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			

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		

[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/

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 – Tuberculosis

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 tuberculosis Global Fund grant(s) with the Round 9 tuberculosis 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_Pol_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, udgeting and fiscal cycle; and/or

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

In developing this proposal, the various contributions of the federal government, partners and the on-going Global Fund Round 5 (GFR5) TB grant have been taken into consideration. Reviewing the fiscal and reporting cycles of all of these entities; it became evident that a calendar year (January 1st to December 31st) cycle for this proposal would ensure the best alignment. The other units with this same cycle include:

- the National Planning, Budgeting and Fiscal cycle
- the National Health Sector Development Plan and the TB Strategic Plan
- the on-going Global Fund Round 5 TB grant
- most TB partner organizations

Although a few partners have a different planning cycle, such partners key into the national planning and budgeting cycle. This makes for synergistic planning, budgeting and implementation of activities. The convenience provided by aligning the period of this grant with the existing planning and fiscal framework will ensure an enabling environment for its successful implementation and reporting.

3.4 Program-based approach for Tuberculosis

3.4.1. Does planning and funding for the country's response to tuberculosis 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 Tuberculosis Proposal

Provide a summary of the tuberculosis proposal described in detail in section 4.

Prepare after completing s.4.

Nigeria, the most populous African nation, ranks 4th among the 22 high TB burden countries in the world according to the 2009 WHO Global TB Report. With an estimated 460,000 new cases annually, TB constitutes a considerable public health problem: in 2007, 2189 TB patients died. The TB burden is borne by the entire population, but especially by higher risk populations such as the urban and rural poor, people with living with HIV/AIDS living and those in congregate settings. There is also a significant socio-economic consequence as the highest prevalence is among the most economically productive age range of 15-45 years. This proposal will reduce the TB burden by complementing and accelerating the activities ongoing by government, partners and under the Global Fund Round 5 (GFR5) grant. The principal focus of the proposal is to provide increased and equitable access to DOTS services and also addressing the MDR-TB.

A comprehensive review of the current programme strengths, weaknesses and planned activities nationwide led to the selection of three main objectives for this proposal:

1. **To pursue high quality DOTS expansion and enhancement**
2. **Scale up TB/HIV collaborative activities and strengthen TB/HIV collaboration**
3. **To strengthen MDR-TB prevention and control**

DOTS expansion and enhancement: DOTS expansion is the central focus of the ongoing GFR5 grant and is additionally supported by contributions from government, USAID and other funding partners; however, the accessibility of DOTS services still falls short of global targets. This proposal will expand upon ongoing activities, striving to provide improved and equitable access to TB services to all populations, in line with the National TB Strategic Plan and the STOP TB strategy. Additional 1,650 new DOTS centers will be established with a specific effort to engage all care providers: public, private, and community organizations. This will include strengthening of the existing laboratories and those to be established in phase 2 round 5 to ensure quality of services. To reduce poverty-related barriers to access, expansion will prioritize to focus more in areas with less number of centers per population while also considering geographic distribution. TB-DOTS (diagnostic and drugs) services will be provided free of charge. An appropriate number of men and women will be trained as healthcare providers in order to address gender equality issues as well as cultural and religious preferences. The monitoring and evaluation system will be strengthened and enhanced, including a revision of tools to allow for gender disaggregation at all reporting levels.

TB/HIV collaborative activities: There has been a substantial increase in the number of TB patients accessing HCT and other HIV services in the last two years due to support from PEPFAR and GFR5 grants and TB-CAP; however, the proportion of DOTS centers (18%) providing such services and the number of patients accessing them are still below the national target. In addition, in most instances TB infection control measures are either weak or neglected. The Round 9 proposal therefore aims at complementing other support structures through expansion of HCT services to 1650 additional DOTS centers, provision of CPT at DOTS centers for HIV^+ TB patients, provision of IPT for HIV/AIDS patients, strengthening referral linkages with HIV service points, and improved implementation of TB infection control measures.

MDR-TB control: The emerging threat of MDR-TB has begun to receive attention from the national programme as evidenced by the formation of a National MDR-TB Committee and the development of MDR-TB policy documents. The magnitude of MDR-TB prevalence is not known; however, MDR-TB survey is planned to start in July, mainly sponsored by government and CDC. The national and 6 zonal reference laboratories are being equipped with support from the GFR5 grant to provide AFB

culture and DST services. Yet, 2nd line drugs for treating those diagnosed with MDR-TB are not available. This proposal will procure 2nd line anti-TB drugs with TA from the Green Light Committee, provide reagents for culture and DST laboratories, provide support for MDR-TB patients for diagnosis and treatment

While accomplishing the three above objectives, the efforts to be made through the implementation of this proposal will contribute to meeting the global TB targets of 70% case detection rate and 85% treatment success rate. More importantly, the attainment of these objectives will relieve the significant burden of TB affecting the people of Nigeria. A total amount of $107,844,907 is required to successfully implement this proposal.

4. PROGRAM DESCRIPTION

4.1 National program and strategy

(a) Briefly summarize:

- the current tuberculosis national program or strategy;
- how the strategy responds comprehensively to current epidemiological situation in the country; and
- the improved tuberculosis outcomes expected from implementation of these programs or strategy.

The Nigerian Health System is structured along the three tiers of government i.e. Federal is responsible for overall policy formulation and tertiary health care services. State is responsible for providing technical guidance to the LGA and also runs the secondary health care while the LGAs are responsible Primary levels of care respectively. The general policy framework for health care is the National Health Policy, which has an overall goal to achieve a level of health that will enable all Nigerians to achieve socially and economically productive lives with Primary Health Care (PHC) as its cornerstone.
Health care services are discharged through about 30,000 public, and about 20,000 private health care facilities. All tertiary and most secondary facilities have laboratories and have the capacity to provide basic laboratory services including AFB microscopy for identification of PTB. The private sector, non-governmental organizations, and local communities also provide considerable services at all the levels of health care

The National Tuberculosis and Leprosy Control Programme (NTBLCP) works under the Department of Public Health in the Federal Ministry of Health (FMOH) and is structured along the three tiers of government: Federal, State and Local Government Area (LGA). At the federal level, the NTBLCP facilitates policy formulation, resource mobilization, supervision, HRD, co-ordination, monitoring and evaluation, drug procurement, logistics management and advocacy. At the State level, the programme is under the Department of Primary Health Care and Disease Control and is responsible for the provision of secondary care as well as providing technical assistance and supervision to the LGA level. The States also ensure the adequate supply of drugs and reagents and all recording and reporting formats to the LGAs and also participate in training and M&E. The LGAs are the operational level of the programme based on the Primary Health Care (PHC) principle. In addition, for administrative convenience, the country is further divided into 6 geo-political Zones to facilitate linkages between national and State levels.

The TB Strategic Plan 2006-2010 of Nigeria is aligned with the WHO's Stop TB Strategy. **The five objectives** include:

- strengthening the technical and managerial capacity of the NTBLCP at all tiers to ensure achievement of at least 80% implementation rate of program activities by 2010;
- to promote behavior change in the community such that about TB 70% of adult population know about TB, its prevention and treatment;
- to increase case detection rate from 26% to 70% by 2010;
- to treat at least 85% of all TB cases detection successfully; and
- to reduce by at least 25% the burden of TB among PLWHA by 2010.

The strategies include:

- enhancing the technical and managerial capacity of the NTBLCP and other implementing partners;
- strengthening the existing services and establish new peripheral DOTS centers;
- provide staff training to health staff;
- strengthen supervision and M&E activities;
- strengthen partnerships to advocate for increased government commitment and ownership of the programme,
- inclusion of the private health case providers and community in the delivery of DOTS.

The **targets** to be achieved by 2010 are: detection of 70% of the estimated smear positive TB cased; treat successfully at least 85% of all smear positive cases detected. **The Findings from a recent mid-term review** of Nigeria's Strategic Plan for TB control in Nigeria, 2006-2010 confirmed its ambitiousness in scaling up TB DOTS. The review highlighted many of the country's achievements and challenges (the latter is described in the next section). By 2008 DOTS services have been expanded to 100% of LGAs (774 of them). The number of laboratories compared to the targets in the Strategic Plan are at 79%, the number of DOTS treatment centres is at 54%, and number of treatment centers with TB/HIV services is 18%. Several initiatives have begun along with development of policies norms, tools and guidelines for these initiatives: PPM DOTS; Community TB Care; ACSM; MDR TB; TB/HIV; and TB infection Control. The review found that several program components are at varying stages of development /implementation. Many technical committees have been established and strong partnerships have been formed, including most recently the National Stop TB Partnership.
It should be noted that, given the expiration date of the current Strategic Plan, this proposal seeks to meet and surpass current goals. In this respect, this proposal is also an important guiding factor in the formulation of the Nigeria Strategic Plan 2011-2015, which is currently being developed.

Consolidating and Expanding DOTS: although the case detection rate of smear positive TB cases was 30.5%, there has been a slow but steady increase in the total TB registered cases reported: from 74,225 in 2006 to 90,311 in 2008. The treatment success rate of smear positive TB cases increased in the last four years, from 73% in 2004 to 82% in 2008. One third (14) of states achieved the minimum of 85% success rate in 2008. At least 62% of TB cases were tested for HIV and of those, 27% were found to be positive. The rate of CPT uptake has improved as has the number of TB cases on ART.

Engaging the "private health care workers" in the delivery of TB DOTS has expanded to include all health care workers, including those in the public sector (prisons, armed forces and large secondary and tertiary institutions) and the private for profit and not for profit institutions. Engaging all providers is meant to improve the case detection and case holding. The proportion of private providers out of all TB services reporting to NTBLCP is currently around 20%. This aspect of the program is one of the key strategies to expanding DOT S as the private sector and the large Tertiary and Secondary level (hospitals) are often preferred as the first contact in terms of care seeking (2008 KAP survey).

TB/HIV. Collaborative activities is expected to address three main areas of TB/HIV namely improving mechanisms of collaboration, decreasing the burden of TB in PLWHA and decreasing the burden of HIV in TB patients as such contributes to the last objective in the strategy, decreasing he burden of TB in PLWHA. At the end of 2009 it is expected that 23/37 states will have functional State TB/HIV working groups, IPT will continue to be scaled up (through R5 phase 2) and TB infection control – as a part of TB/HIV.

MDR. MDR surveillance is key to measure the trends of drug resistance and to plan services accordingly. Of the 6 Zonal culture and DST labs, and 2 Reference labs, three are currently functional. Minimum requirements to upgrade the resultant zonal labs to come on steam to support drug resistant surveillance are needed. Three additional labs supported by partners are now providing Culture and DST services and will shortly be incorporated formally into the National Laboratory network. Within the next year all of these laboratories should be functional and will be able to address the needs of the country in providing quality assured C/DST.
A GLC mission was undertaken in April, 2009, and after careful review of the current situation in Nigeria, recommended that the NTBLCP move forward quickly to applying for 2nd line drugs (see annex 1). The results of the National Drug Resistance Survey (DRS) planned for July 2009, will provide a baseline of the current MDR-TB situation in Nigeria, and enable the NTBLCP to plan expansion of the MDR – TB program accordingly.
Empowering patients and communities: A KAP study from 2008 found that only 19.6 % of study population has correct knowledge about the cause of TB and that TB treatment is free. Improving knowledge about TB is expected to bring about demand for quality diagnosis and treatment services for

TB, and reduce stigma. Limited implementation of related community-based activities is ongoing through the involvement of community based organizations (CBOs), community volunteers/workers, radio and television jingles and production and distribution of IEC materials on TB, and TB/HIV. Lessons learned from initiatives will contribute to national scale up CTBC. Community involvement in HIV/AIDS has been expanding for many years. This infrastructure offers as yet many untapped opportunities for the NTBLCP to scale up TB and TB/HIV services.

(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 7or Round 8 proposal when the document was last submitted, and the Global Fund will obtain this document from our files).*

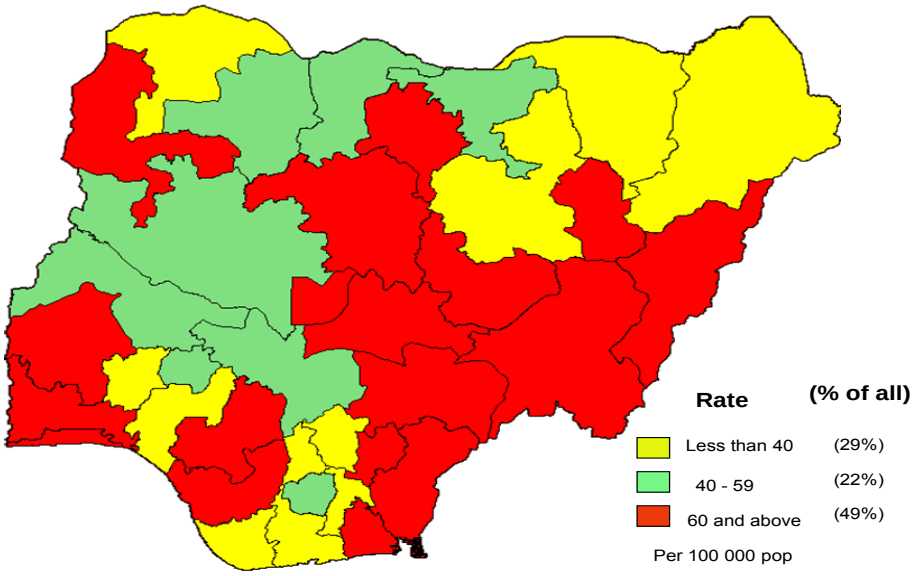
Also identify the specific page(s) (in these documents) that support the descriptions in s.4.1. above.

Document	Proposal Annex Number	Page References
☐ National Health Sector Development/Strategic Plan	1,2	pp 4-9/pp31-32
☐ National Tuberculosis Control Mid Term Strategy or Plan	3	All
☐ National Tuberculosis Guidelines (medical and laboratory)	4,5	All
☐ Important sub-sector policies that are relevant to the proposal *(e.g., national or sub-national human resources policy, or norms and standards)*	6,7	All
☐ Most recent annual reports, monitoring mission reports or reviews, including any epidemiology report directly relevant to the proposal	8,9	All
☐ National Monitoring and Evaluation Plan (health sector, disease specific or other)		
☐ National policies to achieve gender equality in regard to the provision of tuberculosis diagnosis, treatment, and care and support services to all people in need of services		

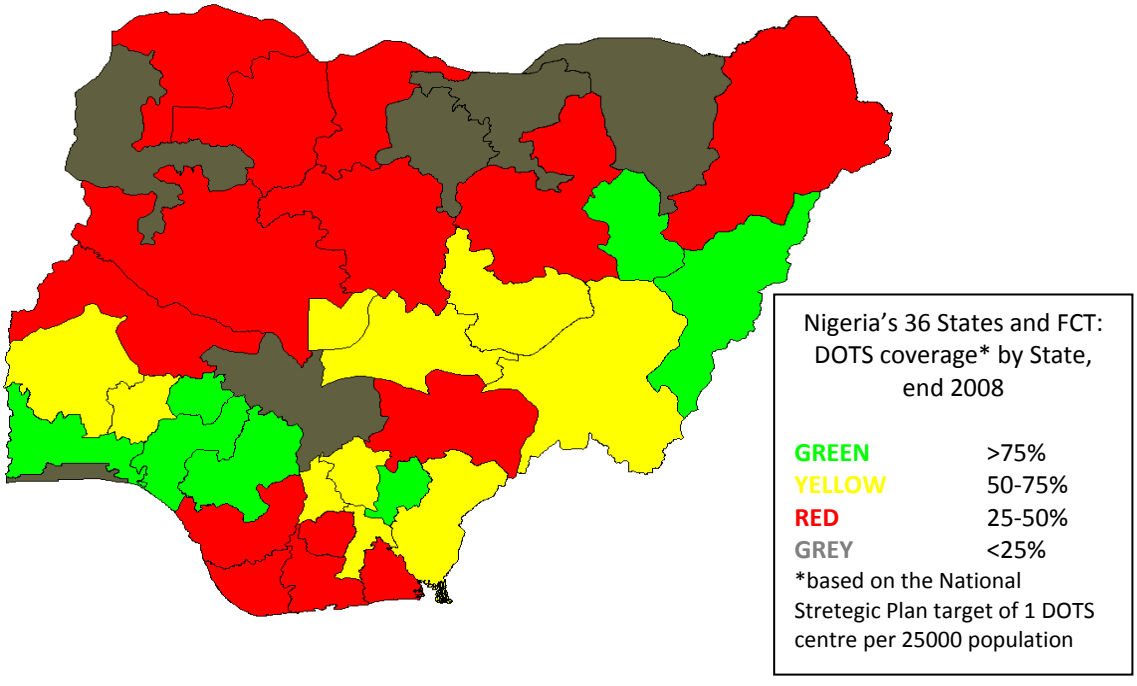
4.2 Epidemiological Background

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*

TB NOTIFICATION RATE (NEW AND RELAPSE), 2008



DOTS CENTRE DISTRIBUTION IN NIGERIA BY STATES



(a) **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	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 **: ****Refer to the Round 9 Guidelines for other possible groups*			
Other **: Women 25-49	21,456,503	NPC 1991 Analysis	2009
Other **: Men 25-64	26,011,810	NPC 1991 Analysis	2009

4.2.2. Tuberculosis epidemiology of target population(s)				
Indicators (see the footnote under this table for the references)			**Number or rate or percentage**	**[Calculation] or (reference)**
TB estimates, 2007				
A	Estimated number of new TB cases (all forms)		460,000	Global Tuberculosis Report WHO, 2009 (1)
		Male 0-14 (5.4% of total number)	24,840	Global Tuberculosis Report WHO, 2009 (1)
		Female 0-14 (6.5% of total number)	29,900	Global Tuberculosis Report WHO, 2009 (1)
B	Estimated number of new TB cases (all forms) per 100 000 population		311	[a/population*100 000], Global Tuberculosis Report, WHO, 2009 (1)

ROUND 9 – Tuberculosis

C	Estimated number of new smear-positive cases		195,000	Global Tuberculosis Report WHO, 2009 (1)
D	Estimated number of new smear-positive cases per 100 000 population		131	[c/population*100 000]
E	Estimated prevalence of TB cases (all forms)		772,000	Global Tuberculosis Report WHO, 2009 (1)
F	Estimated prevalence of TB cases (all forms) per 100 000 population		521	[e/population*100 000]
G	Estimated number of deaths due to TB (all forms)		138,000	Global Tuberculosis Report WHO, 2009 (1)
H	Estimated number of deaths due to TB (all forms) per 100 000 population		93	[g/population*100 000]
I	Estimated number of HIV-positive new TB cases (all forms)		124,200	Global Tuberculosis Report WHO, 2009 (1)
J	Estimated number of HIV-positive new TB cases (all forms) per 100 000 population		83.9	[i/population*100 000]
K	Estimated number of multi-drug resistant patients of TB (new and re-treatment cases combined)		11,171	(2)
Ka	Estimated % of TB cases (new and re-treatment combined) that are multi-drug resistant		2.3%	(2)
TB notifications, 2008				
L	Number of new TB cases (all forms) notified		83,263	(3)
		Male 0-14		
		Male , 15 and more		
		Female 0-14		
		Female, 15 and more		
M	Number of new TB cases (all forms) notified per 100 000 population		56	[l/population*100 000]
N	% of estimated new TB cases (all forms) notified		31.1%	[l/a*100]
O	Number of new smear-positive TB cases notified		46,026	National TB Control Surveillance data (3)
		Male 0-14	579	National TB Control Surveillance data (3)
		Male, 15-44	19,638	National TB Control Surveillance data (3)
		Male, 45 and more	7,075	National TB Control Surveillance data (3)
		Female 0-14	745	National TB Control Surveillance data (3)
		Female 15-44	14,173	National TB Control Surveillance data (3)
		Female, 45 and more	3,816	National TB Control Surveillance data (3)
P	Number of new smear-positive TB cases notified per 100 000 population		31	[o/population*100 000]
Q	% of estimated new smear-positive TB cases notified - Case detection rate of new smear positive TB		30.5%	[o/c*100]
S	Number of TB cases all forms (new and retreatment) that were tested for HIV		56,053	National TB Control Surveillance data (3)
T	% of TB cases all forms (new and retreatment) that		62.1%	[s/l*100]

	were tested for HIV		
U	Number of notified TB cases all forms (new and retreatment cases) that were found or known to be HIV-positive	15,301	National TB Control Surveillance data (3)
V	% of all estimated HIV-positive TB cases that were found or known to be HIV-positive - case detection of HIV+ TB	12.3%	[u/i*100]
W	Number of notified HIV-positive TB cases (new and retreatment) started or continued on CPT	4,686	National TB Control Surveillance data (3)
X	% of all notified HIV-positive TB cases (new and retreatment) started or continued on CPT	31%	[w/u*100]
Y	Number of notified HIV-positive TB cases new and retreatment) started or continued on ART	2,855	National TB Control Surveillance data (3)
Z	% of all notified HIV-positive TB cases (new and retreatment) started or continued on ART	19%	[y/u*100]
Aa	Number of TB cases (new and retreatment) received diagnostic DST	0	National TB Control Surveillance data (3)
Ac	Number of multi-drug resistant TB (MDR-TB) cases notified among new and re-treatment cases	-	National TB Control Surveillance data (3)
Ad	% of all estimated MDR-TB cases that were found or known as MDR-TB - case detection MDR-TB	-	[ac/k*100]
Treatment outcome, 2007			
Ae	Number of new smear-positive cases registered for treatment	44,070*	National TB Control Surveillance data (3)
Af	% of all notified new smear-positive TB cases that were registered for treatment	55%	[ae/o*100]
Ag	Number of new smear-positive TB cases that were successfully treated (2005 cohort)	35,960	National TB Control Surveillance data (3)
Ah	% of all new smear-positive TB cases registered for treatment that were successfully treated (2005 cohort)	82%	[ag/ae*100]
Ai	Number of new smear positive TB cases that failed their treatment	994	National TB Control Surveillance data (3)
Aj	% of all new smear-positive TB cases registered for treatment who failed their treatment (2005 cohort)	2%	[ai/ae*100]
Ak	Number of new smear positive TB cases who died while on TB treatment	2,189	National TB Control Surveillance data (3)
Al	% of all new smear-positive TB cases registered for treatment who died while on TB treatment (2005 cohort)	5%	[ak/ae*100]
Am	Number of new smear positive TB cases who defaulted	3,934	National TB Control Surveillance data (3)
An	% of all new smear-positive TB cases registered for treatment who defaulted (2005 cohort)	9%	[am/ae*100]
Other			
Other			
Other			[*use "Tab" key to add extra rows if needed]*

1. Global tuberculosis control report: WHO 2009. "WHO/HTM/TB/2009.411".
2. Anti-tuberculosis drug resistance in the world. Fourth global report. WHO/HTM/TB/2008.394
3. Data from country TB routine recording and reporting system.

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 tuberculosis diagnosis, treatment, and care and support services, including women, girls, and sexual minorities.)

4.3.1. Tuberculosis program

Describe:

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

Limited coverage and variable quality of basic DOTS services

DOTS expansion is lagging behind the targets set out in the National Strategic Plan. Access to and quality of diagnostic and treatment services is variable in the country.

Gap in 6 most populated States at the end of 2008 is:

States	Kano	Lagos	Kaduna	Katsina	Oyo	Rivers
Projected population for 2008	9,922,314	9, 530,919	6,414,788	6,125,077	5,912,551	5,483,047
# DOTS centers required (1:25,000)	396	380	256	244	236	216
# existing DOTS centers	85	55	104	110	54	112
Achievement (%)	22%	15%	41%	45%	23%	52%
Gap	311	325	152	134	182	104

Source: NTBLCP annual report 2008

Findings from the mid-term review of the Strategic Plan carried out between 26 April – 8 May 2009 (Annex 2) identified the following main reasons for the variable quality of TB services: the quality and quantity of supervision (both patient support and programme supervision), variable QA, lack of supplies and equipment in some AFB microscopy laboratories, need for additional training of DOTS and microscopy staff, drug management problems resulting in stock-outs at some facilities. In addition, the NTBLCP is yet to finalize its M&E plan. Programmatic data is collected but often the skills are lacking to take appropriate action when problems are detected.

Scope and quality of engagement of all health providers

- Most of the tertiary and big secondary health institutions within the pubic health sector that provide diagnostic and treatment services for TB often lack a well defined plan for the introduction and implementation of TB-DOTS resulting in lack of internal coordination between different departments, missed opportunities for case detection, application of non-standardized protocols for diagnosis and treatment of TB, and poor linkages with the NTBLCP. Consequently - high defaulter rates and poor treatment outcomes have been reported.
- The general population's trust in private not-for-profit (PNFP) providers is reported in 2008 KAP survey. Given the analysis of PNFP contribution to case detection, conducted in Ebonyi State in 2007 (see table), current involvement of PNFP providers is insufficient

# diagnostic centers		% of PNFP microscopy centers	# notified sm+ cases		% contribution by PNFP
PNFP	Public		PNFP	Public	
5	16	***24%***	810	981	***83%***

Source: National PPM Steering Committee data, 2008

- Analysis of the implementation of TB services in private-for-profit (PFP) health institutions under Round 5 phase 1 revealed a weakness in the process of selection of involved private providers and the

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

implementation process, which together resulted in a lack of commitment of private providers and low case-load in those institutions.

Insufficient community involvement
Concerns that stigma, discrimination and misconceptions about TB are fueling low case detection have recently been confirmed in the 2008 KAP survey. Community-based activities implemented so far by different partners are insufficient, and face different challenges. Due to limited funds in R 5 Phase 2, reorientation, provision of monitoring tools and supportive supervision for community heath workers trained in R5 phase 1 will be limited to 6 of the 24 states. Although many CBOs have been strengthened to provide home based care, HCT, adherence counseling and support to referral services through HIV/AIDS initiatives funded through PEPFAR and the GF throughout the country, the NTBLCP has yet to make use of these existing structures in community involvement.

Inadequate coverage of TB/HIV collaborative activities and challenging integration of TB/HIV programming
The proportion of HIV positive cases among TB patients is 27% (NTBLCP Report 2008). At the end of 2008, only 500 DOTS centers (18%) were implementing TB/HIV collaborative activities across the country and most of the staff in these centers have yet to receive training in TB infection control. TB/HIV data collection and collation by the national HIV program (NASCP) is too weak which makes measuring outcomes and strategic planning in TB/HIV difficult. Weaknesses identified during quarterly TB/HIV working group meetings include lack of trained counselors at most DOTS centers, recording and reporting forms in HIV are not uniform across different implementing partners, referral system between DOTS centers and HIV service delivery sites is sometimes weak. Involvement of CBOs in community education and treatment support in TB/HIV is insufficient. The TB/HIV working groups at the state level provide a venue for partners to effectively plan, implement and monitor TB/HIV collaborative activities, but only 23 of the 37 States will be covered by the end of 2009. GF R5 phase 2 envisions expansion of these committees to all remaining states over the period of 2009-2011.

Lack of comprehensive MDRTB management system
WHO estimates a total of 11,171 MDR cases in 2008 in Nigeria. Although the NTBLCP has developed National Guidelines for the Control and Clinical Management of MDR- TB, SOPS have not yet been drafted that clearly articulate the roles and responsibilities at the programmatic and clinical levels. One national and six zonal reference laboratories for culture and DST have been established through Round 5 grant, however only the NRL and 1 of the zonal laboratory are functional. The 5 remaining Zonal labs still do not have a full complement of equipment and/or infrastructure to adequately and safely carry our culture and DST services. Although three additional facilities for culture and DST were established by other partners and became functional in April 2009, they have yet to be formally included in the national Laboratory network. Cumulative confirmed cases 2006-2009 first quarter are 160. There are no 2nd line anti-TB drugs available through the NTBLCP in the country and the targeted MDR-TB treatment centers are neitherfully prepared nor functional to receive patients. Staff in these treatment centers has yet to be trained. MDR-TB oversight committees have been established at the National level only.

4.3.2. Health System

Describe the main weaknesses of and/or gaps in the health system that affect tuberculosis 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 tuberculosis outcomes (e.g.: PAL services), but perhaps not also malaria and tuberculosis programming and service delivery.*

The main weaknesses and gaps in the health system that affect tuberculosis are:

Weak PHC system in the country: The PHC has been the cornerstone of Nigeria health policy for several years. Although numerous PHC facilities have been build by all teers of government, these structures have suffered neglet over many years. As a result they are characterised by dilapidated structures in need of urgent refurbishing and equipment in order to deliver even the basic services. This has resulted into most people prefering to patronise secondary and teriary levels that are concentrated in urban areas.

This limits access and increases service delivery cost to the beneficiaries. In addition, weak referral linkages between the differerent levels of health care, limiting the provision of TB, TB/HIV and other health services to the populace.

Weak Procurement Supply Management System (PSM) (including procurement, clearance, storage and distribution): The National PSM system is not well functional. Thus most programmes, including NTBLCP, run a parallel PSM system. This parallel system has been met with several challenges which have often resulted in poor storage, inadequate distribution, and occasional stock-outs at the operational levels.

Inadequate Health Management Information System (HMIS): The routine HMIS does not effectively capture the programmatic data generated at the field for TB, HIV/AIDS and malaria. This has resulted in inadequate reporting of data which often affects national planning, resource allocation and support for interventions for the control of these diseases. The current TB data collected at facility level gets aggregated at the LGA and State level. This has made it difficult to highlight the gender differentials in vulnerability, access to treatment and care, and treatment adherence and outcomes. Aggregation of data mitigates further analysis of high risk populations served (congregate settings), contribution of the private and public sectors to treatment outcomes and case finding, and the contribution of communities involved.

Inadequate Human Resources for programme implementation: There are inadequate health personnel especially at the secondary and primary health care (PHC) facilities. Most PHCs are manned by few workers who are responsible for attending to all types of cases seen in these settings. This often results in an increased workload, overstretching of the capacity of health care workers and affecting the quality of care, including TB services.

Poor work environment and lack of incentives: Those PHC units situated in the rural areas are often in poor condition without electricity or running water. In addition, there is under-funding resulting in low staff motivation. As a result of poor work environment and lack of incentives for rural posting, frequent transfers and staff attrition are common. This explains why over 80% of available medical officers, nurses and laboratory scientists in Nigeria are in the urban areas resulting in inadequate specialized personnel at the rural areas. While in situations where specialized care is needed, patients are often referred to secondary or tertiary treatment centers, many are not able to do so due to high cost of medical fees, transportation and other expenses.

Insufficient political and financial commitment by Government at all levels of the health system: Support of Government at various levels of the health system is insufficient, fueling all weaknesses stated in this section. Some LGAs and States provide support but this is uneven across the country.

Limited TB infection control measures in health care settings: In 2008, NTBLCP and partners developed guidelines for TB Infection Control (see annex 3). However, infrastructure and expertise about TB infection control in the country are insufficient. Overcrowded waiting rooms with poor ventilation are common, even at the HIV/AIDS service delivery sites. Putting systems in place for reduction of nosocomial transmission of TB are lacking.

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 tuberculosis outcomes.

Efforts to resolve the health system weaknesses and gaps outlined above are:

Improving PHC system in the country: With support of HSS R8 grant, 925 PHC centers countrywide will be refurbished to provide better HIV/AIDS, TB, and malaria services in addition to existing services in these centers. Upgrading and adequately equipping 925 centers is aimed at strengthening the entire health system, by improving the geographic and economic access to health services for people living in PHC centers' catchment area, alleviating some burden from secondary and tertiary TB facilities, and providing integrating services. Phase 2 of Round 5, and Round 9 proposal will prioritize adequate training for provision of TB-specific services in PHC centers. Other major partners committed to strengthening the PHC in the country in the next five years are Federal Government, GAVI and DFID.

Strengthening Procurement Supply Management System (PSM): The FMOH through the Department of Food and Drug Services has set up the Drug Management System committee whose objective is to

create an effective drug management system and to promote a favorable platform for partner support. The FMOH, with technical assistance from WHO, has carried out an assessment of requirement needed to address the PSM system. A report has been produced and submitted to government for necessary action. While awaiting government action, through the GFR5 grant, some limited funds have been allocated for the minimal upgrading of the Central Medical Store and 6 zonal stores. Some of these gaps are also being addressed with the support of TBCAP, especially in capacity building at all levels.

Inadequate Health Management Information System: The FMOH has adopted a common HMIS data base for all programme data with plans to roll this out to all LGAs. This has been supported by the WHO. TB data components will be integrated into the database and all TB data collection tools will be revised to capture gender disaggregated data, source of registration (public/private sector; prisons), and TB/HIV co-infection and referrals.

Inadequate Human Resources for programme implementation: The inadequacies of number and quality of health personnel especially at the secondary and primary health care (PHC) facilities are being addressed by more than half of the state governments through the recruitment of more health staff. In addition, different partners such as DFID, WHO, USAID continue to support capacity building of health workers.

Poor work environment and lack of incentives/insufficient political and financial commitment by Government at all levels of the health system: The FMOH, with support from the R5 TB grant, has conducted extensive advocacy visits to all tiers of government and the National Assembly. This is progressively yielding results for increased resource allocation to increase human resources. Thanks to advocacy activities conducted with Round 5 funding, at the end of 2008, 19 out 37 State Governments are providing financial support to TB and TB/HIV control activities, as opposed to only 8 out of 37 State Governments before Round 5. In addition, a special committee on HIV/AIDS, Tuberculosis and Malaria has been constituted by the National Assembly. Finally, Stop TB Partnership Nigeria has just recently been inaugurated, whose terms of reference include advocacy at all levels. These bodies are advocating for sustained political commitment toward TB control in the country. Increased allocation to health through the MDG has also led to improved infrastructures in a few selected facilities. In some states, special incentives are being provided for staff working in the rural areas.

Improving TB infection control measures in health care settings: Structural design and training of health workers in PHC centers has been incorporated in HSS R8 grant. While it is recognized that refurbishing of TB and TB/HIV delivery sites is necessary to conform with infection control measures, it is felt that training on infection control in those facilities is a priority. Infrastructure refurbishments will take place after lessons are learned from implementation at PHC and ART centers.

Clarified section 4.4

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 tuberculosis epidemiology and identified weaknesses and gaps from s.4.2.2 and 4.3.

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

Priority No:	1. DOTS expansion	Historical		Current		Country targets			
Indicator name	Number of DOTS services centers established	2007	2008	2009	2010	2011	2012	2013	2014
A: Country target *(total centers based on WHO Global target of 1 per 25,000 population)*		5,677	5,922	6,017	6,392	6,575	6,763	6,956	7,155
B: Extent of need already planned to be met under other programs		2,321	2,742	3,106	3,638	4,228	4,338	4,458	4,578
C: Expected annual gap in achieving plans		3,356	3,180	2,911	2,754	2,347	2,425	2,498	2,577
D: Round 9 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			150	150	450	450	450

Priority No:	2. *Improving microscopy laboratory Quality Assurance*	Historical		Current		Country targets			
Indicator name	*Number of laboratories performing regular EQA*	2007	2008	2009	2010	2011	2012	2013	2014
A: Country target *(from annual plans where these exist)*		347	622	845	1,110	1,358	1,492	1,637	1,788
B: Extent of need already planned to be met under other programs		347	622	845	-	-	-	-	-
C: Expected annual gap in achieving plans		-	-	-	1,110	1,358	1,492	1,637	1,788
D: Round 9 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			1,110	1,358	1,492	1,637	1,788

ROUND 9 – Tuberculosis

Priority No:	3. TB/HIV collaboration	Historical		Current		Country targets			
Indicator name	*Percentage of registered TB patients tested for HIV*	2007	2008	2009	2010	2011	2012	2013	2014
A: Country target *(from annual plans where these exist)*		59.5% (51,313)	68% (61,411)	75% (77,216)	80% (93,894)	85% (113,730)	89% (135,753)	91% (158,236)	92% (182,372)
B: Extent of need already planned to be met under other programs		32.3% (27,856)	62.1% (56,083)	63% (64,862)	63% (73,942)	63% (84,294)	45% (68,639)	45% (78,249)	45% (89,204)
C: Expected annual gap in achieving plans		27.2% (23,458)	5.9% (5,328)	12% (12,355)	17% (19,953)	22% (29,436)	44% (67,114)	46% (79,988)	47% (93,168)
D: Round 9 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			17% (19,953)	22% (29,436)	44% (67,114)	46% (79,988)	47% (93,168)

Priority No:	4. TB/HIV collaboration	Historical		Current		Country targets			
Indicator name	*Proportion of registered HIV- positive TB patients who receive CPT during TB treatment.*	2007	2008	2009	2010	2011	2012	2013	2014
A: Country target *(from annual plans where these exist)*		30.4%	38.8% (5937)	41% (9498)	46% (26290)	51% (36394	56% (43441	60% (54636	65% (58359
B: Extent of need already planned to be met under other programs		31%	31% (4686)	31% (4744)	31% (14500)	31% (20561)	20% (22689)	20% (24719)	20% (26000)
C: Expected annual gap in achieving plans		0%	7.8%	10%	15% (11790)	20% (16833)	36% (20752)	40% (25917)	45% (32359)
D: Round 9 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			15% 11790)	20% (16833)	36% (20752)	40% (25917)	45% (32359)

ROUND 9 – Tuberculosis

Priority No:	5. MDR-TB prevention and control	Historical		Current		Country targets			
Indicator name	*Proportion of notified re-treatment cases (failures and relapses) tested for MDR*	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target *(from annual plans where these exist)*		-	100	803	1,832	4,177	5,357	6,785	8,509
B: Extent of need already planned to be met under other programs		-	90	-	-	-	-	-	-
C: Expected annual gap in achieving plans		-	10	803	1,832	4,177	5,357	6,785	8,509
D: Round 9 proposal contribution to total need		*(i.e., can be equal to or less than full gap)*			1,832	4,177	5,357	6,785	8,509

Priority No:	6. MDR-TB prevention and control	Historical		Current		Country targets			
Indicator name	*Number of MDR-TB patients put on treatment*	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target *(from annual plans where these exist)*		-	-	80	320	400	400	400	400
B: Extent of need already planned to be met under other programs		-	-	-	-	-	-	-	-
C: Expected annual gap in achieving plans		-	-	80	320	400	400	400	400
D: Round 9 proposal contribution to total need		*(i.e., can be equal to or less than full gap)*			320	400	400	400	400

➔ *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, program work area (or, "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 tuberculosis program description (because they predominantly contribute to tuberculosis 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.*

For objective 1 ARFH will be the PR and the SRs will be, ILEP (GLRA, NLR, TLM), HAF (civil society), and NTBLCP.

Objective 1: To pursue High Quality DOTS expansion and enhancement

SDA 1.1 Political commitment and partnership

This SDA intends to reach out to political office holders to foster political will to enable the different tiers of government place TB high on their political agenda for the purpose of increasing and sustaining financial and other resources for TB control. It will also expand DOTS services to increases access to services.
The **indicator** is the number and percentage of States disbursing funds for TB control in Nigeria.

1.1.1 Strengthening the mechanism for advocacy at national and State levels

Quarterly meetings of the advocacy committees at the national level have been budgeted in Phase 2 of Round 5. This proposal therefore seeks to ensure continuity of these quarterly meetings in last three years of Round 9. State level bi-annual advocacy committee meetings in all years of this grant would strengthen the National advocacy mechanism. Updating existing fact sheets on TB and TB/HIV will provide advocacy material to be used during different advocacy visits.
Advocacy visits to political office holders at national and state levels will be combined with other activities budgeted for in this proposal.

1.1.2 Support the Stop TB Partnership Nigeria

The Partnership has been launched in April 2009, and is aimed at increasing political and financial commitment in the country, and enhanced coordination of implemented TB and TB/HIV activities. Suggested budget in this proposal includes start-up costs for the Partnership: salary of one administrative staff for two years, procuring office equipment (computer, printer, photocopier, stationary, telephone bills), meetings executive committee of the Partnership for first two years of the grant (monthly first quarter, then quarterly), and bi-annual meetings of entire Partnership for first two years.

SDA 1.2 High Quality DOTS in public health facilities

Establishing a total of 1,650 additional DOTS centres in public and private health care facilities through the Round 9 proposal, in addition to other funding sources, will result in 6,228 total DOTS centres in Nigeria by the end of 2014. All DOTS centers will be providing TB/HIV services. The total number of centers in 2014 will represent one DOTS centre per 28,000 population.

	2010	2011	2012	2013	2014
Beginning of period DOTS centers	3,106	3,788	4,528	5,088	5,658
GF Round 9 public DOTS expansion	*100*	*100*	*320*	*320*	*310*
GF Round 9 PPM DOTS expansion	*50*	*50*	*130*	*130*	*140*
GF Round 5 DOTS expansion	*320*	*480*	-	-	-
All other new DOTS center expansions	*212*	*110*	*110*	*120*	*120*
End of period DOTS centers	3,788	4,528	5,088	5,658	6,228

The **targeted population** for this SDA is all TB patients. The **indicators** are 1) the number of successfully treated TB patients and 2) the number of DOTS centers established in Nigeria.

1.2.1 Establishment of 1,150 additional DOTS centers in public health facilities
Establishing the DOTS centres will require systematic identification of suitable facilities. Selection priority will be given to the 925 PHCs being refurbished by the HSS Round 8 funding (notably those that do not have DOTS centres), states with low DOTS population coverage and ART centres without DOTS services.

1.2.2 Training of 2,300 General Health Workers (GHWs) and 575 Medical Officers (MOs) in 1,150 DOTS centers
Training at least two GHWs on TB and TB/HIV per DOTS centre is needed to effectively provide DOTS services. Special consideration will be given to female health workers because they are under-represented in the TB programme.
Although the exact figures will be determined during implementation, it is estimated that 25% of expanded DOTS centres will be in secondary health facilities. Two MOs will be trained in each of these facilities to provide case management for smear negative TB, TB/HIV, TB in children and extra-pulmonary TB. (1,150 centres x 25% x 2 = 575 MOs). Trainings will be conducted using the national training module for GHWs and MOs. Refresher trainings for 600 GHWs and 100 MOs per year will ensure all staff trained more than 3 years ago will be skilled to ensure quality rollout of TB and TB/HIV services. Records of trained staff are kept by the national training centre, ILEP and the State Programme, and will be used to identify staff in need of refresher training, on top of trainings already funded by the GF R5 Phase 2

1.2.3 Procurement of first line anti-TB drugs
Anti-TB drugs will be made available to all patients diagnosed with TB in line with the international standard of care. GF R5 funding will cover anti-TB drug procurement until the end of 2011. The request in Round 9 is to procure GDF TB Patient Kits for the 524,648 estimated cases to be notified requiring treatment from 2012 – 2014. In order to ensure sufficient drugs are available for treatment, funding has been budgeted one year in advance to allow for ordering, payment and delivery. Quality assured first line anti-TB drugs will be procured through the GDF and distributed from National level through the PSM system of the NTBLCP to the DOTS centres. It is estimated that in-country handling (including clearance and distribution) will add 10% to the cost of first line drugs and that 50% buffer stock will be purchased.

SDA 1.3 – Improving diagnosis
This SDA aimes at ensuring quality case detection through quality-assured bacteriology.
The **targeted population** for this SDA is all TB suspects. The **indicator** is the number and percentage of laboratories performing regular external quality assurance for sputum smear microscopy.

Although no new microscopy centers are required as part of the Round 9 funding, to efficiently provide quality diagnostic access in all geographic areas, microscopy laboratories funded in GF Round 5 (Phase 2) will be established on the basis of 1) population coverage requirements (as discussed in Round 5) and 2) HSS Round 8 grant.

1.3.1 Provision of laboratory reagents and consumables to AFB microscopy laboratories
Starting from year 3 of this grant, laboratory reagents and consumables will be needed for all laboratories in the country. Year 1 and 2 are covered in Phase 2 of Round 5.

1.3.2 Annual replacement of 30 light microscopes
30 light microscopes will be procured yearly to replace non-functioning microscopes in existing laboratories at all levels, as identified during peripheral supervisory visits.

1.3.3 QA and EQA
Quarterly review meetings at State level are necessary for re-checking of slides and ensuring quality of microscopy. Bi-annual coordination review meetings between the State focal persons and NRL, ZRL, and NTBLCP are aimed at collating and reviewing quality assurance data from State level and Zonal labs. Both are suggested in all years of this proposal.
Panel testing in 150 labs annually will ensure that all EQA components are actively implemented in the

country. Sensitization about this new activity will take place during QA meetings at State level. Distribution of 20 slides from NRL to each of the 150 laboratories at the periphery will be necessary to conduct this activity; cost of distribution is budgeted in regular supervision activities.

1.3.4 Training for AFB microscopy laboratories' staff

Training of staff for new AFB microscopy laboratories has been included in Phase 2 of Round 5. Printing of training manuals developed with CDC support remains unbudgeted for, as well as printing of SoP manuals. Suggested activity here is printing and distribution of training and SoP manuals. In addition, laboratory supervision visits in some States have revealed no laboratory staff has been trained in the last 5 years. Refresher trainings for 140 laboratory staff (10 per State) in the first year are suggested to address this weakness.

SDA 1.4 - Engaging all health care providers

This SDA seeks to involve health care providers (public and PNFP) that are currently not linked to the national programme in the provision of DOTS services.

The **targeted population** for this SDA are persons in congregate settings, and general population seeking care at large hospitals or PNFP facilities.

1.4.1. Public – Public Mix

1.4.1.1 Establishment of Hospital DOTS Linkage (HDL)

The **indicator** for monitoring this SDA is Number of persons diagnosed and registered (numbers reached) in hospitals implementing HDL.

Establishment of HDL to 36 tertiary and big secondary health institutions is aimed at addressing the challenges of the identified poor DOTS linkage in tertiary and big secondary health institutions. A HDL plan for Nigeria has been developed and is being piloted in 12 tertiary health facilities with funding support from TB CAP. Building on the lessons of this pilot, a phased expansion to additional 36 health institutions will be carried out over a 3 year period. The activities will include different advocacy visits, sensitization of hospital staff from the various departments on DOTS services within the hospital, forming DOTS committees in each of the hospitals, developing HDL plan for the hospital with clear designation of roles and responsibilities.

Training activities in each of the HDLs are: 2 MOs on DOTS (management of smear negative TB, EPTB, TB in children) using the ISTC training module, training of other DOTS clinic staff (2 Nurses, 2 Community Health Extension Workers [CHEWs], 1 Record Officer, 1 Attendant on DOTS implementation), training of lab staff (1 QA officer, 1 lab scientist and 2 lab technicians) on AFB microscopy and quality assurance. Printing and distribution of Nigeria Medical Association endorsed ISTC, and ISTC manual are also required.

Monthly meetings of DOTS committees in all HDL hospitals, as well as regular supportive supervision, monitoring and evaluation will ensure optimal quality of services in these hospitals.

1.4.1.2 Establishing DOTS services in prisons, armed forces (High – risk congregate settings)

Congregate settings are a high-risk group for TB. An estimated 50% of them are already reporting to NTBLCP. It is estimated that phased implementation of proposed activities will not be sufficient to cover all congregate settings.

Situational assessment of DOTS and TB microscopy services in prisons and armed forces health services in the country will provide evidence base for prioritization of facilities to be included in DOTS. A total of 100 congregate settings will have newly established DOTS services by the end of the grant.

Training of GHWs and MOs will be conducted as described above (see 1.2.2); training of 2 staff per laboratory will also be needed. Drugs are budgeted for under 1.4.2. Supervision and M&E will be streamlined with other DOTS activities, through State programme. Laboratories will be assessed and refurbished if necessary, with supply of starter kits of microscopes, consumables and recording and reporting formats, budgeted for in other sections.

1.4.2. Public – Private Mix

1.4.2.1 Private for profit (PFP)

In phase 1 Round 5, 255 PFP providers were targeted for implementation. Re-assessment of 255 PFP facilities is ongoing through TBCAP support. Ensuring compliance with national guidelines will be supported by NTBLCP, and supervision is streamlined with regular programme supervision. It is suggested that no further expansion of this activity takes place as 255 PFP involved does not appear to be cost effective. Further analysis is being conducted though PPM Steering Committee.

1.4.2.2 Private not-for profit (PNFP)
Most of PNFP facilities in Nigeria are run by faith–based organizations (FBOs), at primary and secondary level. A study from one state (see 4.3.1) illustrates the important contribution of FBOs to TB control. The scale up PNFP involvement in TB control (400 facilities) will be conducted through analysis of population access to TB services, in collaboration with State Programmes who have directories of FBOs in the area. Training of GHWs and MOs will be conducted as described above (see 1.2.2); training of 2 staff per laboratory will also be needed. Drugs are budgeted for under 1.4.2. Supervision and M&E will be streamlined with other DOTS activities, through State programme. Laboratories will be assessed and refurbished if necessary, with supply of starter kits of microscopes, consumables and recording and reporting formats, budgeted for in other sections.

SDA 1.5 Community system strengthening
This SDA aims to increase awareness of TB and TB/HIV co-infection and to increase the community's involvement in Community TB Care (CTBC) through a closely linked partnership between the NTBLCP and the Civil Society Coalition on TB at the national level, 24 states, 240 LGAs and 720 communities/wards. The intervention sites will be those communities where previously trained community volunteers (CV) in Round 5 Phase 1 are working. There will be collaboration with the PLWHA support groups and coordination with the Round 8 HSS component to avoid duplication and overlap. A summary of the activities include:

1.5.1 Build the capacity of the Civil Society Coalition on TB in CTBC at the National and State levels.
This Round 9 proposal seeks to strengthen the involvement of CBOs through the recently formed Coalition of Civil Society on TB. The Coalition will, based on pre-established criteria, select and train CBO umbrella organizations in each of the 24 states to plan, implement and monitor community mobilization and CTBC activities. It will also link with existing HIV/AIDS Clusters to improve knowledge of and access to TB and TB/HIV care and treatment.

1.5.2 Re-orientation training for community volunteers
The selected umbrella CBOs will assist STBLCOs in mapping CBOs in their respective states and their proximity to TB diagnostic and treatment centres. They will also participate with the STBLCO, in selecting and training local CBOs and LGA supervisors to expand CTBC. The CBO/LGA supervisor will re-orientate the identified CVs to undertake CTBC. These CVs will be provided with CTBC recording and reporting tools as well as stipends for travel and communication within their communities and DOTS centres.

1.5.3 Organize sensitization and orientation workshops for community and opinion leaders
This is aimed at sensitizing community gate keepers towards raising awareness among community members on TB and TB/HIV activities aimed at dispelling myths and misconceptions about TB and increasing awareness on TB and TB/HIV and the services available. It will be organized by the network of Coalition partners in each state together with the STBLCOs

1.5.4 Link up with HIV Support Groups around all the cluster sites of the GF Round 5 Phase 1 to ensure improved TB/HIV Collaboration and TB prevention and control among PLWH.
Through the Coalition partners, the focus is to build the capacity of PLWHA support groups. This activity will aim to enhance the knowledge of TB and TB/HIV co-infection through building the capacity of PLWH groups on prevention with Isoniazid Preventive Therapy, Infection Control and Intensified Case finding towards improving the level of TB prevention and control among PLWH.

1.5.5 Strengthening of the planning and monitoring activities of CTBC
The LGA supervisors, CBOs will hold quarterly meetings with CVs to reinforce knowledge and skills on CTBC and track CV activities and outputs. There will also be a quarterly national CTBC steering committee to give direction to CTBC activities in the country. The TB coalition will be represented on the CTBC national steering committee and the National TB/HIV working group. The coalition will disseminate information from these national committees to their CBO network; conversely, information from their network will be fed back to these national committees. A national level will also host one workshop per year of all the state-level umbrella CBOs.

SDA 1.6 Management and supervision
Management and supervision activities will build on existing funding from R5 to ensure scaled-up reliable

supervision of TB diagnosis and treatment in the country.
The **targeted population** is health care providers. The **indicator** is the number and percentage of supervisory visits performed with documented reports out of planned visits each year.

1.6.1 Supervision from national level

National supervision activities building on R5 and strengthening supervision include: *quarterly NTBLCP supervision to State TBL Control Programmes; quarterly NTBLCP supervision to 7 ZRLs; and quarterly QA supervision to all States.*

1.6.2 Supervision from State level

State-level supervision will be focused on continuing two key activities from R5: q*uarterly supervision from the 37 states to at least 6 LGAs;* and *quarterly state QA supervision of LGA and microscopic centres (each visiting 15 sites).*

1.6.3. Supervision from LGA level

National guidelines require every DOTS centre be supervised at least once a month by its LGA supervisor. To facilitate this, the key LGA activity from R5 will be maintained in R9:
- *Monthly supervision of DOTS service delivery centres by LGAs (4 DOTS visited per LGA per month)*

SDA 1.7 Monitoring and Evaluation

This SDA will build on existing Round 5 activities to maintain reliable monitoring and evaluation of TB diagnosis and treatment in the country. The **targeted population** is the program staff, notably health care providers. The **indicator** is the proportion of states submitting timely reports to the national programme according to national guidelines.

1.7.1 Periodic surveys

An *End-term evaluation of the NTBLCP 2006 – 2010 Strategic Plan* will be conducted in 2011 to assess its successes and opportunities for further improvement. The mid-term review was funded and carried out as part of the R5 grant.

1.7.2 Programme review and routine M&E

Maintaining three key activities from the R5 grant is key for ensuring quality data in all levels of DOTS:
- *Quarterly programme review meetings at the 6 zones*
- *Quarterly programme review meetings at the 37 States*
- *Printing and distribution of revised R&R forms* (Training of the State programme managers will be conducted in Zonal review meetings. State Control officers will then train LGA supervisors during State review meetings. LGA supervisors will provide on-the-job training to facility staff during regular supervision visits.)

1.7.3 National meetings

National control officer meeting with NTP will ensure review of plans for the coming year. *Quarterly planning cell meetings* will assemble all PRs, SRs and strategic partners on a quarterly basis to review the national plan's quarterly performance and look ahead to the next quarter. Funding is requested to extend to 2014.

SDA 1.8 Cross-cutting Human Resource Development initiatives

Several cross-cutting activities have been identified to strengthen the technical and managerial abilities of program officers at all levels to address the general M&E weakness in the national TB programme.

1.8.1 Technical assistance to NTBLCP, PRs, SRs and State TB programmes by WHO NPOs

The WHO will provide TA on ongoing basis to the national programme stakeholders (e.g. NTBLCP, PRs, SRs) at all levels of management such as GFATM support.

1.8.2 Training and refresher training of NTBLCP staff and State M&E officers on data management

One-time training of key national programme stakeholders is proposed in 2013 to increase data management abilities.

1.8.3 Support attendance of 6 programme staff to attend annual Union Conference.

To enable programme staff who have scientific papers to present at the conference.

For objective 2, PR will be CHAN Medi-Pharm, while FHI, ILEP, and NTBLCP will be SRs.

Objective 2 – To scale-up TB/HIV collaborative activities and strengthen TB/HIV integration

The PR for this objective will be CHAN-MEDI-PHARM and the sub-recipients will be FHI, IHVN and NTBLCP.

Indicators: 1) Proportion of registered TB patients tested for HIV; 2) Proportion of HIV positive TB patients who received CPT during TB treatment.

SDA 2.1 TB/HIV collaborative activities

2.1.1 Expand and strengthen TB/HIV mechanisms for collaboration

TB/HIV WG quarterly meetings are being conducted at national level and in 23 States. Their objectives are joint planning, policy development, and collation/analysis of data. These meetings are currently supported by PEPFAR. GF Round 5 Phase 2 TB grant is expected to support the establishment of TB/HIV WG and related quarterly meetings in the remaining 14 states up till 2011. The GFATM Round 9 TB proposal is therefore expected to continue to provide funding for quarterly meetings of the TB/HIV working group in the 14 states from 2012 to 2014.

2.1.2 Scaling up HCT services to 1650 new DOTS centres

Scale up of HCT in DOTS centres is essential for early diagnosis, treatment, and reduction in morbidity and mortality. Therefore the target is to ensure that 6,228 DOTS centres are providing HCT services by end of 2014.

Currently, there are 500 DOTS centers providing HCT services. GF R5 Phase 2 TB grant is expected to support the establishment of HCT services in 960 additional DOTS centers by end of 2011. GF Round 9 TB proposal aims at ensuring HCT is available in all DOTS centers set up in this grant. Capacity building of the health care providers will be integrated with the general training for DOTS expansion. HIV+ TB patients will be referred to ART centers and community-based support groups.

2.1.3 Conduct HIV test for registered TB patients

62.1% (56,053) of the registered TB patients were tested for HIV in 2008 (NTBLCP 2008 Annual report), National TB strategic plan aimed at testing 92% of the registered TB patients by end of 2014 using the HIV rapid test kits. Ongoing HIV testing in DOTS centers will continue to be provided with support of GF R5 HIV and PEPFAR grants. The gap as a result of HCT scale up in DOTS centers will be filled by the R9 HIV proposal.

2.1.4 Provide CPT for HIV- positive TB patients

To address opportunistic infections - a major cause of morbidity and mortality in HIV positive TB patients - CPT will be provided in accordance with the national guidelines. 27.1% (1530) of the registered TB patients tested (56053) for HIV in 2008 were HIV positive (NTBLCP 2008 Annual report). 4,686 were initiated on CPT. The National TB strategic plan aims at placing 65% of the HIV positive TB patients on CPT by end of 2014. In line with this, a total of 105,489 HIV positive TB patients are expected to initiate CPT within the 5 years span of this proposal. GF R9 HIV proposal will support procurement of CPT.

2.1.5 Monthly joint supervision by the TB/HIV team at State level

Supervision of TB/HIV collaborative activities in both HIV service delivery and DOTS centers at the implementation level is weak: State TBL control officers provide supervision for ongoing activities at DOTS centers while such line of supervision is not available for the HIV/AIDS sites. To address this challenge, a TB/HIV team comprising of the State TBL control officer (STBLCO), the State HIV/AIDS Programme Coordinator (SAPC), the coordinator of State Agency for the control of HIV/AIDS (SACA) and the State TBL supervisor will be created in all the states with the support of this grant. This will also strengthen the M&E system at the state level. Monthly supervision of the facilities by the state team will be supported by this proposal. Training for TB/HIV team on 3I's and TB/HIV integration will be required in all states.

Decrease the burden of TB in HIV/AIDS patients

2.1.6 Procure and strengthen administration of IPT among HIV positive patients who do not have active TB

GF R9 HIV proposal purports to screen registered PLWHA for TB during every clinic appointment. Eligible PLWHA without active TB will be placed on IPT. This proposal will support the procurement of INH for PLWHAs in HIV service delivery centers.

GF R9 HIV proposal estimates 394,360 HIV positive patients; an estimated minimum of 35% (138,026) of these will be eligible for IPT. Different partners (including GF R5 TB Phase2) are supporting a total of 14,300 IPTs in eligible PLWHA, by end of 2011. R9 TB proposal will procure INH for 30,000 PLWHAs from 2012 to 2014. The scope of the scale up plan for IPT parallels the existing capacity of the health system for IPT implementation and is in line with the National strategic plan. NTBLCP will play a supervisory role in the administration of IPT amongst PLWHAs at HIV service delivery sites.

2.1.7 Subsidize X-ray services for PLWHAs eligible for IPT (PR: ARFH; SR: NTBLCP)

This proposal is supporting the procurement of INH for 30, 000 PLWHAs from 2012 to 2014. In order to

increase access to this service, the proposal will subsidize the cost of X-ray for 80% (24,000) of the PLWHAs for poor patients.

Training

2.1.8 Training of State TBHIV team, MOs and GHWs from ART sites on TB/HIV co-management, 3I's, and interpretation of CXR

There are 213 ART sites as at end of 2008. GF R9 HIV proposal will establish additional 194 ART sites. Presently, the training of MOs at 120 ART sites is budgeted in GF R5 Phase 2. This proposal will provide training for all states' TB/HIV teams, 200 MOs and 400 GHWs from 100 additional centers, while the gap in the training at 187 ART sites will be supported by FMOH and PEPFAR. The ART sites will be selected by National HIV/AIDS and STI Control Programme (NASCP) and National TBL Control Programme (NTBLCP) based on set criteria.

2.1.9 Infection control (IC)

National guidelines and SoP for TB IC have been developed with support of USAID. Printing and dissemination of 10,000 copies of each document will be funded by GF R9 TB proposal.

In addition to above training of MOs and GHWs in 100 ART/DOTS sites, it is suggested that TB/HIV IC plan be developed and implemented and evaluated in those sites (in 20 sites in each year). This will involve TB IC expert support in developing IC plan, site assessment, designation of facility IC officer, formation of facility-based IC committees, and on-the-job training of facility staff. Monthly meetings of the facility IC committees will help monitor implementation, and evaluate and review the IC plan.

Objective 3 – To strengthen MDR-TB prevention and control

The PR for this objective will be CHAN MEDI-PHARM and the sub-recipients will be FHI, IHVN and NTBLCP.

In the absence of the Drug Resistance Survey (DRS), this next section describes the initial efforts to move forward in establishing efficient MDR–TB program as recommended by the GLC. Good DOTS implementation according to international standards remains the best method to prevent MDR-TB in the country.

SDA 3.1 MDR

Target populations: all MDR-TB suspects (as defined in the National Guidelines for the Treatment and Control of MDR-TB) and MDR-TB patients diagnosed. The **indicators** are: 1) number and percentage of notified re-treatment cases tested for MDR-TB by Culture and DST and 2) number of MDR-TB patients treated put on treatment.

3.1.1 Laboratory services for drug resistant surveillance

The NTBLCP will build on efforts that were supported from the Round 5 phase 1 proposal and support from partners to enhance the national network of Quality Assured laboratories to provide C/DST services. This will require upgrading to international standards of the 6 zonal laboratories and 1 national reference laboratory. In addition, all Zonal laboratories will be upgraded to undertake Line Probe assays for rapid determination of MDR. Three partner-supported laboratories (Damian Foundation Belgium, Family Health International and Zankli Hospital) will be linked to the network of laboratories in the country and benefit from the national network in terms of a regular supply of reagents and supplies, supportive supervision and EQA for C/DST, which are all considered in this proposal.

To ensure coordination between the TB-DOTS facilities and the microscopy laboratories, specimen collection centers will be identified at the state level, logistics system for transporting specimen will be developed and a feedback mechanism will be provided through courier and phone communication where applicable. This will begin with the 5 functional laboratories, including the NRL (NIMR and Zaria) and expand to the remaining Zonal laboratories as they come on – stream.

Regular management and supervision activities, monitoring and evaluation according to international standards and national protocols will be put into place for all participating laboratories. EQA for the participating laboratories will be undertaken by the two NRLs NIMR and Zaria. Both NRLs will participate in EQA by regular proficiency testing from the SRL in Milan Italy. One supervisory visit per year from the SRL is anticipated.

Strengthening the national capacity to manage drug resistant TB

To adequately address the needs of the MDR-program, focus will be directed to both programmatic and clinical management of MDR-TB.

3.1.2 Support for the National MDR- Committee
To oversee the development, implementation, coordination, regular monitoring and evaluation of the MDR-TB diagnostic and treatment services, a National MDR Committee has been established. This committee will receive continued support to meet quarterly. Participants include the focal persons from all key stakeholders.

3.1.3 Development of SOPs for the clinical and programmatic management of MDR-TB
Detailed SOPs for organization and implementation of the programmatic and clinical management of MDR-TB will be developed and include roles and responsibilities of the staff at each level. These SOPs will also form the basis of training in clinical and programmatic approaches to MDR-TB in Nigeria.

3.1.4 Hospital infrastructure upgrade and renovation
To meet the demands of this initial phase of MDR-TB six hospital wards in the general proximity to the diagnostic centers will be upgraded to accommodate MDR-TB patients for the initial phase of treatment.

3.1.5 Procurement of second line anti-TB drugs
Once the MDR-TB drug resistance survey is completed by the end of 2009, the MDR-TB burden should be better known to estimate the numbers of patients to be treated. Meanwhile, as also recommended by the recent GLC mission, treatment for 80 MDR-TB patients will be fast tracked. It is planned for in the first year to treat 320 patients subsequently, to be scaled up to 400 for each of the remaining years of the grant. In order to ensure sufficient drugs are available for treatment, funding has been budgeted one year in advance to allow for ordering, payment and delivery. The NTBLCP has adopted a standardized regimen: 6(Km-Z-Lfx-Cs-Pto-)18(Z-Km-Lfx-Cs-Pto). Adjustments to this regimen will be made in individual patients depending on intolerance, or life-threatening adverse events or when DST suggests resistance to one or more second line drugs. The second line drugs will be procured from the Green Light Committee.

3.1.6 Procurement of drugs for adverse events
Drugs according the WHO MDR-TB guidelines to manage adverse drug reactions will be procured and distributed to all treatment sites. Guidelines, desk aids, wall charts and algorithms in symptom recognition of adverse effects and protocols to deal with them will be provided to each MDR-TB treatment centre.

Human Resource Development
3.1.7 Programmatic management of MDR-TB
Three international consultants will be engaged annually to provide TA to the national and zonal reference laboratories. This activity will target the National, 6 zonal and other culture and DST laboratories supported by partners and MDR-TB treatment sites.

3.1.8 Building Design and Engineering Approaches to Airborne Infection Control
To effectively address the needs of infection control of in –patient facilities and all BSL2 and BSL3 labs, three building engineers will be trained at Harvard School of Public Health.

3.1.9 Clinical management training of MDR-TB
To ensure a complement of well trained staff in each facility, 4 medical officers, 8 nurses, 1 psychiatrist and 1 social worker from the treatment facilities will be trained on clinical management of MDR-TB. This training will be organized in a Centre of Excellence outside the country. It is anticipated that in a few years NTBLTC Zaria, will take over as the training centre.

3.1.10 Development of Facility- Specific TB infection Control Plan
The risk of transmission of MDR-TB to health workers, laboratory staff, patients and visitors will be minimized by putting in place a package of TB IC measures. This activity will include the development of facility specific TB IC control plans that will include administrative, environmental and personal protection measures. One staff member will be assigned with the overall responsibility for ensuring adherence to the TB IC plan.

3.1.11 Training and refresher training for DOTS providers on identification of high risk groups for MDR-TB, appropriate sputum collection and transportation will be added to the current training curriculum and

to refresher trainings. (no cost and undertaken during regular quarterly meetings)
Refresher training for laboratory personnel: All BSL2 and BSL3 laboratory staff will receive refresher training every 2-3 years to update skills and knowledge to standards.

3.1.12 International study tour to an established MDR-TB program
To facilitate on-the-job training and observation of best practices, an international study visits will be conducted by 6 person representing programmatic and clinical services in the first year of the grant cycle.

3.1.13 Cascade of sensitization and training of MDR-TB
All State TB control officers will be sensitized on the National MDR-TB guidelines and national SOPS on programmatic and case management. In turn, State control officers will sensitize all LGA supervisors during quarterly meetings.

3.1.14 Ambulatory care
A Training module suitable for the local CBOs and treatment supporters will be developed and made available to State TB control officers to ensure proper training on the management of all MDR cases discharged to their corresponding facilities. Training will be targeted to the LGA supervisor and facility level staff on case holding of MDR patients.

Treatment of Drug Resistant patients
Taking into account the necessary preparations for upgrading treatment facilities, development of SOPs, accessing and ensuring clinical training of staff, it is envisioned that the number of patients to enrolled in treatment services as indicated above.
In each treatment facility, a specialized Management Team will be established. This team will include among others clinicians and nursing staff and will oversee Pre-treatment screening and evaluation of MDR patients and monitor patient progress. The team will maintain effective communication with the State TB coordinator on patient progress and the management of contact tracing of each MDR patient. Patient progress will be closely monitored and include routine sputum smear microscopy, culture and DST as per national policies. Early identification of adverse side effects will be undertaken through patient education, routine monitoring signs and symptoms and regular review of biochemistry of all MDR patients, according to the National protocol and in the event of adverse reactions, effective measures will be taken. Protocols for adverse drug events in patients both HIV negative and HIV positive MDR patients will be available at each treatment site according to the national guidelines.
Patient and family education will be supported throughout the course of therapy. IEC materials will be adapted to both literate and illiterate patients and will be available in all treatment facilities. Both the clinical and nursing staff will be trained to provide on-going education to patients during their admission.

3.1.15 Patient support
To reduce the impact of loss of income to the typically poor MDR-TB patients who are required to be on hospital admission for at least 6 months, social support and food packages are to be provided to the patients. This includes payment of admission fees and cost of other hospital services such as routine laboratory monitoring. A stipend for family support while on admission will be provided. During ambulatory care, patients will be evaluated as to their ability to pay and will be offered support for transportation for follow-up visits. Transportation costs for accompanying persons will also be considered. Arrangements will be made to link each patient with a volunteer treatment supporter.

Monitoring and Evaluation
The National MDR Committee will provide oversight to the MDR diagnostic and treatment services nationally and include overall monitoring and evaluation of the program. This Committee will also support the design and implementation of special studies such as surveys to address key programmatic issues. The committee will provide overall supervision, monitoring and evaluation where MDR-TB services are being planned and/or implemented.
Several recording and reporting forms have been designed and cover all aspects of registration, treatment, laboratory requests. Registers for both the facility and diagnostic services are available.
The SOPs for the MDR program will further define the roles and responsibilities in monitoring and evaluation of the MDR.

OVERALL: Strengthening Program Management and Administration.

Linkages: This SDA is linked to all 3 Objectives and addresses the weaknesses identified in previous grant implementation and regular NTBLCP activities.
Background: There are 2 PRs for this grant: ARFH, and CHAN Medi-Pharm. ARFH has significant experience in managing complex Tuberculosis programs, and CHAN Medi-Pharm mostly in procurement of drugs and commodities in malaria.
Aim: To ensure a successful program implementation through strengthening and enhancing program management and administration of the GF Round 9 TB grant.
PRs and SRs: The Principal Recipients for this proposal are ARFH and CHAN Medi-Pharm. The sub-recipients include the NTBLCP, the ILEP members (GLRA, NLR, TLM), HAF (in collaboration with TB Civil Society Coalition), FHI, and IHVN.
Capacity development: In the first and second quarter of grant signing, both PRs will be involved in grant negotiations activities with different stakeholders, 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 HR, training, and office equipment. Training will be aimed at two sets of skills: 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.
Program supervision, monitoring, and quality assurance:
Under this proposal, the following supervision, and M&E meetings will be supported: i) joint national/zonal supervisory teams comprising of FMOH staff, WHO NPOs, and ILEP medical advisors used for quarterly supervision of State TBL Programs, using checklists to ascertain the quality of service provision and M&E system in DOTS centers/States in line with national and international TB program standards, ii) quarterly state and program review meetings that enable collation of data and review of TB M&E records with a view to highlighting performance.
PR will support all programme reviews at all levels, by participating in all supervisory visits. As part of the PRs' oversight function, the project coordinator and 3 other program managers in charge of different geo-political zones will be supervising the SRs. Activities implemented during the quarter will be documented in line with the targets set for the quarter. The supervisory visits by NTBLCP, supported by WHO and the PRs will also serve as one of the means for verification of the activities reported by SRs, as well as ensuring the implementation of projects activities and achievement of project's targets by the SRs/SSRs. PRs' finance managers and auditors will conduct quarterly validation and budget tracking visits to the SRs and SSRs, together with NTBLCP and WHO.

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).

R8 TRP weakness	Adjustments made
Description of health structure and basic TB program structure has not been provided. Therefore, the rationale for activities and sub-activities cannot be fully assessed, especially for Objectives 1&2	Information on the heath structure is found in section 4.1. Further information on the structure of the NTBLCP and achievements measured against the National Strategic Plan recorded in a recent review are provided in section 4.1. Gaps that relate in performance measured against the national strategy are described in 4.3.1. Many of these are directly related to each of the proposal objectives described in 4.5.1.
The additive value to Round 5 grant is not clear	This round 9 proposal builds on achievements recorded by the various funding sources and the Round 5 grant in particular. The proposal addresses key areas in the Global Plan to Stop TB which were inadequately or not addressed in Round 5, nor by other funding sources. Special attention is given to lessons learned from Round 5 implementation, in all areas. Most of the proposed activities in R9 are meant to strengthen and complement existing programme activities. Due to re-allocation of

	funds to cover the increased cost of drugs in R5 phase 2, less budget was available for activities, and those that did receive support reflect the urgent priorities of the program. R9 will continue to build on these and other areas, such as ramping up advocacy efforts at national and state levels, consolidating gains and continued expansion of TB DOTS, building on the efforts to strengthen both the quality assured AFB microscopy network as well as the culture and DST lab network; scaling up CTBC through improved linkages between the NTBLCP and the CBO networks to cover all of the LGAs in 6 states and scale up to the 18 states where CVs have been trained in R5 phase 1; continue to build on TB/HIV collaborative efforts through scale up of HCT services in TB-DOTS centres, scaling up the Three I's (Intensified case finding through interventions targeted at PLWHAs, scale up IPT to more ART centres, expand TB infection control measures in TB and ART services as well as hospitals that will provide MSR services). More co-infected patients will be places on CPT and referred to ART services. Strengthening and expanding supervision and monitoring at all levels will build on previous efforts to ensure performance improvement in all areas of the program. The financial gap analysis in R9 considered Round 5 contributions, and care was taken to establish accurate estimates of government and partner contributions. For more information, please refer to section on linkages with other Global Fund grants.
The indicators by SDA included in the performance framework (Attachment A) are underdeveloped and lacking ambition given the size of the budget for administration, training, M&E, the number of Principal Recipients and proposed activities	The comment on the performance framework has also been taken care of in the text and performance framework by developing more ambitious indicators in all thematic areas.
Indicators are not always aligned with the interventions: For example, Table 4.4 Priority number 3 number of registered TB cases tested and counseled for HIV – the intervention given is: provide basic HIV care to all TB patients. Are there other care indicators beyond HCT to consider for those who test positive?	On the non alignment of the indicators with the interventions of which reference was made to Table 4.4; priority no 3, the indicators and interventions have been reviewed which now include (i) Proportion of registered TB patients who are recorded to be HIV positive who were started or continued on CPT (ii) Percentage of registered TB patients tested for HIV.
SDA 1.3: Community Tuberculosis Care. All indicators provided for this section are process indicators without any measure of outcomes. Situation analysis is not yet done and no clear HRD plan or policy has been described except for the addition of 10,000 community workers who will receive incentives. Why 10 community workers per community? How will their effectiveness be assessed? What is the link to the FHI CTBC program already being implemented? (Note the draft National HR for Health Policy dated 2006).	Community TB Care is no longer an SDA. Community involvement in Round 9 is suggested to be conducted in collaboration with the NTBLCP, by civil society organizations, in order to strengthen community systems, and empower patients and communities. Strengthening of community based organizations (one of the strengths of Round 8 proposal) has been well captured in Health System Strengthening Round 8 proposal. The effectiveness of CV will be reviewed and assessed during the monthly monitoring meetings using standard tools designed for CTBC, The FHI model will continue through USAID-funding. During the annual meeting anticipated for members of the Coalition of CSOs on TB, all partners will have an opportunity to

	present finding from their interventions.
Despite the considerable budget, the R 8 M&E plan is not sufficiently described. Most of the focus is on conducting 2 prevalence surveys. How will the PR/SRs support and monitor of activities be assessed to show impact beyond buying computers and conducting training?	M&E plan section in this proposal has been strengthened. The NTBLCP has established a functional monitoring and evaluation (M&E) system that monitors TB and TB/HIV activities by the use of well defined indicators, data collection and reporting tools, which help determine its progress towards achieving program objectives and targets through measurement of internationally accepted indicators: TB case detection and treatment success rates. M&E activities outlined in the National TB and Leprosy strategic plan (based on outcome and impact measures) are being implemented at national and sub-national levels to address M&E issues and activities. For more detail see in section 4.8.3
M& E indicator on Attachment A: two prevalence surveys planned 2009, 2013) and it is noted that the R5 survey was under budgeted. Will funds from this proposal change the sample size of the first prevalence survey to give it adequate sample size, so that the second one if higher sample size can show a change with adequate precision?	The need for increased funds for the prevalence survey is directly related to changes in the WHO criteria and protocols for this study between the submission of the original Round 5 proposal and the end of phase 1. Due to the urgent need of the prevalence survey, funds were reallocated in Round 5 phase 2 to accommodate the lack of budget in R5Phase 1. Round 9 proposal does not consider a second prevalence survey.
Training objectives: assessment of training objectives is focused on process rather than outcome to demonstrate improvements in the program itself (i.e., lower default rates, higher cure rates, number of contacts identified, number of contacts given preventive therapy, etc)	In this proposal training needs are addressed under different SDAs. Training activities are focusing on priority areas: DOTS expansion (integrated TB and TB/HIV training) for GHWs and MOs, with refresher training for staff trained more than 3 years ago using NTBLCP records; infection control training in sites targeting IC plan implementation; CBOs training; and MDR case-management implementation.
SDA 2.1 – TB/HIV: Basic integration activities and indicators are underdeveloped. i.e., for 2.1.5 referral directories, what is the expected result of printing referral directories? How will this benefit patients? Will the number of persons referred and started on ART be measured? Last joint TB/HIV implementation plan dated March 3, 2004	TB/HIV Referral Directory was produced and circulated among the DOTS and ART Sites by NTBLCP. It will assist in referring patients to the nearest facility around his/her environment for easier access to care.
PPM: activities are not well described, despite the focus of R5 grant. New PPM activities should be incorporated into and developed as a separate SDA	This Round 9 proposal has allocated a separate SDA for engagement of all care providers with activities including Hospital DOTS Linkage. The focus will be on scaling up in the public- public mix sector in the prisons, armed forces and in secondary and tertiary hospital institutions; on consolidating the Public-private mix with the private for profit clinicians trained in R5 and also to scale up the public – not-for profit sector – mostly aimed at mission hospital and clinic facilities.
Management and administration costs appear to be too high	The management and administrative costs have been revised in this proposal and constitute less than 10% of the total budget.
Insufficient indication how TB program funding will articulate with the HSS component.	More attention to the links with HSS grant is now

	provided in section 4.6.1 on linkages with other Global Fund grants and is also articulated in various activities throughout the document.

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)?

The implementation experience of the GFR5 grant as well as activities by CIDA, USAID and other partners has provided invaluable lessons on effective implementation strategies. The implementation plans and activities described above in 4.5.1 draw on these lessons.

First, the underperformance of the GFR5 grant can be traced in part to inexperience and inadequate technical capacity of the PR. Therefore in this proposal, two PRs have been provisionally selected in an effort to combine their strengths to address all managerial areas. Specifically, ARFH has a track record of successful implementation of the GFR5 HIV grant as PR and CHAN Medi-Pharm has experience in Procurement and Supply Management services.

Lessons learned specific to the various activities of this proposal include:

I. **High Quality DOTS**

Since 2002, USAID and CIDA have supported DOTS expansion in the country, and the GFR5 grant has accelerated expansion. During these implementations, the need for diversity in the establishment of DOTS centers has been recognized. In particular, the need to engage all health care providers – public, private, and community – will be addressed in the DOTS expansion proposed here. Mapping of services diagnostic and treatment facilities is important feature in scaling up services, as distance will have an impact of follow-through from diagnosis to treatment and case holding.

II. **Improving Diagnosis**

Support from USAID has provided supervision of the laboratory services but this supervision has proven irregular and inadequate. The inconsistency of concerted monitoring and supervision, coupled by inadequate funding, has raised doubts concerning the quality of smear microscopy testing from TB laboratories. Additionally, only a few of these laboratories are covered by the external quality assurance system (EQA). In response to this, a standardized EQA system and regularized supervisory activities will be developed for the whole country and support to supervision in high density areas will be considered. The Zonal laboratories can plan an important role in the quality assurance of the AFB microscopy network.

III. **Community TB Care**

Based on the experiences of GFR5 grant and CIDA and USAID activities, there are significant challenges in the implementation of community TB care in the country. These include:

- Limited capacity and skills at different levels of programme management for proper implementation of community DOTS
- Limited involvement of CBOs, such that activities of community workers could not be effectively coordinated
- Partners currently implementing CTBC, use various recording and reporting formats
- Lack of supervisory systems to community volunteers/treatment supporters
- Difficulty applying DOTS to patients from distant localities
- Lack of motivation of community workers

Limited capacity and skills of programme staff at different levels is addressed through strengthened involvement of TB civil society in Nigeria. Emphasis on empowering existing CBOs in areas where training of community volunteers took place under R5 is aimed at strengthening CBOs involvement in TB, strengthening activities already funded by GF, and increase case-detection.
Questionable sustainability of FHI intervention in case donor funds run out is addressed through minimal creation of additional structures for community involvement: supervision has been integrated into regular

supervision, and community-based activities will mostly be conducted by CBO staff/volunteers and community volunteers trained in R5. It is expected that these R9 activities will have a positive impact on motivation of community volunteers trained under R5. Recording and reporting forms will be developed in collaboration with the NTBLCP.
Different models and outcomes between TB R9 and HSS R8 will be assessed.

IV. **Monitoring and Evaluation**
More emphasis has been put in M&E activities, and supervision at all levels has been strengthened and budgeted for.

V. **TB/HIV**
Limited coverage of TB/HIV collaborative activities in existing DOTS centers has yielded good results in terms of testing of TB patients for HIV. More than 60% of all TB patients were tested for HIV at the end of 2008, with TB/HIV collaborative activities were available at only 18% of DOTS sites. In order to scale up HIV testing for TB patients and ensure the entire package of TB/HIV activities in line with the national guidelines is implemented, DOTS expansion in R9 will ensure all new sites provide TB/HIV collaborative services. Insufficient joint planning between TB and HIV programmes has revealed a weakness in maximizing impact of TB/HIV activities. Much more emphasis has been put on joint planning of activities in this round across TB and HIV proposal, and all of the challenges observed in implementation have been analyzed and addressed.
Supervision of TB/HIV activities has been challenging for years in Nigeria. This is mostly related to TB/HIV activities being implemented by 57 different partners in the country, who often use different recording and reporting forms, and sometimes do not sufficiently co-ordinate with TB and HIV programmes. In this round, monthly State supervision of TB/HIV teams is suggested to address this weakness. These teams will comprise of TB and HIV programme officers at different levels, and is meant to strengthen TB/HIV collaboration, supervise implemented activities and improve implementation, and strengthen M&E system at state level.

VI. **MDR –TB**

Management of MDR cases has not yet commenced, but is planned for in this proposal. Challenges related to improving culture and DST laboratories will be addressed by different partners. External laboratory consultant will be hired to develop a detailed list of activities and equipment needed to bring existing laboratories up to international standards, and will contribute to strengthening the laboratory network for MDR.

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 tuberculosis diagnosis treatment and 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).*

Nigeria is the most populous country in Africa with a population of over 140 million spread across a total land area of 923,768 km^2. Women constitute 48% of the population: an estimated two-thirds live in rural areas, while 44% are below 15 years old. Nigeria ranks 4^{th} of the 22 highest TB burden countries in the world. TB mostly affects women and men in their economically and reproductively active years (15-45). While the numbers of male and female patients under the age of 24 are nearly equal, there are significantly more cases among males over the age of 24 than females of this same age group (18,133 versus 11,242). Socio-economic and cultural factors play significant roles in determining gender differentials in rates of infection, progression to overt tuberculosis disease, health seeking behavior, case detection, access to treatment and care as well as treatment adherence, all of which have serious implications for successful TB control. The gender division of labor in Nigeria creates situations where women and girls are overburdened with care for sick relatives including their spouses and children with the attendant risks of getting infected and losing livelihood sources. Women face fear of rejection, stigma and discrimination associated with TB and are more likely to patronize alternative healthcare practitioners

than men[1]. Men's heightened vulnerabilities may result from their masculine attitudes of being present in congregate social settings as well as genetic factors. Though case notifications for men are more than those for women, the treatment defaulter rate is higher among men.

Several Nigerian studies have established that considerable delay exists between symptom onset and treatment initiation among pulmonary tuberculosis patients. A study by Okeibunor, *et. al.* 2007 reported that delay in seeking healthcare from DOTS clinics was mainly because most respondents (43.4%) did not consider TB as a serious health problem. Other important reasons for delay included unwelcome attitudes of health workers and the tendency of the respondents to prefer alternative medicine. Delays in seeking treatment among women were associated with ignorance (64%), negative attitude of health workers (16.0%) and the hidden costs associated with treatment (16.0%), especially transportation costs and initial diagnosis as well as seeking permission of their spouses to go for medical check up. Poverty is a recurrent burden in the lives of most Nigerians. The National Bureau of Statistics reported in 2005 that 54.4% of Nigerians live below the poverty line (US$1.0). Poor nutritional status and overcrowding increase the risk of transmitting and developing TB amongst family members. In addition to women, other vulnerable population groups that live in congregate settings including prison inmates, armed forces personnel, and socially marginalized and displaced persons pose special challenges for TB control.

The emergence of the HIV epidemic has resulted in a fivefold increase in the number of TB cases registered by national TB programme in sub-Saharan Africa and have revealed new trends in TB prevalence among women especially female adolescents. In Nigeria, the HIV&AIDS epidemic is feminized and driven by poverty. Women are the poorest of the poor. Poverty, gender inequality, and illiteracy result in gendered vulnerabilities to HIV, the consequent progression of latent TB infection (TB is endemic in Nigeria) to overt disease and limits access to treatment and care in a vicious circle. There is currently a strong National commitment for integration of HIV and TB programme. The National HIV/AIDS Strategic Framework (NSF) for Action, 2005-2009 incorporates gender sensitive strategies towards creating access to services for TB-HIV co-infected persons.

As part of learning to "know your epidemic", the planned epidemiological surveys (prevalence of TB and MDR-TB) in the six geographical zones as planned under WHO and GFR5 grant support, will establish a sex-ratio standard, identify high risk groups and determine the gender and socio-economic barriers which prevent access to TB control services. The National Strategic Plan (2006 – 2010) and all related documents will be reviewed and updated with issues relating to the emerging realities around Gender and TB. Gender equality modules are already being incorporated into all training curricula. With increasing availability of computerized central data recording, processing and reporting systems at State and LGA level, the sex and gender disparities in TB control from case detection to successful recovery and rehabilitation will be captured in the monitoring and evaluation system (HMIS) of the NTBLCP, so that the magnitude of these disparities can be determined and addressed. All data collection tools would be reviewed to allow for disaggregation by sex, socio-economic status, and age. Data Managers and other key personnel will be trained on the interpretation and use of gender-sensitive data for planning.

The R8 TB proposal takes into account the gender dimensions of TB and proposes strategies that create access to TB services for the poor and marginalized. Among other things, this proposal emphasizes further and rapid expansion of TB and TB/HIV services to improve access with a special focus on hard to reach populations including women, children under five years of age, prison inmates, poor rural dwellers, TB-HIV co-infected persons, workers in confined areas and industries and other congregate settings.

In the process of scaling up CTBC to an additional 200 LGAs (5 communities per LGA) under the HSS, community volunteers of both sexes would be involved to ensure proper health promotion, education, a pro-active approach for contact investigation and counseling in local dialects, with the aim of reaching children under five, the hard-to-reach groups, the illiterate and rural poor. Provision of incentives and enablers (social support, food packages, transport vouchers) for 60% of poor individuals infected with TB will improve access to DOTS services and enhance treatment outcomes.

Where possible, employment processes and training of health workers will mainstream gender equality perspectives. Male involvement in care for TB and TB/HIV co-infected patients will be promoted to reduce women's burden of care. Also, an appropriate number of men and women will be employed and trained as healthcare providers in order to address certain norms, cultures and religious preferences that are made by patients. In addition, TB/HIV Support Groups and other key players will be sensitized to

follow up with TB patients on treatment, especially males to ensure treatment adherence.

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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.

The implementation of the activities proposed requires the recruitment of qualified and trainable personnel. It is an established fact that the major challenge Nigeria faces is how to ensure availability and retention of an adequate pool of competent human resources to provide health care in areas where their services are in most need. This challenge is complicated by many global and disease burden issues, such as global changes in health trends, shifts in health needs and demands, declining resources, and changes in global economic, political, and technological situations.

Shortages of health workforce are widespread and the supply of health care professionals and other service providers is inadequate to meet requirements. Additionally, the uneven distribution of competent health workforce deprives many groups access to TB services, a problem exacerbated by accelerated migration in open labor markets that draw skilled workers away from the poorest communities. Addressing these challenges require inter-sectoral collaboration and action since in many instances the precipitating factors are outside the direct control of the health sector.

To address the personnel issues, the available options will either be task sharing or outright recruitment.

The former relates to a situation where there are available and trainable individuals whose job description can be expanded to include responsibilities to provide DOTS services. The latter involves employment of and training of personnel required to provide DOTS services. This proposal will utilize both options to ensure an adequate health workforce for the implementation of activities.

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.

Nigeria TB programme benefited only from Round 5 grant that focuses on enhancing DOTS expansion and putting TB control high on the political agenda of government at all levels. The implementation of the Round 5 grant started in January 2007 and this current proposal builds on achievements recorded by the various funding sources and the Round 5 phase 1 grant in particular. The proposal addresses key areas in the Global Plan to Stop TB which were either inadequately addressed in Round 5 or not at all addressed by other funding sources.

The TB programme is currently facing some challenges due to delayed approval of the re-package phase 2 of round 5. This is sequel to changing of the PR for round 5 CHAN that had low rating throughout the phase 1 implementation.

ROUND 9 – Tuberculosis

In this proposed included mainly activities that are meant to strengthen and complement existing programme activities. It was careful not to duplicate activities already asked for in phase 2 of round 5 and other funding sources. Some of the main activity areas are outlined below:

1. DOTS expansion and enhancement: Most of the funding sources included expansion as priority areas for funding. In the Round 5 grant proposal, DOTS expansion was identified as a major gap in the analysis. The 2006 to 2010 Strategic Plan sets a target of about 5600 DOTS facilities at the end of 2010; this number translates to approximately one DOTS facility per 25,000 persons. After the gap analysis by contributors (ILEP, CIDA, USAID, etc), the unmet need in terms of expansion to facilities for DOTS services was 4225.
   At the current rate of expansion, it is unlikely that this target will be met therefore additional activities have been included in the current proposal to close this gap. It is hoped that when approved, all care providers will be involved to increase access especially to the rural and urban poor, addressing gender issues and vulnerable population (Armed Forces and Police Barracks, under-privileged community settlements, etc). The capacity of health staff will be enhanced through training of various categories of staff in the new STOP TB strategy.
2. Routine Programme Disease Surveillance: Due to the weakness of the routine programme-level surveillance, it is unable to provide an accurate, measure of the disease burden; trends over time cannot be reliably monitored in the absence of a reliable baseline. It is therefore necessary to conduct a prevalence survey in order to establish the prevalence of TB in the country, to help strengthen routine disease surveillance, to guide national policies and guidelines for the control of TB in Nigeria, and to measure progress towards achievement of global targets for TB control and the Millennium Development Goals (MDGs). Nigeria has the political will and human resources to conduct these survey activities. The budgetary provision of only $500,000 for this activity in the Round 5 grant has proven grossly inadequate and a minimum of $2.1 million will be needed based on the costed workplan for this activity (Annex 14). Therefore, a balance of $1.6 million has been requested in phase 2 of round 5 grant. No funding will be asked for in this proposal.
3. MDR-TB: The emergence of drug-resistant TB necessitated the inclusion of the preliminary activities in the Round 5 Grant to enable resistant monitoring for first line anti-Tb drugs. This provision caters to the strengthening and establishment of one culture and drug sensitivity-testing laboratory in NIMR and 6 at the zones. The facilities were planned to become fully functional during the Phase One implementation of the grant. This implementation process has further identified the shortfalls in the provisions made for laboratory reagents and other consumables as well as the need for TA to enable the effective take-off of these laboratories. This proposal will address these gaps taking cognisance of the complementarily of the TA to be provided by TBCAP for situation analysis.
4. Human Resources: Experiences from the implementation of the Round 5 grant identified the need to strengthen human resources for programme implementation at all levels as particularly important for grant implementation and monitoring. Specific strengthening of human resources for the PRs, SRs and the national TB programme are included. WHO remains the major technical partner and does that through National professional Officers (NPOs) for Tuberculosis (3 at Central and 6 at Zonal level). In country, the role of WHO will be strengthened to provide in country support for programme implementation and monitoring at all levels. In addition, technical Assistance will be required in all aspects of planned activities especially in the area of laboratory strengthening (organising laboratory QA, culture and DST, etc), MDR-TB management, CTBC, PPM, etc.
5. Monitoring and evaluation: In accordance with the 2006 – 2010 TB National Strategic Plan and also the Workers' Manual, the Round 5 Grant supports monitoring and evaluation at four levels namely: national to the zones, zones to the states, states to LGAs and LGAs to health facilities. With the increasing challenge of human resources at all levels of the programme implementation, experiences from the GFR5 grant informs that there is need for additional support in this area. This will enable improved coverage as scale-up occurs, from national to states, for the WHO NPOs to increase support for M&E at the zones, and external consultants for yearly review of the programme with a mid and end term evaluation .

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.

The present funding situation indicates that Government contributions primarily account for staff costs and capital expenditures while Partners' contributions have funded the national programme's operating costs. In regards to Partners' contributions, USAID and CIDA have supported the TB programme over the years, with most of these resources dedicated to DOTS Expansion and TB/HIV collaborative activities. The financial contributions of the ILEP members have been dwindling as they have become principal implementers in the GFR5 grant. Contributions with respect to specific focuses of this proposal are:

1. **DOTS Expansion:** During 2006 and 2007, CIDA support allowed for the development of an additional 204 centers. Between 2006 and 2008, USAID support is expected to provide for an additional 408. While this support facilitated DOTS expansion, it did not enable the national programme to meet its facility service target of 25,000 population per facility. Additional provisions are therefore proposed here.
2. **Improved Diagnosis:** During 2006 and 2007, CIDA support allowed for the development of an additional 102 facilities. Between 2006 and 2009, USAID support is expected to provide for an additional 204. While this support facilitated increased laboratory services, it did not enable the national programme to meet its facility service target of 100,000 population per facility. Additional provisions are therefore proposed here. To further accelerate case detection, TBCAP has supported TB/HIV collaborative activities through the ILEP members
3. **Community TB Care:** There is an increasing focus towards community TB care, and a number of organizations are implementing. The GHAIN project provides support to three LGAs one in each of Kano, Nasarawa and Lagos states. Also, CIDA through WHO supported the establishment of CTBC in 2 LGAs in Benue, Ebonyi, Ogun, Delta, Kebbi and Adamawa states. Currently, FHI with support from TB-CAP has planned to roll out to additional LGAs.
4. **TB/HIV collaborative activities:** There has been significant and increasing partner support for HCT services even though currently only 290 DOTS centers with support from WHO/USAID, TBCAP, IHVN, ICAP, AIDS Relief, GHAIN, MSH and APIN+ are providing HCT services thereby limiting access of TB patients to HCT. This proposal will rapidly expand access to HCT services, targeting 2840 DOTS centers (50% of the expected DOTS centers by 2013), while it is expected that partners will scale up HCT services to the remaining 50% of the DOTS centers in the next five years provided the current trends of expansion are maintained.
5. **MDR-TB:** Although MDR-TB is a relative new component to the NTP, the GFR5 grant provided for the establishment of 7 AFB culture and DST facilities. This is being augmented by other partners. In order to assess the magnitude of MDR-TB in the country, a survey is being planned before the end of 2008, supported by the government, CDC, IHVN, GHAIN project, and WHO. The protocol has been developed and being finalized. As part of the preparations for the survey, two additional culture and DST facilities are being developed. One in the national TB training centre Zaria by IHVN and the other in Calabar by the GHAIN project. These two will hopefully be functional before the end of 2008. In addition, TB-CAP will provide support for capacity building and linkages with supranational laboratories.

Table with contributions from major partners can be found below.

Major Partners	What and where
GLRA	Supported States: Abia, Akwa Ibom, Anambra, Bayelsa, Cross River, Delta, Ebonyi, Edo, Ekiti, Enugu, Imo, Ondo, Ogun and Rivers - World TB Day celebration (2.6 million N yearly); - Training MOs at State/National level (1.6 million N yearly); - Training 80 new and 30 existing lab staff per year (5 million N yearly); - Training of 40 LGA supervisors yearly (8.5 million N yearly); - Refresher training of 70 LGA supervisors yearly (4.5 million N yearly); - Participation of GLRA staff in quarterly planning meetings, annual NTBLCP review meetings, and annual joint international monitoring mission
NLR	Supported States: Bauchi, Gombe, Kaduna, Plateau, Adamawa, Benue, Borno, Jigawa, Kano, Katsina, Nasarawa, Taraba,Yobe - Advocacy activities in 13 States (2.7 million N yearly); - Training 4 MOs at State/National level (1 million N yearly); - Supervision to 13 States twice a year (3.5 million N yearly); - 13 vehicles for supervision in 13 States (52 million N total); - 40 motorbikes for supervision at LGA level in 13 States (21.5 million N total); - Training of 33 LGA supervisors in 13 States (4 million N yearly); - Refresher training of 50 LGA supervisors in 13 States (2.5 million N yearly); - Participation of NLR staff in quarterly planning meetings, annual NTBLCP review meetings, and annual joint international monitoring mission
TLMN	Supported States: FCT, Kebbi, Kogi, Kwara, Niger, Sokoto and Zamfara - Advocacy activities in 7 States (2.6 million N yearly); - Training 1 MOs at State/National level (250,000 N yearly); - Quarterly supervision to 7 States (2 million N yearly); - Office equipment at NTBLCP central unit (250,000 N yearly); - Participation of TLMN staff in quarterly planning meetings, Zonal review meetings, annual NTBLCP review meetings, and annual joint international monitoring mission
DFB	Supported States: Oyo, Osun (no written agreement on support 2010-2014) Tentatively, DFB will support: - Ongoing technical assistance for DOTS expansion, and supervision in 2 states. -
TBCAP (financial partner only)	Supported areas of work until October 2010 are below. No indication yet on scope of support after 2010. Strengthening Integration of DOTS into General Health Services - Expansion of DOTS services to additional 2 facilities per LGA in 3 LGAs in 17 states. $**189,550** - Purchase of diagnostic materials and supplies for expansion of DOTS to 3 additional LGAs in 17 states (and for Sustenance of the laboratory reagents and consumables to the existing microscopy centers in the 17 states). $**210,804** - Organize and conduct refresher course on TB management at District level for state TB Control officers and STBLCS and LGA TBLS (5 staff per state) in the 17 states (85). $**60,000** - Support joint quarterly S,M&E plan of the Central unit to the 17 states (4 CU officers visits 1 state per person per quarter, 4 states per quarter) $**11,200** - Reporting and Recording formats for DOTS expansion and TB/HIV

Major Partners	What and where
	collaborative activities. **$22,000** - Establishment of National Lab Steering Committee. $**42,000** <u>Strengthening MDR-TB control</u> **-** Hold orientation workshop for STBLCO and STBLCS from 17 states on National policy for management of MDR-TB cases. **$26,000** - Hold quarterly meetings of the National MDR-TB committee (4 meetings) **$60,000** - Support quarterly Administrative and programmatic coordination and management meeting of the NRL and ZRL. **$40,000** - Support collection, collation and dissemination of Lab QA results from peripheral Lab to LGAs, State, Zones and Nationals(cost for dissemination only). **$2,000** - Support transportation of specimen from NRL to SRL for EQA. $18,000 - Expert meeting to review and adapt referral forms and registers. $15,000 - Print MDR-TB referral forms and registers. $10,000 - Hold Expert meeting to adopt and finalize guidelines for line probe assay. $18,000 - Print 2000 copies of the Guidelines for line probe assay. $10,000 - Hold Orientation meeting for STBLCOs and Lab QA officers from 17 states on line probe assay. $20,400 <u>Strengthening PPM and HDL DOTS linkages</u> - Hold quarterly meetings of National PPM steering committee. $4,000 - Hold quarterly meetings of state PPM steering committees in 12 states. $12,000 - Establish and inaugurate PPM steering committees in 6 additional states. $6,000 - Support 1 week PPM & HDL DOTS study tour by the National and WHO focal person to Ghana. $10,000 - Select 2 Hospitals per state from 6 states. $1,200 - Identify DOTS focal point from 2 hospitals per state in 6 states - Train 2 DOTS focal point per hospitals from 2 hospitals per state in 6 states and LGA TBLS on HDL. $12,000 - Establish HDL committees in 2 hospitals per state from 6 states.(Cost of fuelling and refreshment for state team) (12 hospitals). $2,400 - Hold quarterly meetings of the hospital committees. $3,840 <u>Programme management and coordination</u> **-** Continuing support for the 4 National Professional Officers for 3 zones (South-east, South-south and North-central) and Central NPO TUB at the WHO Country office, Abuja. $354,768 - Continuing support for the 4 drivers and AAs for 3 zones (South-east, South-south and North-central) and Central WHO Country office, Abuja. $208,656 - Support WHO TB CAP staff (NPO TB CAP & NPO TB/HIV) (salaries for 5 months). $73,910 - Support 3 NPOs under CIDA grant (6 months). $240,000 **-** Facilitate NPO Zonal supervisory and coordinating activities by funding the in country TAs for NPOs. $60,000 - Facilitate NPO Zonal supervisory and coordinating activities by funding the in country TAs for Drivers and the CU AA. $25'000 - Fuelling and maintenance of the 4 zonal vehicles. $12,000 - Hold Joint mission to review the 2006 – 2010 National TB Strategic plan. $30,000 <u>TB/HIV</u> - $1,000,000

Major Partners	What and where
Federal Gov	1. Establishment of 51 microscopy centres N20,000, 000 2. Establishment of 102 DOTS centres N 20, 000, 000 3. Supervision of State TB programme N10,000,000 4. Procurement of 51 microscopes N 25, 500, 000 5. Procurement of anti-TB drugs N25, 500, 000 6. Procurement of reagents N30,000, 000 7. Printing of R&R forms N19, 500, 000
State Gov	States that are supporting TB initiatives are currently funding staff salaries, secondary health facilities and some training activities.

Clarified section 4.6.3

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.)*

This proposal intends to engage the private not-for-profit sector (largely faith-based institutions). 2008 KAP Survey has confirmed that faith-based institutions are often preferred over public health providers. A study in Ebonyi State in 2007 confirmed that faith-based institutions reporting to NTBLCP significantly contribute to case finding.

The main contributions of the private sector will be in the following areas:

DOTS expansion and TB/HIV collaborative activities – Case detection over the years has been far below the Global Targets. The aim here is to involve all health care providers in the areas of community mobilization, provision of diagnostic service, direct observation of treatment, follow up of patients and defaulter retrieval. Currently, the private sector is involved in DOTS services in most parts of the country supported by different funding sources. One such source is the GFR5 grant involving 100 private health facilities and 30 facilities in south-eastern Nigeria respectively implemented by CHAN and GLRA as sub-recipients. Other sources are Mission Hospitals in several States and TB-CAP through WHO in the next coming years.

In the MDR-TB control strategies, a private hospital (Zankli Medical Center, Abuja) which has capacity for culture and DST will be fully involved in a contractual agreement. The experiences of the staff will be shared especially with those laboratories yet to start. It will be expected that the capacity of staff in the laboratory and clinicians will be enhanced to handle culture, DST and clinical management of MDT-TB in the catchments areas of Abuja. The NTBLCP is expected to sign a memorandum of understanding with the facility. Areas such as supply of reagents and consumables, contribution to maintenance of equipments, handling of anticipated large volume of sputum samples will be addressed.

(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)?*) ➔	No response provided following clarification

Contribution Value (in USD or EURO)

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

FBOs	Payment of staff salaries and community mobilization.	Cannot be estimated	Cannot be estimated	Cannot be estimated	Cannot be estimated	Cannot be estimated	
Zankli Medical centre	DST for suspected MDR-TB cases and assist patients in management	Centre cannot estimate contribution	Centre cannot estimate contribution	Centre cannot estimate contribution	Centre cannot estimate contribution	Centre cannot estimate contribution	
[use "Tab" key to add extra rows if needed]							

4.7. Program Sustainability

4.7.1. Strengthening capacity and processes to achieve improved tuberculosis 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 contact, 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 tuberculosis service delivery and outcomes. ➔ *Refer to country evaluation reviews, if available*.

Engaging all health providers

In some parts of the country the private sector provide as much as 60% of the health services. Hence, the national TB programme has recognized the need for the expansion of engagement of all health providers in provision of DOTS services. In this proposal, just as in activities from other funding sources (R5, CIDA and TB-CAP), DOTS expansion will target the public high-risk facilities in congregate settings, large hospitals with weak or no DOTS services and faith based providers. These providers have been selected through evidence base on patient and community behavior and providers' capacity to ensure quality TB services.

Community Involvement

This proposal provides for the engagement of existing CBOs and the empowerment of through sensitization activities and stigma-reduction strategies. These activities will build on lessons learned from ongoing activities in the country, and efforts to engage communities in R5. The current involvement CBOs in TB control activities is limited and needs strengthening. The CBOs work with community based volunteer and workers to mobilize communities under the community TB care initiative. The activities of the community based volunteers and workers include TB case suspicion and referral, treatment support, home based care and client tracking. Activities are aimed at community ownership and sustainability of TB control activities, assist to reduce stigma associated with tuberculosis, and reduce diagnostic delays leading to early commencement of treatment. The impact of some of these activities has been limited – this is described in other sections of this proposal.

As stated in activity 4.5.1 above, the plan is to intensify the involvement of CBOs in areas where community volunteers have been trained in R5, and ensure that HIV support groups are sensitized on TB/HIV linkages in 180 LGAs. Criteria for selection of communities where CBOs involvement should be strengthened also include the presence of functioning DOTS services and LGA commitment and willingness to participate.

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.

1. The Global Plan to Stop TB 2006 - 2015
This proposal will contribute towards achieving the Millennium Development Goals (MDGs), linked to detecting 70% of estimated infectious TB cases and curing 85% of them. This will result in reduction in transmission, halting and reversing TB prevalence and incidence rates by 2015, in line with the desired outcome of MDG goal 6, target 8.

2. Contribution to Health Sector Reform
The National Health Sector Reform Programme in Nigeria is based on the principle that qualitative and efficient health care delivery can only be achieved in the context of a strong health structure/system. The strategic thrust of the reform includes reduction of disease burden improving availability of health resources and their management; improving access to quality health services and improving community awareness and involvement. The national tuberculosis control programme strategies operate within this framework and the activities presented in this proposal serve to help strengthen the primary health care system in the country.

3. Contribution to National Poverty Eradication Programme (NAPEP)
The NAPEP is an initiative to alleviate poverty by providing facilities for small scale entrepreneurship and job creation. This objective is enhanced by the proposed tuberculosis control activities by reducing the disease burden on the most productive segment of the population. This will allow for increased success in the NAPEP initiative, increased productivity, and poverty reduction.

4. National Economic Empowerment Development Strategy (NEEDS)
TB control will contribute to the reversal of economic losses due to tuberculosis and improve wealth generation. Furthermore the proposed strategy of TB control includes various capacity building activities that empower numerous health staff, community members, and people living with TB and HIV, thus serving as a stimulus for economic development in Nigeria.

5. Highly Indebted Poor Country Initiative (HIPC)
The HIPC provides debt relief to highly indebted poor countries under the premise that the money saved in interest payments will be invested in the social sector. Nigeria has been fortunate enough to be included in this initiative, and, as reflected in the financial gap analysis (s.5.1), a significant amount of debt relief funds have been diverted to various aspects of the public sector namely: Health, Agriculture and Education. Of the Health sector allocation, approximately $8.7m has been released for TB control activities since 2005. These funds have mainly supported the extensive refurbishment of the NTBLTC, Zaria, with additional support being made available for other TB control centers nationwide.

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 tuberculosis outcomes and measuring impact.

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

NTBLCP has established an M&E system that monitors TB and TB/HIV collaborative programme activities by the use of well defined indicators, data collection and reporting tools which help determine its progress towards programme objectives, targets and achievements through epidemiological estimates such as TB case detection and treatment success rates.

Main Strengths (Outcomes and Impact measurement)

1. NTBLCP with the support of other stakeholders in the country have improved the TB M&E tools by revising them to include information on more TB treatment outcomes, hence making it possible to conduct a more in depth cohort analysis and generate complete information for evaluations.
2. The first TB prevalence surveys to accurately determine the burden of TB in the country should take place in 2009.

3. The drug resistance survey is in its planning phase and the resultant estimates would help determine population needs regarding the use of 2nd line TB medications.

Main Strengths (Process and Output measurement)

1. To ensure standardization, TB M&E forms were recently harmonized to enable the use of the same set of forms in all states of the country. The revised National TB M&E tools include information on HIV/AIDS, bolstering the National Health Management Information System (NHMIS) in highlighting service quality gaps related to identification, care and treatment for patients co-infected with TB and HIV.
2. There is a well defined four-level structure (Facility, LGA, State and National) that enables data collection at the points of service delivery in facilities and reporting to higher levels with corresponding feed back at each level of the health tier structure .
3. The HIV/AIDS care and treatment M&E system is aligned with the NHMIS. It incorporates information on TB and promotes continued collaboration of TB/HIV M&E activities with NTBLCP.
4. Joint national/zonal supervisory teams comprising of FMOH staff, WHO NPOs, and ILEP medical advisors use checklists to ascertain the quality of service provision and M&E system in DOTS centers/States. There are quarterly state and programme review meetings that enable collation of data and review of TB M&E records with a view to highlighting performance
5. Electronic reporting format was recently designed to enable timely submission of quarterly reports via email to the National level.

Weaknesses (Outcomes and Impact measurement)

- The paper-based laboratory and treatment M&E system for TB and HIV patients has been a major constraint for *demonstrating direct effects of treatment***.** It is slow and sometimes inefficient at facility level. There is need to use an electronic patient recording and monitoring tool to help analyze information on *TB treatment effects/outcomes per cohort.*
- Given the fact that NHMIS is a source for the numerator of many TB and TB/HIV outcome indicators, misalignment between the NHMIS and NTBLCP recording and reporting (particularly age and sex disaggregation) results in gaps in analytical capabilities activities and outcomes.
- Little has been to done to ascertain the impact of the current TB programme on the target population. Much of the data on TB disease burden and mortality come from WHO estimates. This is certainly a major weakness of the country's impact measurement system.

Weaknesses (Process and Output measurement)

Quarterly M&E meetings-Data analysis and feedback: A major weakness of the M&E system in Nigeria is that much of the data collected is neither analyzed nor fed back to the facilities and stakeholders for use in decision making/improving programme performance. Though M&E meetings are held on a quarterly basis; one of the biggest challenges for M&E at the state and LGA level is a lack of funding and support for M&E meetings. Absence of meetings makes it difficult for collective data review, sharing of experiences and forming consensus on the way forward. Quality of data and data validation are also key concerns that have led to problems between Nigeria and GF in the past and will be addressed in this round of GF programme, as described in this proposal.

Indicators: Some indicators required by the GF/Principal recipients are not captured by the current reporting formats.

Supervision/Quality Assurance: There is insufficient capacity in programme supervision particularly at the LGA which may result in significant deviations from pre-set data and service quality standards in the DOTS centers.

Partners' collaboration: In a bid to meet up with donor indicator requirements, some implementing partners run parallel M&E systems, monitoring missions, evaluation exercises, etc, using separate M&E tools not in line with the routine M&E systems of the NTBLCP.

LMIS: Parallel LMIS systems by different programmes lead to duplication of effort, resource waste and weakening of the health system, especially at the PHC level where skilled human resources are scarce. An integrated LMIS system will help avoid these problems of parallel systems and also benefit other non-GF supported programme, including immunization programme.

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)?

The established TB/HIV working group will ensure that all stakeholders are in agreement regarding components of the NTBLCP M&E system (most particularly recording, reporting tools, data flow and quality assurance activities). Due to challenges related to the use of different recording and reporting tools in the monitoring in HIV activities in the country, there is a proposed strengthened regular TB/HIV supervision in all States.

An important strategy to avoid parallel reporting systems is to align the NTBLCP HMIS structure with that of the FMOH with a view to ensuring strengthened TB-HIV collaborative activities in the country.

Clear delineation of responsibilities amongst principal, sub-recipients and other stakeholders will reduce the duplication of M&E efforts and parallel reporting.

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.*

The NTBLCP with support of WHO is responsible for all M&E and supervision in the country, across all TB and TB/HIV control activities at all levels of the system. Supervision will be conducted through the use of well defined indicators, data collection and reporting tools, which help determine its progress towards achieving programme objectives and targets through measurement of internationally accepted indicators: TB case detection and treatment success rates. M&E activities outlined in the National TB and Leprosy strategic plan (based on outcome and impact measures) are being implemented at national and sub-national levels to address M&R issues and they include:

1. The health management information system of the NTBLCP which involves the use of recording tools (TB treatment cards, TB laboratory, TB treatment registers and other source documents) and reporting tools for TB and TB-HIV service provision.
2. Mid-Term and Terminal evaluations of the program to demonstrate the effect of strategies in alleviating disease the burden of TB and reducing mortality rates and also to assist in further planning.
3. TB M&E forms were recently harmonized to ensure the use of the same set of forms in all states of the country. The revised National TB M&E tools include information on HIV/AIDS, bolstering the National Health Management Information System (NHMIS) in highlighting service quality gaps related to identification, care and treatment for patients co-infected with TB and HIV.
4. There is a well defined four-level structure (Facility, LGA, State and National) that enables data collection at the points of service delivery in facilities and reporting to higher levels with corresponding feed back at each level of the health tier structure .
5. A well established HIV/AIDS care and treatment M&E system in the country which aligns well with the NHMIS, incorporates information on TB and promotes continued collaboration of TB-HIV M&E activities with NTBLCP.
6. Joint national/zonal supervisory teams comprising of FMOH staff, WHO NPOs, and ILEP medical advisors are now used for quarterly supervision of State TBL Programs. This is done by the use of checklists to ascertain the quality of service provision and M&E system in DOTS centers/States in line with national and international TB program standards.
7. There is adequate capacity of the national, state, and LGA M&E TB control teams to routinely collect, collate and report data in a timely and complete manner.
8. There are quarterly state and program review meetings that enable collation of data and review of TB M&E records with a view to highlighting performance
9. Electronic reporting format was recently designed to enable timely submission of quarterly reports via email to the National level.

PR will support all programme reviews at all levels, by participating in all supervisory visits. As part of the PRs' oversight function, the project coordinator and 3 other program managers in charge of different geo-political zones will be supervising the SRs. Activities implemented during the quarter will be documented in line with the targets set for the quarter. The supervisory visits by NTBLCP, supported by WHO and the PRs will also serve as one of the means for verification of the activities reported by SRs, as well as ensuring the implementation of projects activities and achievement of project's targets by the SRs/SSRs. PRs' finance managers and auditors will conduct quarterly validation and budget tracking visits to the SRs and SSRs, together with NTBLCP and WHO.

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	[Name] Association for Reproductive and Family Health (ARFH)
Address	[street address] ARFH House, Plot 815A, Army Officers' Mess Road, Near Ikolaba Grammar School, Agodi, GRA, Ikolaba, Ibadan. P. O. Box 30259 Secretariat Ibadan, Oyo State, Nigeria

ARFH is a national, non-governmental organization established in 1989 and registered in 1991 with the mission to initiate, promote, implement and monitor quality community based reproductive health programme through training, provision of technical assistance and programme development, evaluation and operations research.

Under the able leadership of the founders – Professor O.A. Ladipo and Mrs. Grace Ebun Delano – with a dedicated workforce of 76 staff (9 Management, 43 Senior and professional comprising of Public Health, Laboratory Sciences, Demography, Sociology, Nursing, Health Education, Monitoring And Evaluation and Admin/Finance staff, etc; and 24 other support staff) - the organization has grown to become one of the leading NGOs in the country. ARFH provides training, research, and technical assistance, and mentoring to a number of NGOs and CBOs in more than 28 states of the Federation.

Since January 2007, ARFH as Principal Recipient of GFATM Round 5 has provided oversight functions to her four Sub-Recipients {NEPWAN, CiSHAN, NYSC and Federal Ministry of Women's Affairs and Social Development}. In this capacity, she has maintained an excellent performance record of 'A' grade in all the objectives and SDAs.

Those objectives and SDAs currently in 24 states are now to be expanded to all 36 states and the Federal Capital Territory (FCT) in Phase II. Correspondingly, ARFH is increasing the human resource base with additional hire and expansion to six geopolitical offices from the existing four (Ibadan, Abuja, Owerri and Minna).

In the 18 years of its existence, ARFH has managed 70 projects with a budget of $16M, Naira 83M, £1M and €179,000.00 sourced from more than 20 international and national donors. Most of these projects had gained national recognition and are being replicated nationwide. Examples of such projects include the Community/Market Based Distribution of health services, Women Development/Empowerment, Women Reproductive Health, including male involvement, Adolescent Reproductive Health based on Life Planning Education/Family Life Education projects and the setting up of Model Service Centers (Family Health/Planning Clinics and Youth Friendly Centers.

Apart from the partnership with the private sector, ARFH has a history of working with the public sector. A notable example is the Expanded Life Planning Education (ELPE) involving partnership with Oyo State Ministries of Education and Health and which is a learning context for the operations and implementation of the National Family Life and Health Education programme. In addition, ARFH was one of the technical partners in the implementation of the NYSC HIV/AIDS Prevention Project in Nigeria in collaboration with UNICEF.

ARFH has experience account team headed by a Chartered Accountant. It accounts are annually being audited by an International audit firm.

However, Procurement and Supply Management of health sector goods is a challenge. This will be addressed through partnership with other organizations with expertise in PSM. ARFH, however, has a consultant specialist on PSM who currently complement the effort of two of our staff who have had training in PSM.

PR 2	[Name] CHAN MEDI-PHARM
Address	[street address] 3RD Floor Reinsurance Building, Herbert Macauly Way, Central Business District, Abuja, Nigeria

CHAN MEDI-PHARM LTD/GTE is a private not for profit, charitable, faith based non-governmental organization (NGO) registered in Nigeria under the Companies and Allied Matters Act, 1990 to promote equity and access to quality health care products and services in Nigeria and elsewhere.

CHAN Medi-Pharm Started in 1979 as CHANPharm being an ecumenical drug supply organization founded by three prominent church bodies to coordinate the provision of essential medicines and medical supplies for church owned health facilities in the country. CHAN Medi-Pharm became an autonomous and independent subsidiary of Christian Health Association of Nigeria (CHAN) in 2004 following a DFID funded institutional development program. The name was then changed from CHANPharm to CHAN Medi-Pharm Ltd/Gte having being registered as an organization limited by guarantee and not by shares has a separate self governing Board of Directors, distinct Management, discrete accounting and financial systems and an independent internal audit. In fact the Programme office which is in Abuja operates as sovereign division.

The MD CEO reports to the board while the Six Managerial Divisions report to the MD CEO. These Divisions include Logistics and Supply chain Management, Sales and Customer service, Programme and advocacy, Internal Audit, Human Resource and Administration, Finance and Information systems. The Divisional Heads of all these Division are well seasoned and qualified persons. They oversee operational activities and they coordinate all personnel in their departments to implement strategic goals of the organization.

CHAN Medi-Pharm's performance as the second SR's responsible for distribution and inventory management in the Malaria GF round 4 Phase 2 project has been satisfactory. Currently the Malaria programme has an A rating. CHAN Medi-Pharm is managing commodities worth 32million USD.

To manage the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) grant, CHAN Medi-Pharm hopes to build on the existing Project Unit in the Programme Management structure as the capacity of staff have been built in the areas of procurement; monitoring & evaluation; logistics; financial management; human resource & general management

Other sources of funding of commodities that has been and is being managed by CHAN Medi-Pharm stands at a total of $368 Million USD

1. PSM of anti malaria to 8 states in Nigeria from DFID - $96Million USD (over 2 years)

2. Procurement and distribution of ARTs to 39 HIV/AIDS treatment sites for Catholic Relief Services - 163Million USD.(over 3 years)

3. Procurement and distribution of ARTs and test kits to HIV/AIDS treatment and testing sites for NACA and SFH on GF Round 5 HIV/AIDS Grant - 109Million USD (over 2years)

Our core competencies include:

Drug and Commodity Supply Management Services

- Forecasting
- Procurement

- Port and Customs Clearance
- Distribution
- Drug Management and Information Systems
- Training and Capacity Building
- System Design and Development in such Areas as:
- Procurement
- Distribution
- Rational Use and Sustainable Drug Revolving Fund Scheme with Mechanisms to Provide for the Indigent and Medically Needy
- Formulary Management

CHAN Medi-Pharm has compiled a comprehensive financial policy and procedure for all its operations.
Internal Control - there is an internal audit department that is well manned by qualified personnel for internal control purposes.

External Audit – CHAN Medi-Pharm accounts are audited every year by a firm of chartered accountants.

CHAN Medi-Pharm runs robust accounting software (Sage Pastel).

Every funded project is treated as client. An account is opened for the client. All services rendered to the client are billed and debited to the client.

Also, a separate cost center is created for all income and expenses of a project. This is to enable us ascertain at all times the performance and status of each project.

The annual budget and business plan guides our operations. Annual Budget for any financial year is for the purpose of control and performance management in that year.

The Head of Finance & Information Systems is responsible for initiating the budgeting process. The budget process for any year starts in the first week of the month of August of the preceding year.

The Head of Finance in consultation with the CEO fix a meeting for management to agree on the key assumptions and premises that will underline the budget. This will be the formal initiation of the budget process. The Head of Finance & Information Systems will then circulate budget forms requesting Heads of Department and Heads of Division to provide realistic estimate of their activities for the coming year.

Challenge:
To strengthen the PSM component in Round 9, CHAN MEDI-PHARM LTD would need a robust LMIS system. This will include training and capacity building and robust logistic and inventory management software.

PR 3	[Name]
Address	[street address]
[Description]	

➔ ***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?	☒ Yesx ☐ 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 (In the text) ***[Insert Annex Number for list]*** ☐ 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.	

The PR's allocation of responsibility to sub-recipients follows a principle of creating synergies through shared responsibility. Several of the selected SRs for the GF Round 9 TB grant are currently implementing more than one SDA in Nigeria, but the scope of SR's activities is nuanced. Even though the SRs have a broad range of activities, each has a niche, a distinct area of comparative advantage. The allocation of responsibility to the SRs has been based on the identified area of comparative advantage.

This allocation however, does not exclude the SRs from being subcontracted by fellow SRs in other SDAs should their participation add value or be deemed cost efficient. Hence an SR responsible for TB/HIV in the whole country for example may also be subcontracted to implement DOTS in specific geographic locations where they are present and the SR responsible for DOTS is not present.

This matrix arrangement relies upon the strong existing relationships and partnerships among the SRs, most of whom are the traditional players in the TB control programme in Nigeria. While maintaining a clear definition of responsibility, it allows for the flexibility to ensure the most practical and cost-effective implementation.

Responsibilities have been allocated as follows:

NTBLCP is a cross-cutting sub-recipient. Their primary responsibilities would be in the areas of policy, national survey, training (including guidelines and modules), national M&E framework and will therefore work across all the three objectives in coordination with the PRs and other SRs.

DOTS Expansion and Enhancement
The primary responsibility for this objective will be held by the ILEP partners (German Leprosy Relief Association (GLRA), Netherlands Leprosy Relief (NLR), and The Leprosy Mission Nigeria (TLMN)), who have significant implementation experience in this area (as described below). These organizations currently operate in all 36 states and the FCT, with GLRA covering 17 states, NLR covering 13 states,

and TLMN covering 7 states. Under the R9 grant, they will maintain the same break-up of states and LGAs, and work will be apportioned accordingly. FHI will support the area of MDRTB. In the specific SDA of community system strengthening, Health Alive Foundation (HAF) will share responsibility in the states that they currently operate, in collaboration with Civil Society Coalition on TB.

TB/HIV
The primary responsibility for this objective will be held by Family Health International (FHI), and Institute of Human Virology Nigeria (IHVN). These organizations have the most implementation experience in this objective, and combined, have presence throughout the country. Under the R9 grant, they will divide the work evenly, each organization covering half of the states and LGAs.

MDR-TB
The primary responsibility for this objective will also be held by FHI and IHVN, due to their current implementation experience. They will similarly divide the work evenly.

PSM
The PR is CHAN Medi-Pharm for in-country distribution and clearance. Both 1st and 2nd line drugs will be directly procured through GDF.

All sectors have been represented by the selected SRs. These sectors include: Civil Society Organizations (CSOs), public sector, private sector and international NGOs. The CSOs would be further engaged as Sub – Sub-recipient at the LGAs and community levels to contribute to community system strengthening trough engagement of CBOs.

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.

Family Health International (FHI)
Family Health International (FHI) has global experiences implementing TB and integrated TB/HIV collaborative programme in 12 countries, including Nigeria. FHI is a partner in the TB Coalition for Technical Assistance which was awarded the USAID-funded TBCAP. In Nigeria, TBCAP provides technical assistance and support to the implementation of TB control activities. Further, FHI is leading the USG/PEPFAR funded Global HIV/AIDS Initiative Nigeria (GHAIN) consortium implementing countrywide TB DOTS expansion and TB/HIV collaborative activities in 30 states of the country.
Currently, FHI is pioneering the roll-out of CTBC in eleven LGAs in urban and rural settings in close collaboration with local, state and national TB control programme and other stakeholders including CBOs in Nigeria. Between July 2006 and March 2008, the programme has provided care to more than 16,000 TB patients in TB/HIV settings. TB care is now being implemented by FHI as a key component of the decentralized and integrated HIV/AIDS, sexual and reproductive health and TB (HAST) model of health services delivery at the LGA level.
FHI has provided technical assistance to NTBLCP in developing the national community TB care guidelines and curriculum and training of community volunteers and also provided technical support to the development of National TB/HIV strategic framework and guidelines and infection control guidelines. FHI also established the first state level TB culture and DST laboratory in Calabar in Cross River State. In addition, FHI is well-positioned to participate in policy-level dialogues, as it is a member of the national MDR-TB Committee, National TB planning cell and National TB/HIV working group.
Challenges
Specific challenges in relation to programme implementation include the following:

- Transport Logistics – additional motor vehicles will be required to facilitate programme monitoring and supervision
- Manpower – the rapid scale up of programme implementation will require additional man power that will provide technical assistance and general oversight of programme implementation
- Office Accommodation – in view of service expansion, additional offices will be opened to ensure closeness of programme supervisors to the field
- Human Resource Development – programme focal persons will need to be updated on current advances and best practices in programme implementation. It is therefore necessary to provide

funds for the participation in workshops and conferences both local and international

Institute of Human Virology (IHVN)
Institute of Human Virology (IHVN) has worked closely with NTBLCP to review national training manuals for the TB programme in tune with global best practices. We were also involved, in conjunction with the NTBLCP in training of General Health Care Workers (GHCW) in TB DOTS management, as well as training of laboratory staff in smear microscopy and Good Laboratory practice (GLP). These activities focused on high quality detection, diagnosis, resistance testing and care delivery in supporting NTBLCP control strategies. Improving the quality of smear microscopy and TB laboratory diagnosis remained a major focus. IHVN in collaboration with NTBLCP initiated panel testing, for EQA for TB microscopy and has produced for the national programme over 100 panels used across DOTS sites all over the country. Over 20 scientist have been trained by IHVN in panel testing as part of the strengthening the diagnostic arm of NTBLCP. Personnel trained on all cadres have also being trained on HIV counseling and testing (HCT) so that co-infected patients will be properly counseled and tested in DOTS clinics. As HCT in DOTS clinic is currently limited IHVN can utilize it network of training centers, regional training and monitoring staff, regional supply chain management system, and QA programme to complement and ensure ongoing HCT in assigned region of the country.

IHVN is working with Zankli Clinic and Gates Funded TB consortium at the John Hopkins University to pilot LED fluorescence microscopy and other diagnostic TB techniques to enhance direct smear microscopy for TB. IHVN is planning to expand the LED fluorescent technology which has already been shown to increase detection by 30% in a pilot study to 250 points of service
ACTION has strengthened the routine screening for TB among HIV+ persons at all 'hub' and 'satellite' sites, as well as referred and treated them for TB resulting in increased access of PLWHA to TB care and support. Site mentoring visits and quarterly review meetings are held. In addition, key medical thought leaders were invited to regional 'TB Scientific Symposia' with internationally recognized TB experts. The use of Isoniazid Prophylactic Treatment has been piloted by IHVN on behalf of the NTBLCP.

Capacity:
1. As an affiliate to a University with the fifth oldest and first public medical school and the first medical school to initiate residency programme, one of our core competencies is excellent medical training and clinical services. We leverage the experiences of our national staff and international faculty and staff to bring this standard of excellence to bear in all our clinical operations and training.
2. We have well-established competencies in laboratory services including the setting up of patient monitoring laboratories, PCR based pediatrics diagnosis laboratories (currently fully functional in 6 locations and 2 additional ones under development) and TB diagnosis and culture laboratory with a training center attached with a fully mobile X-ray equipment, the only laboratory Quality Assurance and Quality Control programme in the country, and excellent training programme for laboratory scientists and technicians (supported by a National training center and three regional training centers).
3. We have well-established competencies in HIV counseling and testing. We collaborate with and support Community Based Organizations (CBOs), Faith Based Organizations (FBOs) and Non-Governmental Organizations (NGOs) to reach challenging high risk TB and HIV populations; we have also pioneered fully mobile counseling and testing vehicles capable of handling patient samples at testing sites and transporting samples for further confirmatory tests in the laboratory (2 operational and a total of 5 regionally placed mobile counseling and testing vehicles planned).
4. We also have established competencies in providing care and support services to TB and HIV affected individuals (children, adolescents and adults). In this area, we also work with our implementing sites to provide institutional based care and services to our clients when they visit the clinic and we work with community leaders and organizations to provide community based care and support services to our clients in their community.
5. We have also established competencies in the implementation of public health programme as evidenced by the successes of our AIDS Care and Treatment in Nigeria (ACTION) programme which is currently funded by the United States Government.
6. As an affiliate of a University and a medical school highly ranked as a research institution in the United States, we have also established competencies in basic, applied and operational research. We have trained and continue to train our national staff and site staff in research administration and research ethics including human subject protection. We also have excellent collaboration with the relevant research institutions and regulatory bodies in Nigeria.

7. Human Capacity: We have very well trained and competent national staff complemented by an appreciable number of technical advisors from the ranks of faculty and staff of University of Maryland Schools of Medicine and Nursing. We continuously train our staff and the staff of our implementing sites in modern patient management and service techniques, evidenced-based best practices and the efficient use of resources in a public health setting with focus on excellent quality patient care.
8. Training Capacity: We have a national laboratory training center and three regional laboratory training centers each of which is capable of training twenty five laboratory scientists or technicians at one time. We also have a clinical training center where doctors and nurses are trained in best practices, where cases conferences are held to discuss challenging cases and where a modern and realistic patient flow is modeled for trainees. We also have a functional training department that coordinates all trainings and manages the efficient use of all our training resources
9. TB Diagnosis and Culture: We are supporting the development of a BL-3 level TB diagnosis and culture laboratory at the National TB and Leprosy Training Center in Zaria; we have also establishes a training center equipped with a mobile X-ray equipment for the training of clinicians, nurses and other relevant health workers in TB diagnosis, culture and treatment.
10. We have a robust technical, operational and management infrastructure with the head office in Abuja and regional offices in the FCT, Kano, Jos, Lagos and Benin. All these offices have functional internet infrastructure for effective communication and programme monitoring, programme staff on ground in all major focus areas, and a regional warehouse with dedicated logistics staff.
11. Research: We have a functional research department adequately staffed by Nigerian nationals and technically supported by the research faculty of the University Of Maryland School Of Medicine. Our experiences in on-going research activities and our laboratory and training infrastructure further enhance our research capacity.

Challenges: there is need for additional human resources, transport and logistics.

Health Alive Foundation (HAF)
HAF is a non-governmental, non-profit and apolitical organization established in 1999 with headquarters in Ilorin, Kwara State. It was registered with the State in 2002 and with the corporate affairs commission in 2004. Their vision is to keep health Alive and make life fulfilling and meaningful for all.

HAF's activities since inception nine years ago have focused on ATM control initiatives, reproductive and maternal health as well as mental health issues in the North Central zone and surrounding south west states of Nigeria.

Advocacy, communication and social mobilization, training of trainers, general health workers and community volunteers, procurement and distribution of health sector goods as well as working closely with community based organizations have formed the thrust of HAF's activities. HAF has a pool of highly skilled and qualified staff with vast experience in the field of public health, with a board of trustees. The DG/CEO reports to the board and managerial divisions report to the DG/CEO. These divisions include Programme and advocacy, administration, M&E, and accounts.

HAF has worked extensively in tuberculosis control initiatives. HAF was a sub-sub recipient in the Global Fund Rd 5 for TB with Inter-Gender in the 3rd and 6th quarter, with involvement in ACSM. Activities included work with community leaders and members on spreading information about DOTS, interpersonal communication and counseling for youths, and distribution of IEC materials in various communities.

HAF has also been actively involved in training and re-training of general and community health workers on TB related issues to build capacity and improve community care and support. HAF has established an extensive network of community based organizations within its area of coverage to help carry out its various activities.

HAF has a good financial management system, with auditing by a reputable audit firm.

Challenges: procurement and supply management, human resources, transportation and logistics.

German Leprosy and TB Relief Association (GLRA)

GLRA is an international medico-social NGO founded in 1957 with headquarters in Wurzburg, Germany. It currently supports 350 projects in 39 countries worldwide. In Nigeria, GLRA has been supporting leprosy services since the 1960s and was one of the first to implement TB DOTS in the country from 1993 with Logistics, Managerial and Technical Support. The organization, with offices in Enugu and Abuja, is headed by a Country Representative based in Abuja, while the Enugu Office is led by a Country Administrator. The Medico-Social Department has 4 Medical Advisors, 2 M&E Officers and 2 SER/CBR Officers. The Finance Department has 4 Accounting Personnel led by a Finance Officer. The Office Manager heads a secretarial staff complement of 4 while the Logistics Unit is made up of 6 drivers, 2 store workers and an Assistant Logistics Officer, led by an IT/Logistics Officer.

Current Activities:

1. GLRA is currently supporting the NTBLCP/FMOH in TB and Leprosy Control in 14 States in Southern Nigeria.
2. GLRA is also supporting ILEP projects and particularly Community-based Rehabilitation/ Socio-economic Rehabilitation for Persons Affected by Leprosy (PALs).
3. GLRA is a member of the GHAIN consortium, where it works with other partners in the delivery of TB/HIV services including Community TB Care (CTBC).
4. GLRA is a sub-recipient of GFATM round 5 TB grant responsible for 17 States including Lagos, Osun and Oyo States in Training and technical assistance in areas of PPM, TB-HIV, Community TB care and ACSM.
5. GLRA is a direct recipient of TBCAP Nigeria grant for delivery of TB-HIV services in some states in southern Nigeria with potential for scale up.
6. GLRA is also playing a leading role in programme-based operational research with engagement of 2 Research Consultants. The organization is currently collaborating with Public Health Department of University of Nigeria, Enugu Campus in operational research in TB and TB/HIV.

Program Delivery, Reporting & Budgeting Capacity: The trainings on PPM for TB care in Round 5 phase1 were conducted through the State programs while the TB-HIV trainings were directly implemented by GLRA Medical Advisors with appropriate external facilitators. All trainings were done using standard NTBLCP materials. GLRA Medical Advisors conducted 12 supervisory visits to PPM facilities quarterly. Other activities were implemented through the sub-sub-recipients (SSRs). Program performance was monitored and reported using standardized Global Fund monitoring tools quarterly. Routinely submitted data were verified by the GLRA M&E officer during visits to the programs. Financial reports were collected and collated monthly by the finance team. All reports were submitted to the PR every quarter. Regularly, GLRA financial and program teams prepared and reviewed program budgets. GLRA participated in all quarterly programme review meetings with the PR.

Perceived Constraints:

1. To facilitate implementation of expansion of DOTS coverage in round 9 and ensure optimal quality service delivery in training, supervision and mentoring and financial management, the medical and finance departments will need to be reinforced with additional human resources, transport and logistics.
2. To further ensure improved programme quality, GLRA as an SR, needs to be provided for to conduct regular supervision of the SSR programme implementation

Netherlands Leprosy Relief (NLR)

NLR is a non governmental organization for medical development cooperation, with a special focus on the eradication of leprosy and its consequences, particularly by preventing nerve damage and disabilities. NLR has been a partner to the Nigerian federal government for close to 30 years and has actively contributed to the establishment, improvement and maintenance of the infrastructure which is essential to carry out combined TB and leprosy control programme. This support has over the years mainly come in the form of transfer of knowledge, human resource development, resources to enable effective supervision (transportation, allowances) and management and systems support such as the establishment of information exchange, data analysis, logistics and Health Systems Research.

NLR supports the NTBLCP in 13 States in Northern Nigeria, the office of the Central Unit in Abuja and the National TBL Training Center in Zaria. To provide technical support to the Control Programme, NLR employs 2 full time Medical Advisers and one Medical Adviser paid by R5 who tour the states on regular basis to monitor the activities and provide advice and feedback to the State Ministries of Health and the

TBL Control Officers. NLR supports annually one STBLCO for long term training abroad, usually the Masters in Public Health course at the Royal Tropical Institute in Amsterdam, or for hospital MOs the Diploma Course in Tropical Dermatology at Cardiff University in Wales.

The service delivery by NLR is done inline with the NTBLCP guidelines. The organization has an agreement with each state government to ensure ownership of the programme by the state governments. The reporting format used by NLR is the format provided by the NTBLCP and finance staffs have good capacity for budgeting and reporting.

NLR has experience in implementing R5 Grant in the areas of :
1. Health System Research (HSR) as an operational research to improve programme performance. A total of 6 and 5 states were involved in a workshop conducted in 2007 and 2008 respectively.
2. Procurement of motorcycles and computers for all the state programme.
3. Airing of Radio and TV jingles for the 13 states in the NLR supported states.
4. Monitoring the supervision of TB programme at state and LGA levels as well as Quality Assurance supervision in 13 states.
5. Organize meetings for quarterly review by state and LGA, Quality Assurance, TB/HIV collaboration and advocacy committees.
6. Currently, NLR is implementing TB/HIV collaborative activities in some of their supported states with direct grant from TBCAP Nigeria.

The current structure of NLR will not have any issues implementing R8 activities, however there may be need for review of the Human resource positions at the end of round 5.

The Leprosy Mission (TLM)
TLM is an international Christian charity, founded in 1874. It is a member of the International Federation of Anti-leprosy Associations (ILEP), with its headquarters in London, United Kingdom.
It was incorporated in Nigeria by the name, The Leprosy Mission Nigeria (TLMN) in 2001 and is based in Minna, Niger state with a liaison office in Abuja.

Areas of Experience:
TLMN supports the National Tuberculosis and Leprosy Control Programme (NTBLCP) in 7 states in the country since 1991. These are: Kogi, Kwara, Niger and FCT (North-Central Zone); Kebbi, Sokoto, and Zamfara states (North-West Zone). TLMN support tuberculosis control activities that are in combination with leprosy control such as the training of TBLS in TB/Leprosy, the supervision of programme activities and advocacy activities aimed at strengthening/ increasing Government commitment/funding.
There are 14 projects receiving funds from TLM Nigeria. These are the 7 States (including FCT) TB/Leprosy Control Programme; 5 leprosy referral hospitals; and an Orthopedic workshop in Minna, Niger State.
These projects address the identification of hidden cases that are yet unreported as leprosy, getting treatment to patients, providing hospital care and preventing deformities.
It also helps individuals develop resources to recover from social and economic assaults of leprosy by rebuilding affected communities as well as conduct researches especially in the areas of disability prevention.

As a sub-recipient of the GFATM Round 5 TB Grant to scale up DOTS Expansion in line with the national strategic plan on TB control in the above 7 states we focus on:
1. Supervision of the Tuberculosis Patient Management, which includes DOTS services at the delivery centres, Case Detection, laboratory quality assurance, Treatment of patients and tracing of defaulters.
2. Health systems strengthening including the Training of Public and private health care workers on TB/HIV control, Health facilities upgrading and the expansion of DOTS services into new sites.
3. Advocacy, Communication and Social Mobilization, ACSM, for demand creation for TB control services as well as encourage community ownership and government commitment.
Delivery, reporting, and budgeting capacity**:**
Service delivery and reporting are in line with the National Tuberculosis and Leprosy control Programme implementation, monitoring and evaluation system as well as with TLM International guidelines. Our accounting system is computerized and uses the QuickBooks. All 14 projects have their own multi-year

budgets/proposal prepared in a 2007 and based on their needs spanning 2008 to 2012. Quarterly financial and programme reports from the projects are sent to the national office in Minna which then collate, analyze and communicate to the NTBLCP, TLMN and GFATM.
TLM as ILEP member is a direct recipient of TBCAP Nigeria grant to implement TB/HIV collaborative activities in some states in the TLM-supported states.

Key constraints are n the area of human resources, M&E, office space, transport and logistics.

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

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)*.

Coordination between the two Principal Recipients will be handled through a Project Coordination Committee (PCC). This is the model currently used with good success under the Global Fund Round 5 HIV grant in Nigeria, under which ARFH is one of the Principal Recipients. The structure and activities of the PCC are as follows:

- The PPC governance will be comprised of a Chair, Vice-Chair, and 2nd Vice-Chair to be filled by 1 representative of each PR organization. In addition, the organization serving as chair will provide the secretariat.
- The PCC will meet biweekly for the first sixth months, during the initial phase of the grant, to establish a strong coordinating relationship. After six months, the PCC will continue to meet on a monthly basis, unless more frequent meetings are required.
- The PCC will convene a retreat with representatives of the Sub recipients on a quarterly basis to facilitate communication, evaluate progress, and mitigate challenges.
- Prior to grant reporting dates, PCC meetings will focus on aligning reports such that reporting to the Global Fund will be done in a consistent, coherent way which reflects the activities of the entire grant as a whole
- The PCC will oversee the development of a consistent M&E backbone and PSM system at the outset of the grant
- The PCC would facilitate the development of a costed technical assistance plan by the PRs, SRs and other stakeholders.

Another level of interaction would be at the Technical Advisory Committee (TAC) level which is currently in existence under round 5 TB grant. Membership includes WHO, ILEP partners, PRs, SRs and the National programme. It major functions are technical and advisory.

The Technical Advisory Committee (TAC) would be meeting monthly for three months in the initial period of the project, then quarterly to ensure effective and efficient implementation of the project. Its decisions would be implemented by the PCC.

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.)*

The skill mix of the selected PRs is such that they would complement the capacities of one another. Specifically, ARFH has a track record of successful implementation of the GFR5 HIV grant as a PR, while CHAN-Med Pham has experience in Procurement and Supply Management services.

The planned implementation of high quality DOTS expansion, scale up of TB/HIV collaborative activities and strengthening of MDR-TB control in Nigeria entails developing the capacity of medical officers, health workers and laboratories. This strengthening and expansion constitutes a huge capacity challenge in terms of human resource development and overall programme management. Specifically, MDR-TB requires significant technical assistance from abroad due to the complexity and hazardous nature of the disease. This proposal will address these challenges at all levels through training and provision of technical assistance.

The GFR5 phase 1 had provided support for human resource capacity at the NTBLCP through the provision of support for the employment of an epidemiologist, laboratory experts, 2 senior medical officers, an ACSM consultant, a finance officer, and a PSM specialist. Funding was asked for in phase 2 of the grant to continue to maintain an epidemiologist, a laboratory specialist and a finance person. WHO has been providing technical support and will continue though out the grant period in the form of National and Zonal professional officers to strengthen the supervision of TB control activities in all the states and LGAs. The Government of Nigeria has further strengthened the staff of the NTBLCP through deployment of additional technical staff.

CCM-Nigeria has undertaken a preliminary capacity assessment of PRs and SRs prior to their provisional selection and a further assessment will be made after grant approval. Meanwhile, through self-recognition, the PRs and SRs have identified various technical needs (as described above in 4.9.1 and 4.9.3). During grant negotiation these needs will be verified and the necessary technical assistance will be granted.

Both PRs will adopt standard guidelines for the request for consultants if need be. The technical assistance would be obtained through a competitive and transparent means. The process will take into account the need for high quality services; the need for economy and efficiency; the need to provide all qualified technical assistance providers the opportunity to compete; and the need for fairness.

In this regards, Quality and Cost-Based Selection (QCBS) method would be used in the selection process. Terms of Reference (TOR) would be developed for each area of technical assistance. Then a request for proposal (which includes a letter of invitation (LOI), an instruction to consultants (ITC), and the draft contract) would be developed and advertised. Qualified technical assistance providers would be short listed. Evaluation of technical proposal with consideration for quality would be made and then public

opening and evaluation of financial proposal would be made as well. In very specific cases, the traditional TB technical providers – WHO, TB CAP, TB TEAM and TB partnership - would be requested to provide TA directly.

The effectiveness of the technical assistance would be evaluated through assessment of the deliverables as stated in the TOR. Assessment will also be based on improvement in overall grant performance and its ability to reach its targets.

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.***

Clarified section 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 (National TB & Leprosy Control Programme)	Sub-Recipient	☐ Yes ☒ No
Intellectual property rights	Federal Ministry of Health (National TB & Leprosy Control Programme)	Sub-Recipient	☐ Yes ☒ No
Quality assurance and quality control	Federal Ministry of Health, (National Agency for Food and Drug Administration and Control)	Drug Control Agent	☐ Yes ☒ ☐ No
Management and coordination *More details required in s.4.10.3.*	NTBLCP	Sub-recipient	☐ Yes ☒ ☐ No
Product selection	NTBLCP/WHO	Sub-recipient/TA	☐ Yes ☒ ☐ No
Management Information Systems (MIS)	NTBLCP	Sub-recipient	☐ Yes ☒ ☐ No
Forecasting	NTBLCP/WHO	Sub-recipient/TA	☐ Yes ☒ ☐ No
Procurement and planning	NTBLCP/WHO	Sub-recipient/TA	☐ Yes ☒ ☐ No
Storage and inventory management *More details required in s.4.10.4*	NTBLCP/ARFH	Sub-recipient & PR	☐ Yes ☒ ☐ No
Distribution to other stores and end-users *More details required in*	NTBLCP/ARFH	Sub-recipient & PR	☐ Yes ☒ ☐ No

s.4.10.4			
Ensuring rational use and patient safety (pharmacovigilance)	NTBLCP	Sub-recipient	☐ 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)*
Global Drug Facility (Procurement)	Agent	
NTBLCP and ARFH (Storage and distribution)	SR & PR	Storage and distribution only
[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.

The national drug and commodity management system has drug chain of (for more detail see Annex 16):

1. Forecasting and Procurement
2. Arrival at the Port
3. Clearance from the port
4. Storage at the Central Medical Store (CMS) Lagos
5. Distribution from CMS Lagos to 6 Zonal Drug Stores (ZDS), to 37 State Drug Stores (SDS), to 774 Local Government Area and 2321(EOY 2007) health facilities providing DOTS.
6. Dispensed to end user
7. Rational drug use and pharmacovigilance
8. Quarterly drug stock Monitoring and Supply using Logistics Management Information System (LMIS) – recording and reporting tools
9. Quarterly supervision of drug and commodity management at sub-national levels – using LMIS supervision checklist
10. Annual report of stock movement

This proposal shall utilize, when possible, the existing procurement, supply and distribution systems of the National programme and the drug and commodity management system outlined above.

Clarified section 4.10.5 (b) and (c)

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.

No significant change in the volume of pharmaceutical and health products.

(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.

No significant change in the volume of pharmaceutical and health products. The current government distribution will be used and to be supported and strengthened by the Principal Recipients who have vast experience in the distribution of pharmaceutical and health products.

Clarified Section 4.10.6

4.10.6. Pharmaceutical and health products for initial two years

Complete 'Attachment B-Tuberculosis' 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-Tuberculosis' 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 is attached.

4.10.7. Multi-drug-resistant tuberculosis

Is the provision of treatment of multi-drug-resistant tuberculosis included in this tuberculosis proposal?	☒ Yes *In the budget, include USD 50,000 per year over the full proposal term to contribute to the costs of Green Light Committee Secretariat support services.*
	☐ No *Do not include these costs*

4B. PROGRAM DESCRIPTION – HSS CROSS-CUTTING INTERVENTIONS

Optional section for applicants

SECTION 4B CAN ONLY BE INCLUDED IN ONE DISEASE IN ROUND 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 HIV 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 - Tuberculosis

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

Financial gap analysis (same currency as identified on proposal coversheet)

Note ➔ Adjust headings (as necessary) in tables from calendar years to financial years (e.g., FY ending 2008 etc.) to align with national planning and fiscal periods

	Actual		Planned		Estimated			
	2007	2008	2009	2010	2011	2012	2013	2014
Tuberculosis program funding needs to deliver comprehensive diagnosis, treatment and care and support services to target populations								
Line A ➔ Provide annual amounts	53,392,904	79,395,907	84,169,165	92,062,455	94,823,093	102,062,754	107,356,956	117,412,997
Line A.1 ➔ Total need over length of Round 9 Funding Request				*(combined total need over Round 9 proposal term)*				**513,718,255**
Current and future resources to meet financial need								
Domestic source **B1**: Loans and debt relief (*provide name of source*)	1,367,521	2,136,752	-	-	-	-	-	-
Domestic source **B2** National funding resources	2,692,308	470,085	1,071,429	1,785,714	2,500,000	3,214,286	3,928,571	402,345
Domestic source **B2** State funding resources	352,435	865,567	1,082,364	1,428,571	1,785,714	2,142,857	2,500,000	2,857,143
Domestic source **B3** Private Sector contributions (national)				-	-	-	-	-
Total of Line B entries ➔ Total current & planned DOMESTIC (including debt relief) resources:	4,412,264	3,472,404	2,153,793	3,214,285	4,285,714	5,357,143	6,428,571	3,259,488
External source **C 1** (*USAID (including TB CAP)*)	1,200,000	1,700,000	3, 398, 205	3,200,000	-	-	-	-

ROUND 9 – Tuberculosis

External source **C2** (*CIDA*)	1300000	-	-	-	-	-	-	-
The Leprosy Mission Nigeria (TLMN)	117,857	128,571	51,571	42,143	46,000	50,571	54,000	57,500
Netherlands Leprosy Relief (NLR)	383,071	217,000	162,036	204,893	173,143	207,071	175,321	209,250
German Leprosy Relief Organization (GLRA)	80,833	79,034	128,971	141,869	156,055	171,661	188,827	207,710
Damien Foundation Belgium (DFB)	378,000	391,500	405,000	432,000	459,000	486,000	513,000	5,400,000
External source **C3** Private Sector contributions (International)				-	-	-	-	-
Total of Line C entries → Total current & planned EXTERNAL (non-Global Fund grant) resources:	3,459,761	2,516,105	747,578	4,020,905	834,198	915,303	931,148	5,874,460
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	14,486,883	11,899,648	16,270,564	16,429,191	9,995,705	-	-	-
Line E → Total current and planned resources (i.e. Line E = Line B total + Line C total + Lind D Total)	22,358,908	17,888,157	19,171,935	23,664,381	15,115,617	6,272,446	7,359,719	9,133,948
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)	31,033,996	61,507,750	64,997,230	68,398,074	79,707,476	95,790,308	99,997,237	108,279,049
Line G = Round 9 tuberculosis funding request *(same amount as requested in table 5.3 for this disease)*				8,937,024	22,578,136	32,524,897	34,947,901	14,344,143

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

In Round 9, the total maximum funding request for tuberculosis in Line G is:

*(a) For **Lower-Middle income countries**, an amount that results in the Global Fund's overall contribution (all grants) to the national program reaching not more than 65% of the national disease program funding needs over the proposal term; and*

*(b) For **Upper-Middle income countries**, an amount that results in the Global Fund overall contribution (all grants) to the national program reaching not more than 35% of the national disease program funding needs over the proposal term.*

Line H ➔ Cost Sharing calculation as a percentage (%) of overall funding from Global Fund	
Cost sharing = (Total of Line D entries over 2010-2014 period + Line G Total) X 100 / Line A.1	**27.25%**

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 tuberculosis program and strategy.

The annual financial needs of the national TB programme were developed originally with the National TB Strategic Plan 2006-2010. For the purpose of this proposal, these amounts were found to be inappropriate for several reasons:

1. The Strategic Plan covers only 2006-2010, while this proposal will run until 2014
2. The Strategic Plan was developed in 2005 and the costing analysis would be inaccurate for this proposal
3. The Strategic Plan was developed before the STOP TB strategy and did not include all of the elements required for a comprehensive national TB programme.

In light of these shortcomings, to determine the overall needs of the national TB programme, a different method was used. The TB Planning and Budgeting tool, provided by WHO, was adopted by the NTBLCP in 2007. This tool allows for all inputs for the comprehensive country-specific response, and calculates the required annual need. The numbers found above on line A are taken from the tool, which is provided as Annex 19 of round 8 application.

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 tuberculosis 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, diagnosis, care and support strategy at the national, sub-national and community levels.

As can be seen in line B1 above, HIPC debt relief has contributed, and is expected to continue contributing, substantial funding to the NTBLCP budget. This supplements the less consistent regular funding through the Ministry of Health. These contributions are used mainly to improve infrastructure in National Training centre for TB and Leprosy in Zaria and procurements of anti-TB drugs and laboratory reagents for AFB. In addition, government pays salaries of health staff at various levels of the programme. National contribution values for 2006-2009 were provided by the NTBLCP, while, because of the inconsistency of annual contributions, values for 2010-2013 were calculated as the average contribution from 2006-2009.

States have contributed substantial funding to the national response through agreements with the ILEP partners. TLM has signed agreements with three states for 10M Naira annually from 2007-2011, several states in which NLR works have made contributions, and the 17 states where GLRA and DFB operate have contributed the balance. From 2006 to 2009, state contributions were very consistent. Thus, in addition to the agreed contributions through TLM in 2010 and 2011, it was assumed that an $4,500,000 in 2010 and 2011, and $5,000,000 in 2012 and 2013 would be contributed by states.

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 ILEP (NLR, GLRA, and TLM) member contributions have been consistent (2010-2014 are estimates), but are tailing off. USAID and CIDA provide substantial funding, although it varies year to year and there is no assurance of future funding. Even with the important partner funding, the programme gap remains very large and thus the Global Fund is essential to programme success.

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/

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

Objective Number	Service delivery area	Year 1	Year 2	Year 3	Year 4	Year 5	Total
1	Political commitment & partnership	217,175	226,286	259,233	268,368	285,805	1,256,867
1	High Quality DOTS in PHCs	961,741	15,440,895	18,452,334	21,479,495	1,639,513	57,973,978
1	Improving diagnosis	212,450	49,140	1,865,428	2,019,934	2,173,949	6,320,902
1	Engaging all health care providers	778,199	607,212	883,130	601,759	651,048	3,521,348
1	Communities	644,628	782,568	653,669	323,231	339,392	2,743,488
1	Mgmt and supervision	-	-	1,278,057	1,341,959	1,409,057	4,029,073
1	M&E	41,085	43,140	2,133,090	1,704,498	1,789,723	5,711,536
1	Cross-cutting HRD	21,462	22,535	315,067	225,931	347,361	932,355
2	TB / HIV	676,951	767,425	448,285	528,985	616,635	3,038,281
3	MDR-TB	3,445,695	2,941,420	2,724,117	3,004,401	1,654,548	13,770,181
-	Strengthening Program Mgmt and Admin	1,937,638	1,697,515	3,512,488	3,449,338	3,437,111	14,034,090
Round 9 tuberculosis funding request:		8,937,024	22,578,136	32,524,897	34,947,901	14,344,143	113,332,101

ROUND 9 – Tuberculosis

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.)*

Avoid using the "other" category unless necessary – read the Round 9 Guidelines	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Pharmaceutical Products (Medicines)	1,993,373	14,827,597	18,399,142	21,330,768	2,148,944	58,699,824
Monitoring and Evaluation (M&E)	550,033	683,732	4,812,857	4,495,246	4,697,000	15,238,868
Training	2,881,682	2,425,518	2,838,822	2,387,470	2,534,274	13,067,765
Planning and Administration	1,057,369	1,219,775	1,642,356	1,652,853	1,753,685	7,326,037
Human Resources	625,174	625,174	1,649,871	1,649,871	1,649,871	6,199,959
Procurement and Supply Management Costs (PSM)	194,337	1,477,510	1,826,034	2,118,502	199,591	5,815,974
Living Support to Clients/Target Population	401,631	563,995	706,855	742,198	779,308	3,193,987
Overheads	302,457	302,457	451,311	387,025	387,025	1,830,275
Infrastructure and Other Equipment	868,258	401,952	163,417	168,850	174,555	1,777,032
Communication Materials	62,710	50,426	34,233	15,118	19,892	182,379
Round 9 tuberculosis funding request	8,937,024	22,578,136	32,524,897	34,947,901	14,344,143	113,332,101

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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Pharmaceutical Products represents the single largest cost category, notably in years 2, 3 and 4 because of the large quantities of first line drugs (enough for 524,648 patients) that will be required in Nigeria in years 3, 4 and 5 of the Round 9 grant. In order to ensure sufficient drugs are on the ground, funding for first line (and second line) drugs has been budgeted one year in advance to allow for ordering, payment and delivery.

Monitoring and evaluation costs in excess of $15M are focused on continuing four critical M&E activities already in place: quarterly programmatic reviews at the state level ($3.9M), quarterly meetings of state microscopy focal persons ($2.0M), quarterly supervision of at least 6 LGAs per state to ensure microscopy QA ($1.6M) and quarterly state QA supervision of LGA and microscopy centers. Since these activities are currently funded by the GF Round 5 grant, M&E costs are relatively small in years 1 and 2.

Training requests in excess of $13M are primarily focused on developing General Health Care Workers and Medical Officers to effectively treat patients at the new DOTS centers being established in the Round 9 grant.

Procurement supply and management (PSM) for first and second line drugs and laboratory reagents has been budgeted at 10% of commodity costs to allow for in-country distribution, totaling in excess of $5.8M. The majority of these costs are for first line drugs ($4.7M) because of the large quantity being purchased for the country. Once again, since these drugs are being purchased for treatment in years 3, 4 and 5, PSM costs are greatest in years 2, 3 and 4.

Planning and Administration is focused on strengthening management and administration of local implementing organizations, conducting quarterly ACSM committee meetings at the state level ($1.2M) and conducting facility-based TB / HIV meetings in 100 facilities with DOTS and ART services ($0.9M) throughout the term of the grant.

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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*

HALF PAGE MAXIMUM

The primary HR costs over the first two years of the grant are to support and strengthen CHAN MEDIPHARM. ARFH is expected to receive sufficient HR funding from the Global Fund Phase 2 Round 5 grant and will therefore not require further HR funding until Year 3.

In light of the current economic slowdown, HR costs have been flat-lined in years 3, 4 and 5 to focus financial resources on programmatic activities.

HR spending will facilitate capacity building within each of the PRs and SRs over the course of the grant and ensure that capable staff is available and has a limited turnover.

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 tuberculosis program. ➔ *Attach supporting information as a clearly named and numbered annex*
HALF PAGE MAXIMUM "Other" was not used as a Cost Category in this proposal.

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.*
N/A
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.
N/A
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 tuberculosis program, applicants must explain the process by which they will ensure that funds requested will contribute towards achieving impact on tuberculosis outcomes during the proposal term.*
N/A

5B. FUNDING REQUEST – HSS CROSS-CUTTING INTERVENTIONS

Applying for funding for HSS cross-cutting interventions is optional in Round 9

SECTION 5B CAN ONLY BE INCLUDED IN ***ONE DISEASE*** *IN ROUND 9 and only if this disease includes the applicant's programmatic description of HSS cross-cutting interventions in s.4B.*

Read the Round 9 Guidelines to consider including HSS cross-cutting interventions

Download 'Section 5B' from the Global Fund website here if the applicant intends to apply for 'Health systems strengthening cross-cutting interventions' ('HSS cross-cutting interventions') ***in Round 9 and has completed section 4B and included that section in the Tuberculosis proposal sections.***

Proposal checklist - Section 1 and 2

Section 3 and 4: Program Description		List Annex Name and Number
4.1	Supporting documentation for National Strategy	
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	
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).	
4.8.1	**A recent evaluation of the 'Impact Measurement Systems'** as relevant to the proposal (if one exists)	
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)	
4.10.6	**A completed 'List of Pharmaceutical and Health Products'** by disease (if applicable).	**Attachment B**
Section 4B: HSS Cross-cutting (once only in whole country proposal)		**List Annex Name and Number**
4B.2	**A completed separate HSS cross-cutting '*Performance Framework' (or add a separate "worksheet" to the disease 'Performance Framework' under which s. 4B is submitted)*** **Refer to the M&E Toolkit for help in completing this table**.	**Attachment A**
4B.2	**A detailed separate HSS cross-cutting Work Plan *(or add a separate "worksheet" to the disease Work Plan under which s. 4B is submitted)*** (quarterly information for the first two years and annual information for years 3, 4 and 5).	**Work plan**

Proposal checklist - Section 1 and 2

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	
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	
Section 5B: HSS Cross-cutting financial information		**List Annex Name and Number**
5B.1	**A separate HSS cross-cutting 'detailed budget' *(or add a separate "worksheet" to the disease 'detailed budget' under which s. 4B is submitted).* Quarterly information for the first two years, and annual information for years 3, 4 and 5).**	**Detailed Budget**
5B.4.2	Information on basis for budget calculation and diagram and/or list of planned human resources funded by proposal (only if relevant)	
5B.4.3	Information on basis of costing for 'large cost category' items	
Other documents relevant to sections 3, 4 and 5 attached by Applicant:		**List Annex Name and Number**
	GLC mission report	Annex 1, All pages
	Mid-Term Review of TB strategic plan summary presentation	Annex 2, All slides
	National TB Infection control Guidelines	Annex 3, All pages
	List of abbreviations	Annex 4, All pages

Attachment A - Tuberculosis Performance Framework

Program Details

Country:	Nigeria
Disease:	Tuberculosis
Proposal ID:	

Program Goal, impact and ouctome indicators

	Goals
1	To reduce significantly the burden, socio-economic impact and transmission of TB in Nigeria

Impact and outcome Indicators	Indicator	Baseline			Targets					Comments*
		value	Year	Source	Year 1	Year 2	Year 3	Year 4	Year 5	
impact	TB prevalence rate	521 per 100,000 population	2008	WHO Global Tuberculosis Control Report 2009						Baseline target will be obtained following the TB prevalence study that is planned in Phase 2 of Global Fund Round 5 TB Phase 2 grant
outcome	Case detection rate: new smear positive TB cases	30.5%	2008	2008 NTBLCP Annual report	43.3%	49.7%	55.1%	60.5%	65.5%	
outcome	Treatment success rate: new smear positive TB cases	82%	2008	2008 NTBLCP Annual report	84%	85%	85%	85%	85%	

* 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 pursue High Quality DOTS expansion and enhancement	
2	To scale-up TB/HIV collaborative activities and strengthen TB/HIV integration	
3	To Strengthen MDR-TB Prevention and Control	

Attachment A - Tuberculosis Performance Framework

Program Details

Country:	Nigeria
Disease:	Tuberculosis
Proposal ID:	

Objective / Indicator Number (e.g.: 1.1, 1.2)	Service Delivery Area	Indicator	Baseline (if applicable)			Targets for year 1 and year 2				Annual targets for years 3, 4 and 5			Directly tied (Y/N)	Baselines included in targets (Y/N)	Targets cumulative (Y-over program term/Y-cumulative annually/N-not cumulative)	DTF: Name of PR responsible for implementation of the corresponding activity	Comments, methods and frequency of data collection
			Value	Year	Source	6 months	12 months	18 months	24 months	Year 3	Year 4	Year 5					
1.1	Political commitment and partnership	Number and percentage of states disbursing funds for TB control	19 (51%)	2008	2008 NTBLCP Annual report		23 (62%)		25 (68%)	27 (73%)	29 (78%)	31 (84%)	N	Y	Y - cumulative annually	ARFH	
1.2	High Quality DOTS	Number of additional health facilities providing DOTS services	2,742	2008	2008 NTBLCP Annual report		150		300	750	1,200	1,650	Y	N	Y - cumulative annually	ARFH	
1.3	High Quality DOTS	Number of new smear positive TB patients successfully treated (cured plus treatment completed)	35,960	2008	2008 NTBLCP Annual report		38,198		57,912	69,654	79,499	88,346	Y	N	Y - over program term	ARFH	The value provided is the cohort of the preceeding year
1.3	Improving diagnosis	Number of new smear positive pulmonary TB patients reported	46,022	2008	2008 NTBLCP Annual report		81,946		93,528	103,936	114,488	124,849	Y	N	Y - cumulative annually	ARFH	
1.3	Improving diagnosis	Number and percentage of laboratories performing regular external quality assurance for sputum smear microscopy	622 (69%)	2008	2008 NTBLCP Annual report		1,110 (80%)		1,358 (85%)	1,492 (90%)	1,637 (95%)	1,788 (100%)	Y	N	Y - cumulative annually	ARFH	
1.4	All care providers (PPM / ISTC)	Number of all forms of TB cases notified by hospitals participating in Hospital DOTS linkage	NA		please select…		2,974		4,255	5,756	5,901	6,111	N	N	N - not cumulative	ARFH	
1.5	Community System Strengthening	Number of patients accessing treatment through community DOTS	NA		please select…		4,695		6,690	9,152	12,172	15,858	Y	N	N - not cumulative	ARFH	
1.6	Management & Supervision	Number and percentage of supervisory visits performed with documented reports at the national level out of planned visits each year	24 (100%)	2008	2008 NTBLCP Annual report		24 (100%)		24 (100%)	24 (100%)	24 (100%)	24 (100%)	Y	N	N - not cumulative	ARFH	
1.7	M&E	Proportion of states submitting timely reports to the national programme according to national guidelines	90%	2008	2008 NTBLCP Annual report		100%		100%	100%	100%	100%	Y	N	N - not cumulative	ARFH	
1.8	HRD: Health Workforce	Number of programme staff train and retrain on M&E	40	2008	2008 NTBLCP Annual report						80		Y	N	N - not cumulative	ARFH	
2.1	TB/HIV	Proportion of registered TB patients tested for HIV	62.1%	2008	2008 NTBLCP Annual report		80%		85%	89%	91%	92%	Y	N	N - not cumulative	CHAN MEDI-PHARM	
2.2	TB/HIV	Proportion of HIV positive TB patients who received CPT	31%	2008	2008 NTBLCP Annual report		46%		51%	56%	60%	65%	N	N	Y - cumulative annually	CHAN MEDI-PHARM	
3.1	MDR-TB	Number and percentage of notified re-treatment cases (failures, return after default, relapses and others) receiving diagnostic culture and DST for MDR-TB	90 (1.3%)	2008	please select…		1,832 (20%)		4,177 (40%)	5,357 (45%)	6,785 (50%)	8,509 (55%)	N	N	Y - cumulative annually	CHAN MEDI-PHARM	
3.2	MDR-TB	Number of MDR-TB patients put on treatment	NA		please select…		320		720	1,120	1,520	1,920	Y	N	Y - cumulative annually	CHAN MEDI-PHARM	