successful implementation of the activities in this proposal will contribute to the achievement of the NEEDS and contribute to the attainment of the Millennium Development Goals (MDGs) as well as the Universal Access targets to which Nigeria has subscribed.

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, and most-at-risk population groups that are not adequately catered for by the existing service delivery mechanisms. It 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.

The National HIV/AIDS response is based on the **"3 ones'** Principle (one coordinating authority, one Strategy and one M&E Framework) to which Nigeria has subscribed: The National and State Agencies for the control of AIDS have the mandate to ensure that all the partners in the national response to the HIV/AIDS epidemic support the achievement of the national targets as set in NSF. 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.

ONE PAGE MAXIMUM

Nigeria's current impact measurement system focuses on tracking levels and trends in behaviors, HIV and Syphilis prevalence, The following are data sources of Nigeria's HIV impact measurement system:

- HIV/STI Sentinel Surveillance Surveys among women 15-49 years attending antenatal clinics in Nigeria are conducted every two years to produce proxy data on the levels and trends of HIV prevalence in the country. The strengths include: lack of selection bias, availability of regular survey reports from 1991 to 2008 that enables determination of HIV infection trends. The main weakness is that the surveys exclude men, non pregnant women and infertile women in the population.
- National HIV/AIDS and Reproductive Health Surveys (NARHS) are household surveys conducted every two years since 2003 to generate datasets and reliable figures on key indicators that will facilitate trend analysis

pertaining to HIV/AIDS and RH knowledge, attitudes and behaviours. The strength is that these surveys have been implemented consistently since 2003 yielding 3 survey datasets so far. The weakness is that it is difficult to link the behavior trends to the HIV prevalence trends derived from the HIV/STI Sentinel Surveillance Surveys.

- National HIV/AIDS and Reproductive Health Surveys (NARHS+) For the first time in 2007, NARHS methodology incorporated HIV testing in order to provide population based estimates of HIV prevalence for the various population groups. The strengths are that more reliable data is available for HIV/AIDS policy formulation and implementation, for planning and better targeting of interventions and for more accurate estimation of the national HIV prevalence. The weaknesses include the high cost that poses a limitation to repeating them as planned every two years, and the high potential of selection bias.
- Behavior Surveillance Surveys (BSS) are conducted every two years (2000, 2003, 2005) tracking knowledge, attitudes and behaviors among Female Sex workers, Transport Workers, Armed Forces, Police, and Youths.
- Integrated Bio-Behavioral Sentinel Surveys (IBBSS) In 2007, the protocol for the BSS was modified dropping Youths and adding Males having sex with males (MSM), and injecting drug users (IDU) while including HIV and Syphilis testing to the behavioral parameters thereby generating the first Integrated Bio-Behavioral Sentinel Surveys (IBBSS) in Nigeria. The strengths include: ability to track behavior trends, ability to link behaviors to HIV and syphilis prevalence, and generation of information for better targeting of interventions to specific target groups. The weakness remains that the protocol applied does not allow for size estimation of the groups. This weakness has been addressed in this proposal, whereby the revision of the protocol and financial contribution to the conduct of 2011 IBBSS round have been included in SDA 4: BCC Community Outreach (MARPs).
- Orphans and Vulnerable Children (OVC) Surveys provide insight in terms of the social impact of HIV and AIDS vis-à-vis orphanhood and child vulnerability.
- Non-HIV-specific National Surveys and Assessments such as (1) Nigeria Demographic and Health Survey; (2) Health Facility Assessment); (3) Integrated Socio Economic Household Survey; and (4) the National Population and Housing Census help to contextualize evidence related to HIV and AIDS and have provided important data inputs for modeling exercises and national target setting.

The following are current **strengths in Nigeria's impact measurement system**:

- Existence of a harmonized set of national indicators and a National M&E Operational Plan
- Wide breadth of outcomes and impacts assessed (e.g., epidemiological impact, socioeconomic impact, behavior change, process measures related to service use and quality)
- Use of scientifically rigorous methodologies by using nationally adapted international protocols and standardized tools;
- Triangulation of data from the above sources will inform estimates and projection exercises.

The **weaknesses** (as contained in the Review Report of the National M&E System (see ANNEX 7) are:

- The current National M&E Operational Plan has not been costed.
- Complete rollout of a harmonized national MIS has not taken place.
- There is a limited availability of staff with sufficient capacity in data production, reporting, and data use.
- Shortcomings in data transmission logistics, data feedback/use in different sectors and at different levels.
- Parallel reporting in selected program areas such as ART, HCT and PMTCT.
- Data quality shortcomings (e.g., double counting or incomplete data reporting for selected parameters).
- Limited data pertaining to community-based efforts (e.g., MARPS, OVC, community and home-based care).
- Need for improvement in surveillance of other STIs, as well as HIV drug resistance monitoring.

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)?

HALF PAGE MAXIMUM

A 2007 assessment of the national HIV/AIDS M&E system identified parallel reporting—particularly as it pertains to ART, PMTCT, and HIV counseling and testing—as an issue that warrants future attention. The country has made a conscious effort to harmonize national indicators and M&E arrangements across organizational players, funding mechanisms, and reporting cycles. The current National M&E Operational Plan, 2007-2010 (NOP) reflects this

harmonized approach. In addition, the NNRIMS (Nigerian National Response Information Management System) reflects the vision for integrated data flow for multiple diseases/outcomes across sectors and harmonized/compatible information technology (IT) platforms to facilitate knowledge management by stakeholders at different levels.

In acknowledgement of the need to avoid the creation of parallel reporting systems, the Round 9 HIV performance framework (Attachment A) is in complete alignment with the National HIV M&E Framework, relying upon a subset of nationally agreed-upon indicators, tools, and systems. In addition, a number of measures will be put in place to prevent parallel reporting and minimize double counting:

1. Involvement of the same entities that coordinate and implement broader national M&E efforts (e.g., National Agency for the Control of AIDS [NACA]; Federal Ministry of Health [FMOH]; State Ministries of Health (SMOH), State Agencies for the Control of AIDS [SACAs], etc.) in performance monitoring related to the Round 9 GF grant.
2. Field supervision and data quality assurance measures have been instituted, with NACA and other entities working closely with the Principal Recipients and Sub-recipients on issues of M&E capacity strengthening and data quality assurance to minimize over/under reporting and double counting in data capture, collation, analysis, and reporting.
3. Completion of the roll out of NNRIMS across the country (which facilitates harmonized routine data collection, data flow, and systematic data use)

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.*

ONE PAGE MAXIMUM

Performance measurement for the proposed Round 9 Global Fund Project will utilize pre-existing indicators, tools, protocols, and data flow arrangements. Round 9 PRs will report to the GF and designated national entities (e.g., FMOH/NACA, SMOH/SACA, LACA) quarterly, whereas SRs will report monthly to the respective PRs. The various implementing partner organizations will report to the respective SRs on a quarterly basis.

Nigeria's National M&E Operational Plan (NOP) is a road map for M&E strengthening across implementers, sectors, funding mechanisms, and reporting cycles. The Round 5 Global Fund grant, helped to increase access to ART, with concomitant improvements in the monitoring and tracking of ART clients and outcomes. The approved Round 8 Health System Strengthening (HSS) component is supporting the rollout of an expanded Health Management Information System ('expanded' in the sense that it will eventually track outcomes and activities outside the health sector) among primary health care facilities (PHCs) in 185 LGAs (i.e., districts). The Round 8 HSS grant also partially funds selected impact measurement surveys.

It is proposed that the following activities be supported under the auspices of the Round 9 project:

(I) Rollout the expanded "HMIS" to PHCs in the remaining 589 LGAs (Districts), and ensure rollout to all secondary and tertiary-level institutions across the 774 LGAs—There is a vision for one information system, the Nigerian National Response Information Management System (NNRIMS), which will consolidate all evidence pertaining to the multi-sectoral HIV response. The expanded HMIS is the precursor to NNRIMS and will serve as the backbone for the integrated information system. Under the Round 9 project, NNRIMS-HMIS rollout will entail: (1) training and other capacity development of service providers, data management personnel, and program managers in quality data capture, storage, retrieval, and use for service delivery improvement; (2) provision of necessary IT infrastructure to LGAs and service delivery points to facilitate local data management, reporting, and use; (3) integration of pre-existing IT platforms (e.g. LHPMIP/DHIS) with the broader NNRIMS database; and (4) continuation of field support and data quality assurance mechanisms. In addition to the above, support for M&E coordination and technical direction at National (NACA)/FMOH, sectoral, State (SACA)/SMOH, and LGA levels is critical. Since the current M&E Operational Plan expires at the end of 2010, there will be a need to develop and cost a new national operational plan.

(II) Bolster surveillance, impact measurement, and operational research—Surveillance of HIV, syphilis, and behavioral outcomes in specific sub-populations have become a standard fixture in the national M&E system. Round 9 resources will support planned ANC sentinel surveys (2010, 2012, 2014); IBBSS (2011, 2013); and NARHS

(2011, 2013). Round 9 resources will also strengthen other forms of surveillance (namely: STIs, drug resistance, TB-HIV co-infection, and community-based surveillance of vulnerable children). Finally this proposal will support operational research to fill identified information gaps.

(III) Expand the evidence base on most-at-risk populations (MARPs)—This Round 9 proposal articulates an expanded strategy to reach MARPs. At present, the IBBSS is the sole source of evidence on MARPs in Nigeria. Round 9 GF resources will be used to expand the evidence base via the following: (1) mapping of entities and organizations with access to MARP groups; (2) MARP size estimation (notably, the only available estimates have been based on mathematical models); and (3) routine monitoring of MARP interventions (reach, quality, effectiveness) using harmonized monitoring tools.

(IV) Improve efforts to monitor quality of program implementation
The Round 9 project will facilitate the development and implementation of new strategies and systems for Quality Assurance/Quality Improvement (QA/QI). The QA/QI strategy will involve components such as: (1) sensitization and engagement of heads of health facilities and service delivery points outside the health sector in defining QA/QI goals, creating sustainable QA/QI approaches and structures, and defining roles and responsibilities among service providers; (2) integration of QA/QI with efforts aimed at increasing data use; (3) identification of performance indicators that can highlight quality gaps and track quality improvement; (4) utilization of routine (e.g., NNRIMS, early-warning systems) and non-routine (e.g., health facility assessments; periodic assessments of client satisfaction) measurements of quality of care; (5) capacity strengthening of LGA (district) and facility-based M&E officers to support various aspects of QA/QI; and (6) the expansion of integrated supportive supervision. As part of QA/QI, health system strengthening will also be monitored as a critical element in ensuring delivery of quality services towards the achievement of Universal Access.

(V) Facilitate knowledge management and data use—Round 9 GF resources will also support the systematic review and use of available data via: (1) development/adaptation of M&E Standard Operating Procedures and data use "job aids" (e.g., community-based M&E toolkits); (2) periodic multisectoral exercises in data triangulation and in-depth data analysis to identify changing dynamics in the epidemic, gender disparities and social equity issues; gaps in coverage and quality of care, and intervention effectiveness; and (3) development of dissemination products (e.g., research briefs, policy briefs) that "translate" evidence for intended end users.

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 financial resources, advocacy, M&E, and participation in policy 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 program 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 Programs 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 programs at national and regional level. The finance and administrative manager has oversight of finance and administrative related issues. The Programs 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 programs 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 program. 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 programs and achieved project goals, objectives and outputs across Nigeria including The World Bank HIV/AIDS Program 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 programs 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. NACA Through the Federal Ministry of Finance and on behalf of the Federal Government has just completed the negotiation of a $225million credit for MAP II, to address further gaps within the response, complementary to what other development assistance is doing in the country. The facility will be available from September 2009 to expand Public sector response, build on critical capacity, strengthen SACAs and State responses as well as expand civil society interventions over a five year period across the country.

Technical Capacity: NACA's senior and program 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 programs 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 program 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 program 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 PPFN 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 **See GF 9 proposal section 4.9.2 (e)**
	☐ 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.	

MAXIMUM TWO PAGES

i) NACA: NACA has provisionally selected about 8 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 8 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 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; and CS = Civil Society).

1. FMOH HIV/AIDS Division (Formerly NASCP)
2. Family Health International
3. HYGEIA Foundation
4. Institute for Human Virology
5. Harvard University/AIDS Prevention Initiative in Nigeria
6. Journalists Against AIDS
7. Society for Family Health
8. British Broadcasting Corporation World Service Trust

Primary Area	Sub Recipients and sectors
Regulatory / Accreditation	FMoH (P);

Policy & Guidelines	FMoH (P);
Curriculum development	FMoH (P)
Central training	FMoH (P)
Standard setting / QA	FMoH (P);
Site assessment & selection	FMoH (P);
Facility level Implementation (scale up of comprehensive integrated programs and services at PHC and community level)	FMoH (P); FHI-GHAIN (CS), SFH (CS), IHV (CS) HYGEIA Foundation (PV) CHAI(PV)
Behavior Change Communications –Mass media	BBC WST; SFH, JAAIDS
Development of community based communication strategies and BCC programs	SFH (CS) Journalists Against AIDS (CS)

i) CiSHAN: This PR has identified seven sub-recipients as follows:

a. Network of People Living with HIV/AIDS: Core Program area: Stigma Reduction, care and support for PLWHA
b. Federal Ministry of Education: HIV/AIDS, FHLE School Curriculum
c. Federal Ministry of Women and Social Affairs: Care and support – OVC
d. Association for Reproductive and Family Health
e. National Youth Service Corps: BCC- Youth
f. Action Health Inc: FLHE School Based Programs
g. Society for Family Health: Out of School Youth and MARPS through the Peer Education Plus
h. National HIV/AIDS Research Network: MARPs Operations Research, M & E.

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

a. FHI/GHAIN: HIV/AIDS Prevention HCT
b. Federal Ministry of Labor & Productivity (FMoL&P): HIV/AIDS Prevention, Workplace Policy
c. NIBUCAA: HIV/AIDS Prevention Workplace Programming
d. Society for Family Health: HIV/AIDS Prevention Workplace Programming.
e. Association for Reproductive and Family Health: Sexual Reproductive Health services/ HIV/AIDS Prevention:
f. Interfaith Coalition against HIV/AIDS in Nigeria: BCC, Prevention & HCT

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. 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.
v. 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
vi. Institute of Human Virology Nigeria: A University of Maryland USA affiliate and a implementer of the PEPFAR program in Nigeria
vii. Journalists Against AIDS: A Nigerian NGO with the capacity to handle communications and

Behavioral Change Communications programs

viii. Harvard University/AIDS Prevention Initiative in Nigeria: A private Foundation with global experience in HIV Programming particularly in HIV Prevention activities such as PMTCT, ART programming and pediatric ART.

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

a. FHI/GHAIN: 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
b. 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 programs 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.
c. Interfaith Coalition Against HIV/AIDS: a national network of Faith Based organizations involved in the national HIV/AIDS response.
d. 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
e. NIBUCAA: A coalition of business concerns around HIV/AIDS with experience as SR in workplace interventions in the GF round 5.
f. Federal Ministry of Labour & Productivity (FMoL&P): A ministry of government with long running workplace programming experience. An SR in the implementation of the Objective 4 of the HIV Round 5 grant

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. Federal Ministry of Women Affairs and social Development: 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 agency in charge of the Youth Corp Scheme which trains Peer Educators and places them in communities all over the nation. It is a SR under GFATM R5
d. 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.
e. ActionHealth Inc. – A Nigerian NGO facilitated the development of the FLHE curriculum for the FMoE and implements substantial ARH interventions
f. Association for Reproductive and Family Health: A national NGO with expertise in Reproductive and Family Health, OVC interventions and community based initiatives. Also a PR for the Round 5 HIV grant.
g. 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
h. 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 program in Nigeria

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 9 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 program 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 programs, 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 8 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 6 SRs, PPFN planned to provide Quality assurance training for them, and support the recruitment of additional staff for each of them to provide administrative, program 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 Program 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 9 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 *More details required in s.4.10.3.*	Federal Ministry of Health NACA	Sub-recipient Principal Recipient	☒ Yes ☐ 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	Federal Ministry of Health,	SR	☒ Yes

More details required in s.4.10.4	CMS	Warehousing Agent	☐ 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
[use the "Tab" key to add extra rows if more than four organizations will be involved in the management of this work]		

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 9 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 program. 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 9 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 9 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 Program 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.

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.
Attachment B completed.

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.*
	X 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 9 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 9 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').

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.*

Clarified section 5.1

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 2008 etc.) to align with national planning and fiscal periods**								
	Actual		**Planned**		**Estimated**			
	2007	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
HIV program funding needs to deliver comprehensive prevention, treatment and care and support services to target populations								
Line A ➔ Provide annual amounts	**209,515,896**	**286,503,601**	**525,853,976**	**681,730,689**	**838,473,680**	**1,109,660,029**	**1,273,274,038**	**1,553,663,493**
Line A.1 ➔ Total need over length of Round 9 Funding Request *(combined total need over Round 9 proposal term)*							**5,456,801,931**	
Current and future resources to meet financial need								
Domestic source **B1**: Loans and debt relief (*provide name of source*)	**0**	**0**	**50,000,000**	**0**	**0**	**0**	**0**	**0**
Domestic source **B2** National funding resources	**3,733,326**	**3,801,104**	**37,015,961**	**4,733,326**	**4,733,326**	**5,033,326**	**5,033,326**	**5,966,666**
Domestic source **B3** Private Sector contributions (national)				**1,500,000**	**1,500,000**	**1,500,000**	**1,500,000**	**1,500,000**
Total of Line B entries ➔ Total current & planned DOMESTIC (including debt relief) resources:	**3,733,326**	**3,801,104**	**87,015,961**	**6,233,326**	**6,233,326**	**6,533,326**	**6,533,326**	**7,466,666**
External source **C 1** (*USG/PEPFAR*)	**55,627,375**	**81,151,375**	**87,565,375**	0	0	0	0	0

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 2008 etc.) to align with national planning and fiscal periods**								
	Actual		**Planned**		**Estimated**			
	2007	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
External source **C2** (United Nations Agencies)	**3819328**	**2862743**	**3228860**	**3542261**	**3896487**	**2621982**	**126260**	**138886**
External source **C2** (UK Government (DfID)	**14,375,112**	**13,952,708**	**19,019,891**	**22,337,893**	**22,147,827**	**22,786,532**	**24,878,939**	**14,705,207**
External source **C2** (CIDA)	**0**	**1,040,000**	**0**	**0**	**0**	**0**	**0**	**0**
External source **C3** Private Sector contributions (International)				**5,295,536.53**	**5,000,000**	**5,000,000**	**5,000,000**	**5,000,000**
Total of Line C entries ➔ Total current & planned EXTERNAL (non-Global Fund grant) resources:	**73,821,815.12**	**99,006,826**	**109,814,126**	**31,175,691**	**31,044,314**	**30408514.35**	**30005199.96**	**19844093.58**
In line D below, insert additional separate lines for each separate Global Fund grant. This will ensure that you show information on different Global Fund grants.								
Line D: Annual value of all existing Global Fund grants for same disease: Include unsigned 'Phase 2' amounts as "planned" amounts in relevant years	**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)	**101,471,715**	**141,941,033**	**235,963,190**	**76,542,120**	**76,410,743**	**36,941,840**	**36,538,525**	**27,310,759**
Calculation of gap in financial resources and summary of total funding requested in Round 9 *(to be supported by detailed budget)*								
Line F ➔ Total funding gap (i.e. Line F = Line A – Line E)	**108,044,181**	**144,462,568**	**289,890,786**	**605,188,569**	**762,062,937**	**1,072,718,189**	**1,236,735,513**	**1,526,352,734**

ROUND 9 – 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 2008 etc.) to align with national planning and fiscal periods**

	Actual		Planned		Estimated			
	2007	2008	2009	2010	2011	2012	2013	2014
Line G = Round 9 HIV funding request *(same amount as requested in table 5.3 for this disease)*				25,783,005	36,197,491	64,372,670	97,262,426	117,404,316

Part H – 'Cost Sharing' calculation for Lower-middle income and Upper-middle income applicants

In Round 9, 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

$$\text{Cost sharing} = \frac{(\text{Total of Line D entries over 2010-2014 period} + \text{Line G Total}) \times 100}{\text{Line A.1}}$$

7.7%

Clarified section 5.1.1

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 fully implementation of country's HIV program strategies.

The Annual financial needs were derived from the Annual Costed National Targets for the Period 2010-2015. This Document is submitted as attachment…….

Clarified Section 5.1.2

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.

The major criteria applied in allocating domestic financial resources is existence of funding gap to priority HIV/AIDS interventions. Using this criteria most of the domestic funding has been used to procure HIV test kits for HIV Counselling and Testing services where the demand for services far exceeded planned expectations.

Clarified Section 5.1.3

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 major external financial source to HIV/AIDS Programme has been PEPFAR/USG. The modality of funding from PEPFAR will change as of 2010, whereby it will be based on the Partnership Framework and Implementation Plan that will in turn be linked to the National Health Strategy Development Plan and the National HIV Startegic Framework. Because the Partnership Framework is currently under development it is not possible to predict the future funding levels from this source. It has not been easy for most Development Partners to provide projected HIV/AIDS financial support for future. With the current Global Financial Crisis, we can only anticipate a reduction in external funding.

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/rounds/9/single/#budget

2. Ensure the detailed budget is consistent with the detailed workplan 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 9. 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/ccm/

Clarified section 5.3

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	$ 280,737	$ 754,954	$ 1,566,576	$ 2,328,779	$ 2,234,106	$ 7,165,152
	HCT	$1,361,441	$ 2,324,449	$ 5,384,154	$ 7,221,709	$ 6,460,052	$ 22,751,805
	BCC - Mass media	$ 239,435	$ 2,623,254	$ 3,568,406	$ 3,746,827	$ 3,934,167	$ 14,112,089
	BCC - community outreach	$2,582,316	$ 3,199,589	$ 4,798,959	$ 6,548,727	$ 7,127,349	$ 24,256,940
	HIV/SRH integration	$1,010,888	$ 1,170,158	$ 2,693,162	$ 3,702,700	$ 3,635,611	$ 12,212,519
2	Antiretroviral treatment (ART) and monitoring	$3,284,181	$ 7,310,764	$ 19,319,970	$ 34,887,516	$ 48,634,303	$ 113,436,734
	Prophylaxis and treatment of opportunistic infections (OIs)	$ 844,706	$ 2,208,549	$ 4,924,222	$ 8,457,584	$ 11,102,356	$ 27,537,417
	TB/HIV	$ 124,000	$ 20,417	$ 37,928	$ 64,065	$ 67,268	$ 313,678
3	Care and support for the chronically ill	$ 821,379	$ 2,083,793	$ 3,989,626	$ 6,369,922	$ 5,285,648	$ 18,550,368
	Support for orphans and vulnerable children (OVC)	$ 672,371	$ 2,308,589	$ 5,351,054	$ 10,186,154	$ 15,118,908	$ 33,637,076
4	Policy development including workplace policy	$ 57,545	$ 498,579	$ 187,857	$ 220,828	$ 207,113	$ 1,171,922
5	Program management and administration	$ 9,711,462	$ 7,578,133	$ 8,072,087	$ 9,019,816	$ 9,083,334	$ 43,464,832
	Strategic information and program M&E	$ 4,792,544	$ 4,116,263	$ 4,478,669	$ 4,507,799	$ 4,514,101	$ 22,409,376

ROUND 9 – HIV

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
	TOTAL	**$ 25,783,005**	**$ 36,197,491**	**$ 64,372,670**	**$ 97,262,426**	**$ 117,404,316**	**$ 341,019,908**

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.)*

Clarified section 5.4

Avoid using the "other" category unless necessary – read the Round 9 Guidelines.

	(same currency as on cover sheet of Proposal Form)					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Human resources	$ 3,756,730	$ 4,198,412	$ 4,499,293	$ 4,858,626	$ 5,103,018	$ 22,416,079
Technical and Management Assistance	$ 690,751	$ 979,133	$ 1,413,312	$ 2,178,377	$ 2,132,764	$ 7,394,337
Training	$ 2,543,985	$ 2,818,024	$ 4,442,766	$ 5,159,176	$ 4,833,119	$ 19,797,070
Health products and health equipment	$ 1,534,652	$ 4,905,553	$ 11,568,781	$ 17,971,303	$ 22,165,138	$ 58,145,427
Pharmaceutical products (medicines)	$ 733,963	$ 3,497,712	$ 10,285,348	$ 18,836,656	$ 26,641,104	$ 59,994,783
Procurement and supply management costs	$ 448,749	$ 1,821,946	$ 4,976,041	$ 8,755,657	$ 12,270,975	$ 28,273,368
Infrastructure and other equipment	$ 4,464,424	$ 2,918,616	$ 5,228,627	$ 7,357,558	$ 8,168,797	$ 28,138,022
Communication Materials	$ 1,228,890	$ 3,498,114	$ 5,220,594	$ 6,371,636	$ 6,021,632	$ 22,340,866
Monitoring & Evaluation	$ 6,111,359	$ 4,965,176	$ 6,036,038	$ 8,008,398	$ 8,705,548	$ 33,826,519
Living Support to Clients/Target Populations	$ 941,429	$ 2,984,464	$ 6,389,670	$ 11,708,838	$ 14,957,878	$ 36,982,279
Planning and administration	$ 2,439,585	$ 2,471,707	$ 2,323,089	$ 2,497,760	$ 2,595,936	$ 12,328,077
Overheads	$ 888,488	$ 1,110,606	$ 1,989,111	$ 3,527,541	$ 3,808,407	$ 11,324,153
Other: *(Use to meet national budget planning categories, if required)*	$ -	$ 28,028	$ -	$ 30,900	$ -	$ 58,928
Round 9 HIV funding request (*Should be the same annual totals as table 5.2*)	**$ 25,783,005**	**$ 36,197,491**	**$ 64,372,670**	**$ 97,262,426**	**$ 117,404,316**	**$ 341,019,908**

5.4.1. Overall budget context

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

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The majority of cost categories steadily increase over the five year period at rates reflective of the established roll out plans for 2010-2014.

The largest cost categories, Pharmaceutical Products (Medicines) and Health Products and Health Equipment, show variation reflective of the increased number of total patients each year requiring ARVs and other necessary medicines for treatment, as well as the laboratory reagents and consumables which are needed at secondary facilities throughout the grant. As Procurement and Supply Management Costs are calculated as a percentage of the commodity costs and directly linked to the amount for each of these categories, this area also increases significantly through 2014.

After commodity costs, the largest cost category is the Living Support Provided to Clients. This is primarily driven by the provision of nutritional support to OVCs and the support to OVCs for schooling, vocational skills training, income generation activities and micro credit. The variation in this category is attributable to the steadily increasing number of OVCs and chronically ill people who are receiving support.

The proposed scale up for each of the above activities is further explained in Section 4.1.2 and the major cost drivers are highlighted in Annex 8.

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 are expected to account for approximately 6.6% of the total grant and $22.4million overall. The main drivers for this cost category are the salary costs for the identified PRs and SRs which are not expected to have much variation over the course of the grant.

Detailed budget breakdowns for the three identified PRs are attached in Annex 10 to support the calculations for years one through five.

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*

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In addition to Pharmaceutical Products (Medicines), Health Products and Health Equipment, Procurement and Supply Management Costs, and Living Support, the two cost categories which

represents significant proportions of the budget are Training and Infrastructure and Other Equipment.

The costs incurred through Training activities are necessary to both strengthen the existing HIV/AIDS program and to build capacity for its expansion through education and skill development. The major activity contributing to this total is the training of Family Life Health Education (FLHE) trainers which will account for nearly $10.2M over the five years and result in reaching 4.8 million cumulative students.

Infrastructure and Other Equipment commitments are primarily for the equipping of new ART sites. This represents a total of $28M over the five years and will provide equipment such as CD4 machines and Hematology Analyzers to 194 ART sites; the necessary infrastructure investments for these sites are to be contributed by the Government of Nigeria.

The proposed scale up for each of the above activities is further explained in Section 4.1.2 and the major cost drivers are highlighted in Annex 8.

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.

Clarified section 5.5.1

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.*

Nigeria does not apply the common funding mechanism.

Clarified section 5.5.2

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

Clarified section 5.5.3

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

Section 3 and 4: Program Description		List Annex Name and Number
4.1	Supporting documentation for National Strategy	☒ National Strategic Framework 2007-09 (Annex 4.1-2 , GF Round 8 Proposal)
4.2.1	Map if proposal targets specific region/population group	
4.3.2	Any recent report on health system weaknesses and gaps that impact outcomes for the three diseases (and beyond if it exists).	
4.4	Document(s) that explain basis for coverage targets	☒National HIV/AIDS Targets (Annex 5, GF Round 9)
4.5.1	**A completed '*Performance Framework*' by disease** **Refer to the M&E Toolkit for help in completing this table**.	**Attachment A**
4.5.1	**A detailed component Work Plan** (quarterly information for the first two years and annual information for years 3, 4 and 5) by disease.	**Work plan**
4.5.2	**A copy of the Technical Review Panel (TRP) Review Form** for unapproved Round 7 or Round 8 proposals (only if relevant).	☒ TRP Review Form for Round 8; Annex 6, GF Round 9
4.8.1	**A recent evaluation of the 'Impact Measurement Systems'** as relevant to the proposal (if one exists)	☒ National M&E Plan: Program/Project M&E Systems Strengthening Assessment Report; Annex 7 GF R9 proposal
4.9.1	**A recent assessment of the Principal Recipient capacities** (other than Global Fund Grant Performance Report).	
4.9.1 *(for non-CCM applicants)*	**Document describing the organization such as: official registration papers, summary of recent history of organization, management team information**	
4.9.2	**List of sub-recipients already identified** (including name, sector they represent, and SDA(s) most relevant to their activities during the proposal term)	☒ ***See GF 9 proposal section 4.9.2 (e***
4.10.6	**A completed 'List of Pharmaceutical and Health Products'** by disease (if applicable).	**Attachment B**

Section 5: Financial Information		List Annex Name and Number
5.2	**A 'detailed budget' (quarterly information for the first two years, and annual information for years 3, 4 and 5)**	**Detailed Budget**
5.4.2	Information on basis for budget calculation and diagram and/or list of planned human resources funded by proposal (only if relevant)	
5.4.3	Information on basis of costing for 'large cost category' items	☒ Large Cost Category in Excess of 5% budget Annex 8 GF R9
5.5.1 *(if common funding mechanism)*	Documentation describing the functioning of the common funding mechanism	
5.5.2 *(if common funding mechanism)*	Most recent assessment of the performance of the common funding mechanism	
Other documents relevant to sections 3, 4 and 5 attached by Applicant:		**List Annex Name and Number**
☒4.5.1	☒Roll Out Plans for Selected SDAs	☒ Roll Out Plans for Selected SDAs: Annex 9, GF Round 9 proposal

Attachment A - HIV Performance Framework

Program Details

Country:	NIGERIA
Disease:	HIV (Round 9)
Proposal ID:	

Program Goal, impact and outcome indicators

	Goals
1	To contribute to the expansion of HIV/AIDS prevention, treatment care and support services in Nigeria, in order to reduce HIV incidence and mitigate the impact on women, children, and other vulnerable groups and the general population in the country
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	
impact	% of young women aged 15-24 who are HIV infected	4.6%	2008	ANC Sentinel Survey	4.6%	--	3.8%	--	3.6%	Assessed every 2 years. In comparison to previous rounds, the 2008 round of ANC SS suggests that there is not yet a definitive declining trend in the value of this indicator. The R9 targets reflect an aim to "stablize" this indicator in the short term and achieve a modest "decline" (compared to baseline levels) by 2014.
impact	% of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	94.6%	2007	Patient records (ICAP Programme Records)	95%	95%	95%	95%	95%	As one of the aims of R9 is to expand ART coverage considerably, this impact indicator will be monitored to ensure that already high levels of ART continuation are maintained as more ART beneficiaries are added to the treatment programme; In addition to being an impact measure, it will also be used for quality monitoring.
impact	% of children under age 18 years who are orphans	25%	2008	Orphan Situation Assessment and Analysis	--	24%	--	--	20%	Indicator will be assessed twice over the next five years
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	44%	2007	Household survey (NARHS)	46%	--	48%	--	50%	Will examine values for this indicator according to sex (male, female)
outcome	% of young women and men aged 15-24 who have never had sex	49%	2007	Household survey (NARHS)	45%	--	50%	--	60%	Will examine values for this indicator according to sex (male, female)

* 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 scale up gender-senstive 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 services for PLWHA, orphans and vulnerable children	
4	To create a supportive environment for delivery of comprehensive gender-sensitive HIV/AIDS services	
5	To enhance the management and coordination of HIV/AIDS programs	
6		

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 and percentage of pregnant women who were tested for HIV and who know their results	605,875	2008	HMIS; ANC programme records/facility registers	0	75,000	110,000	180,000	912,000	1,332,000	1,332,000	Y	N	Y - cumulative annually	NACA	Also a national indicator	
1.2	PMTCT	Number and percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	13,883	2008	Nigeria Global Universal Access Report	0	3,450	8,000	9,940	41,952	61,272	61,272	Y	N	Y - cumulative annually	NACA	A "Top 10" GF indicator	
1.3	HIV Counseling and Testing	Number of women and men aged 15+ who received an HIV test in the last 12 months and who know their test results	1,635,852	2008	Nigeria Global Universal Access Report	0	182,160	300,000	467,520	2,070,720	2,776,320	2,776,320	Y	N	Y - cumulative annually	NACA	A "Top 10" GF indicator; will be disaggregated by age and sex	
1.4	HIV Counseling and Testing	Number of sites providing counseling and testing according to national guidelines	897	2008	Nigeria Global Universal Access Report		125	200	325	1,130	1,480	1,480	Y	N	Y - over program term	NACA	To be disaggregated according to type of SDP (i.e., PHC versus FBO sites)	
1.5	BCC - Mass media	Number of broadcasts of HIV-related mass media program spots and jingles on television and radio	0	2008	Reports from media monitoring agencies	0	50	104	156	208	208	208	Y	N	Y - cumulative annually	NACA	Ultimate target: 4 airings/week (i.e., 208 broadcasts)	
1.6	BCC - Community Outreach	Number of students receiving Family Life and HIV Education (FLHE); b) injecting drug users/non-injecting drug users (IDU), c) female sex workers (FSW), and d) men who have sex with men (MSM) reached with HIV/AIDS prevention programs	FLHE 120,000 (pilot); MARPs: 27000	2008	Reports (Programme reports from Min. Of Education and civil-society orgs.)		FHLE - 768,000; MARPs=14,000 (IDU: 5,460; FSW: 3,640; MSM: 4,900)		FHLE - 1,536,000; MARPs=46,500(IDU: 18,135; FSW: 12,090; MSM: 16,275)	FHLE - 2,640,000; MARPs=107,250 (IDU: 41,828; FSW: 27,885; MSM:37,538)	FHLE - 3,7444,000; MARPs=204,750 (IDU: 79,833; FSW: 53,235; MSM: 71,663)	FHLE - 4,848,000; MARPs=345,200 (IDU: 134,628; FSW: 89,752; MSM: 120,820)	Y	N	Y - over program term	CiSHAN in collaboration with NACA	Modified "Top 10" GF indicator; among MARPs, target values for each group mirror the actual distribution in the total MARP population (i.e., 26% FSW, 35% MSM, 39% IDU (which, in sum, is100% of all MARPS)	
1.7	SRH/HIV Integration	Number of people provided with integrated RH/HIV services	0	2008	Reports (programme records)		29,145	60,000	62,803	331,315	444,211	444,211	Y	N	Y - cumulative annually	NACA		
2.1	Anti-Retroviral Treatment (ART) and Monitoring	Number and percentage of adults & children with advanced HIV infection currently receiving antiretroviral therapy	231,079	2008	Program Implementation Reports	0	1,883	5,000	10,020	31,588	60,807	90,025	Y	N	Y - cumulative annually	NACA	"Top 10" indicator; disagg. by sex, child vs. adult	Please note that Yr 2 target is 10,020
2.2	Anti-Retroviral Treatment (ART) and Monitoring	Percentage of people starting antiretroviral therapy who picked up all prescribed antiretroviral drugs on time	Not available	Not available	Program Implementation Reports	80	80	80	80	80	80	80	Y	N	N - not cumulative	NACA	Part of quality monitoring; efforts to minimise MDR	
2.3	Prophylaxis and Treatment of Opportunistic Infections	Number of adults and children enrolled in HIV care and eligible for co-trimoxazole prophylaxis currently receiving co-trimoxazole prophylaxis	66,995	2008	Program Implementation Reports	0	21,155	25,000	35,396	131,307	181,680	188,122	Y	N	Y - cumulative annually	NACA	Already tracked under R5 HIV Project; critical for monitoring trends	
2.4	TB/HIV Collaborative Activities	Percentage of adults and children enrolled in HIV care who had TB status assessed and recorded within the last 12 months, among all adults and children enrolled in HIV care in the reporting period	80%	2008	Program Implementation Reports	80%	82%	85%	90%	95%	100%	100%	Y	N	Y - cumulative annually	NACA (in close collaboration with ARFH and IHV, who are the PRs under the Round 9 TB Proposal)	A critical milestone in ensuring effective co-management of HIV and TB; Also a quality measure because TB screening is part of the essential package of HIV clinical services	
2.5	TB/HIV Collaborative Activities	No. of TB/HIV co-infected patients who received CPT after completing TB treatment at DOTS centers	7,930	2008	TB Program Implementation Report	0	39,786	41,000	42,175	44,974	47,901	50,573	Y	Y	Y - cumulative annually	NACA (in close collaboration with ARFH and IHV, who are the PRs under the Round 9 TB Proposal)		
3.1	Care and Support for the Chronically ill	Number of adults and children living with HIV who receive care and support services outside facilities	62,582	2008	Program Implementation Reports (from CBOs/FBOs)	2250	5,250	9,000	13,500	30750	58500	86,250	Y	N	Y - over program term	CiSHAN; NACA	PLWHAs receiving home-based care from CBOs and PLWHAs involved in support groups will be counted in the indicator	
3.2	Support for Orphans and Vulnerable Children	No. OVC receiving material and psychosocial support	74,122	2008	Program Implementation Reports		1,300	2,000	4,500	10,300	19,500	28,800	Y	N	Y - over program term	NACA		
4.1	Policy Development Including Workplace Policy	Number of small and medium enterprises receiving support for implementation of HIV workplace programme	130	2008	Reports (Annual sector reports)		40	60	80	120	160	200	Y	N	Y - over program term	PPFN		
5.1	Strengthening Programme Management and Administration	Proportion of Implementing Organizations strengthened	0	2008	Programme Implementation Reports	50%	70%	80%	90%	100%	100%	100%	Y	N	Y - cumulative annually	NACA		
5.2	Strategic Information	Percentage of supported SDPs with timely and complete reports of routine HIV data in the last 12 months	90%	2008	Quarterly reports	90%	90%	90%	90%	90%	90%	90%	Y	N	Y - cumulative annually	NACA		