The Global Fund to Fight AIDS, Tuberculosis and Malaria

Geneva, July 2002

For the use of the Global Fund Secretariat:
Date Received:
ID No:

PROPOSAL FORM

Before starting to fill out this proposal form, please read the *Guidelines for Proposals* carefully. When completing each question in the proposal form, please note the reference given to the corresponding section of the guidelines.

<u>This form is divided into 4 main parts</u>:

SECTION I is an executive summary of the proposal and *should be filled out only AFTER the rest of the form has been completed*.

SECTION II asks for information on the applicant.

SECTION III seeks summary information on the country setting.

SECTIONS IV to VIII seek details on the content of the proposal by different components.

<u>How to use this form</u>:

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

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

3. **All answers, unless specified otherwise, should be provided in the form**. If submitting additional pages, please mark clearly on the pages which section and numbered question this relates to.

4. To avoid duplication of efforts, we urge you to **make maximum use of existing information** (e.g., from pogramme documents written for other donors/funding agencies).

5. When **using tables**, all cells are automatically expanded as you write in them. Should you wish to **add a new row**, place the cursor on the outside of the cell at the bottom right-hand corner of the table and press ENTER.

   To copy tables, select all cells in the table and press CTRL+C. Place cursor where you would like the new table to begin and press CTRL+V.

   Please DO NOT fill in shaded cells.

SECTION I: Executive summary of Proposal

Please note: The Executive Summary will be used to present an overview of the proposal to various members of the Secretariat, the Technical Review Panel and the Board of the Global
Fund.
TO BE COMPLETED AFTER THE OTHER SECTIONS HAVE BEEN FILLED OUT

Background

The fourth meeting of Nigeria's CCM took place on 20th September 2002. The CCM in Nigeria is now fully established and have been meeting regularly. It has also obtained a separate office facilities that accommodates only CCM staff and also efforts are made to provide adequate communication and information technology facilities (IT).

Nigeria being the most populous country in Africa and also with a state of health being increasingly dire, was considered by the CCM as one of the most vulnerable among countries situated in the areas endemic to the three diseases. It is in this regard that the CCM processed the 98 proposals received from the various applicants in Nigeria and is recommending the enclosed Country Coordinated Proposal (CCP) for your consideration. Sirs, I believe you will agree with me that the successful control of these diseases (HIV.AIDS, TB and Malaria) will go a long way in reducing the rate of their transmission in the African continent and in the World as a whole with their subsequent full control and possible elimination or eradication. The submission of this proposal had not only received the endorsement of the CCM, but it also has the received a full support from Nigerian Health authorities and that of His Excellency President Olusegun Obasanjo.

CCP Process

The disease working groups of the Technical Review sub-committee of the CCM, Nigeria had after reviewing all proposals received, prepared a review comprehensive, all-inclusive proposals, or of proposing highly targeted expansions of current efforts. With the understanding that GFATM wishes to be a partner of countries and provide ongoing levels of support based on measurable outcomes, the teams chose extremely specific projects that met the following high-level criteria:

- Existing knowledge and experience in implementation
- Addressing critical areas of disease burden
- Super-scaleable results for the rest of the country
- Highly monitorable results and indicators
- Capacity for implementation in the next 12 months
- Urgent need for targeted action

The Technical Review Committee of the CCM, in consultation with the Minister of Health, partner NGOs and CBOs, international experts and other development partners, reviewed professionally the 98 received proposals and recommended a country coordinating proposal (CCP) that addresses three disease. These proposal was further discussed at the full meeting of the CCM and only those that met members satisfaction to have met the requirements of the GF ATM were endorsed. The CCP addresses the prevention care and support and technical support to improve quality of service. These proposals by no means represent the full range of need in Nigeria but are proposed for funding so as to fill gaps in the target diseases prevention and control. activities.

The first sets of proposals sent for consideration to the GF ATM received favourable consideration thereby confirming the seriousness with which CCM Nigeria works. The only two sent for re-submission have been reviewed with all observation of the TRP taking into consideration and now included into the new CCP. A new component proposal on prevention and care and Support of HIV/AIDS is added with the main intention of supporting and strengthening the on-going prevention, care and support projects, including the ART project earlier approved by the GF ATM for Nigeria. Each component is a cornerstone of the national fight against these three scourges and could make immediate and effective use of financing from GFATM.

Nigeria's CCM

Nigeria's CCM has begun with 38 members drawn from the private sector, civil society, NGOs, government ministries, people living with HIV/AIDS and TB, as well as academics and medical practitioners. The CCM voted to have a rotating chairman of one-year tenure, and elected its chairman for this year, Dr. A. Nasidi, a Director in the Ministry of Health and a former member of the GFATM Secretariat. The CCM follows democratic procedures with each member holding an equal vote. All parties involved in the fight against HIV/AIDS, TB and Malaria are represented on the CCM, as are Government, UN and Bilateral Agencies, NGOs, Civil Society and the Private Sector. The CCM has formed technical working groups for each of the three diseases, as well as a Finance Task Force and a TRP. In its last meeting, ExxonMobil was endorsed as a new member of the CCM to boost private sector participation.

The CCM Nigeria has commenced putting in place an effective financial mechanism and has identified the GTZ (German Technical Corporation) and the UNOPS (UNDP/WHO) as our possible Principal Recipients and LFA. Both organizations are reputable and have internationally acclaimed financial and auditing mechanisms that will ensure transparency of our operations.

Among our responsibilities for managing the Nigeria CCM the following are also areas of our activities that will be taken very seriously:

1) Develop, review and submit proposals to the GFATM
2) Manage funds with our Principal Recipient
3) Monitor and evaluate all projects
4) Monitor and track all expenditures
5) Audit internal and project specific accounts
6) Write regular reports on performance of each project and the activities of the CCM in general

Independence

The CCM is determined that it should be a partner to the Nigerian Government as well as of NGOs, donors, bilaterals, and multilaterals. However, it also decided that the CCM must function completely independently.

Submission of this Proposal

The members unanimously decided to submit the CCP to GFATM for funding. Attached to this is a list of the CCM members and their signatures approving the submission and the **minutes of the meeting where such decision** was taken.

General information:

Table I.a

Proposal title (Title should reflect scope of proposal)**:**	**SCALING UP HIV/AIDS, TUBERCULOSIS, and MALARIA PREVENTION CARE AND SUPPORT IN NIGERIA**			
Country or region covered:	**NIGERIA**			
Name of applicant:	**CCM NIGERIA**			
Constituencies represented in CCM (write the number of members from each Category)**:**	**1**	**Government – Health ministry**	**3**	**UN/Multilateral agency**
	6	**Government – Other ministries**	**3**	**Bilateral agency**
	9	**NGO/Community-based organizations**	**6**	**Academic/Educational Organizations**
	5	**Private Sector**	**2**	**Religious/Faith groups**
	3	**People living with HIV/TB/Malaria***	**5**	**Other** (please specify):
If the proposal is NOT submitted through a CCM, briefly state why:	**NOT APPLICABLE**			

Specify which component(s) this proposal is targeting and the amount requested from the Global Fund:**

Table I.b

* According to national epidemiological profile/characteristics

** If the proposal is fully integrated, whereby one component cannot be separated from another, and where splitting budgets would not be realistic or feasible, only fill the "Total" row.

			Amount requested from the GF (USD thousands)					
			Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Component(s) (mark with X):	**X**	**HIV/AIDS**	40,829,621	46,954,064	27,267,517	22,276,030	19,859,306	157,186,538
	x	**Tuberculosis**	5,812,780	4,009,285	4,130,100	4,175,560	4,321,316	22,449,042
	x	**Malaria**	8,513,203	9,315,605	8,888,169	8,417,573	9,180,140	44,314,689
		HIV/TB						
		Total	55,155,604	60,278,954	56,411,035	55,985,899	56,894,222	284,725,712
Total funds from other sources for activities related to proposal			29,511,942	**31,983,963**	**31,916,641**	**36,602,297**	**Not available**	**130,014,843**

Please specify how you would like your proposal to be evaluated[***] (mark with X):

The Proposal should be evaluated as a whole	
The Proposal should be evaluated as separate components	**X**

NB: Please note that TB and Malaria are for re-submissions and not new proposals.

[***] This will ensure the proposal is evaluated in the same spirit as it was written. If evaluated as a whole, all components will be considered as parts of an integrated proposal. If evaluated as separate components, each component will be considered as a stand-alone component.

Brief proposal summary (1 page)(please include quantitative information where possible)**:**

- **Describe the overall goals, objectives and broad activities per component, including expected results and timeframe for achieving these results:**

GOALS: This country proposal contains three components aimed at reducing the burden of the three diseases in Nigeria. It aims to reduce the prevalence of HIV/AIDS in Nigeria by 30% by the year 2007; to increase the coverage of care provided to the infected and affected; achieve a 100% Directly Observed Treatment Schedule (DOTS) coverage in the country by 2005, sustained through to 2007; and to reduce the Malaria mortality and morbidity in children under five and pregnant women, by 30% by the year 2007.

OBJECTIVES:

1. To increase awareness of HIV/AIDS, and increase behavioural changes towards safer sexual practices thereby lowering the prevalence of HIV/AIDS by 30% by the year 2007.
2. To reduce the present level of discrimination and stigmatization of **People Living With HIV/AIDS (PLWHAs), and to** increase their access to home based care and support and to improve their standard of living through poverty reduction by 2007.
3. To strengthen the capacity of non-governmental and governmental organizations and their staff to implement HIV/AIDS interventions.
4. To increase the use of Insecticide Treated Nets (ITNs), from 5.0 to 55% by 2007
5. To increase the proportion of under fives correctly treated for malaria from 12% to 60% by 2007
6. To increase the proportion of pregnant women that use Intermittent Preventive Treatment (IPT) according to the new national guidelines from 0% to 50% by 2007
7. To increase TB case detection rate from current level of 15% to 80% by the end of 2007
8. To increase cure rate of TB from the current level of 66% to at least 90% by 2007;
9. To achieve 100% DOTS coveragenation-wide by end of 2005 by integrating DOTS into the PHC

BROAD ACTIVITIES:

The HIV/AIDS component of the proposal will scale up present ongoing HIV interventions. It will mobilise all sectors of government and civil society to respond to the epidemic; Increase advocacy, sensitization and mobilization activities on HIV/AIDS at all levels for the rights of PLWHAS ;advocate for an enabling environment for HIV interventions; advocate for the use of developed curricula for sexuality education; and the use of mass media in all the county r for HIV interventions; .

It will also establish support groups for PLWHAs and People Affected by HIV/AIDS (PABAs) at community level; provide home based care activities; provide income generating activities, and support for PLWHAs, People affected by AIDS and Orphans and vulnerable children. It will also train and retrain health workers, non-health workers including PLWHAs, community volunteers; non-governmental and governmental organizations involved in HIV preventive and community care interventions in the country

The TB component will sensitize governments on the need to commence DOTS, expand the DOTS services within the states; expand the diagnostic network of AFB smear microscopy through the country and train the health facility staff to be able to correctly manage patients according to DOTS guidelines. It will also provide new guidelines for the treatment of TB and review the curriculum of medical and paramedical staff.

The Malaria component will ensure the adequate and distribution of ITNs and ensure demand creation through awareness and education campaigns. It will also ensure adequate re-treatment of nets. To ensure correct treatment of malaria it will create awareness the correct treatment of malaria and the procurement of pre-packaged colour coded drugs as well as teach mother son how to use them. Lastly it will provide re-training activities for health personnel in the use of Sulphadoxine-pyrimenthamine in the ante natal care malaria prophylaxis according to the new guidelines.

EXPECTED RESULTS:

- **Specify the beneficiaries of the proposal per component and the benefits expected to accrue to them** (including target populations and their estimated number):
- **If there are several components, describe the synergies, if any, expected from the combination of different components** (By *synergies*, we mean the added value the different components bring to each other, or how the combination of these components may have effects beyond the effects of each component taken individually):

The HIV/AIDS component aims to benefit the general population with a decreased risk of infection by teaching them to adopt protective behaviour. It will also benefit 3.5 million HIV infected persons with increased access to support and health care services. People affected by AIDS including Orphans will also be supported.
The expected results include

1. Increased commitment from all sectors of the government and private sector on need to carry out interventions. It is also expected that an enabling environment for the implementation of HIV interventions will be created
2. A better standard of living for PLWHAs due to the reduced level of stigmatisation and discrimination; increased access to health care and a reduction in poverty in this subpopulation. Also increased support for PABAs.
3. A reduction in high-risk behaviour in the general population and high risk groups leading to decreased incidence of HIV infections
4. An improved capacity of health and non-health workers to implement HIV/AIDS preventive and care and support interventions.

The TB component is expected to benefit 122,551 adult tuberculosis cases and 12,255 children who will receive effective treatment with DOTS. This should lead to:

- a cure,
- increased productivity,
- reduced poverty,
- Prolong life of PLWHAs coninfected with TB,
- increased child survival and
- reduced transmission of the disease in the community.

Malaria component is expected to benefit all 4,442,515 children less than five years by reduced morbidity and mortality due to malaria. Additionally about 873,125 pregnant women per year should also benefit by:

- reducing morbidity and mortality due to malaria among pregnant women and children under five
- improved knowledge of mothers and other caregivers on appropriate management of malaria aamong under fives
- initiate the use of Sulphafoxine-pyrimethamine (SP) for Intermitent Preventive Treatment (IPT) for malaria in pregnancy.
- increased number of mothers who know how to effect home treatment of malaria.
- ITNs: beneficiaries are 4,442,515 children and 873,125
- Home Management of Malaria: the beneficiaries are 4,034,326 children with attendant
- IPTs: 582,084 pregnant women to benefit with attendant safe motherhood and increased life expectancy

SECTION II: Information about the applicant

Table IIa serves to help you know which questions you should answer in this Section, reflecting the different types of application mechanisms and proposals.

For further guidance on who can apply, refer to Guidelines para. II.8–33

Table IIa

Application mechanism	Type of proposal	Questions to answer
National CCM	Country-wide proposal *(Guidelines para. 14–15)*	1–9
Regional CCM	Coordinated Regional proposal from multiple countries reflecting national CCM composition *(Guidelines para. 24–25)*	1–9 and 10
	Small Island States proposal with representation from all participating countries but without need for national CCM *(Guidelines para. 24 and 26)*	
Sub-national CCM	Sub-national proposal *(Guidelines para. 27)*	1–9 and 11
Non-CCM	In-country proposal *(Guidelines para. 28–30)*	12 – 16
Regional Non-CCM	Regional proposal *(Guidelines para. 31)*	12 – 15 and 17

Proposals from countries in complex emergencies will be dealt with on a case-by-case basis (Guidelines para. 32)

Country Coordinating Mechanism (CCM), (Refer to *Guidelines paragraph 72–78)*

Table IIb

Preliminary questions	(Yes/No)
a). Has the CCM applied to the Fund in previous rounds?	**YES**
b). Has the composition of the CCM changed since the last submission?	**YES**
c). If composition of CCM has changed, briefly outline changes (e.g., list of new members or sector representatives)**:**	

1. **Name of CCM** (e.g., CCM Country name, National Committee to fight AIDS, TB and Malaria, etc):

Country Coordinating Mechanism (CCM), Nigeria

2. **Date of constitution of the current CCM** (The date the CCM was formed for the purpose of the Global Fund application. If the CCM builds on or uses an existing process – which is encouraged – please explain this in Question 3)**:**

MARCH 5, 2002

3. **Describe the background and the process of forming the CCM** (including whether the CCM is an entirely new mechanism or building on existing bodies, how the other partners were contacted and chosen, etc.), (1 paragraph):

CCM, Nigeria is an entirely new mechanism, which draws membership from existing

bodies to establish an enabling framework that would foster public-private sector partnership, while encouraging equity of participation and inclusiveness. A new structure was necessary under the Nigerian situation, to ensure the independence of the CCM. Membership of the CCM is drawn from a list of existing partners in health and other development areas. At the inaugural meeting, the willingness of members to participate was sought and obtained, followed by a subsequent endorsement of membership of the CCM by government through a Presidential approval (**Attachment I**). The inaugural meeting formally installed the CCM and established the Terms of Reference for the CCM, while members at the meeting elected the officials of the CCM.

3.1. If the CCM is or includes an already existing body, briefly describe the work previously done, programmes implemented and results achieved (1 paragraph):

The CCM as stated above is a new body and consists of partners that were working as a multi-sectoral group but not centrally coordinated. The CCM has now brought all Partners together to work towards attaining set objectives

4. Describe the organizational processes (e.g., secretariat, sub-committee, stand-alone; describe the decision-making mechanism. Provide Terms of Reference, operating rules or other relevant documents as attachments), (1 paragraph):

The Organisational frame of the CCM includes a democratically elected Chairman, and a focal Secretary who operates the CCM Secretariat with its staff compliment, while being supported by additional two Assistant Secretaries. Four Sub-committees are set up with their specific Terms of Reference (TOR) to address specific areas namely: Financial Management Subcommittee, Technical Subcommittee, Monitoring and Evaluation Subcommittee and Secretariat Subcommittee (**Attachments II and III**).

The CCM operates standard and transparent procedures in its conduct of meetings and business; and maintains democratic channels for its decision – making processes on most matters of concern to the CCM, GFATM and Nigeria at large.

5. Describe the mode of operation of the CCM (e.g., frequency of meetings, functions and responsibilities of the CCM. Provide the minutes or records of previous meetings as attachments), (1 paragraph):

The CCM meets bi-monthly, or as emergent issues may dictate. Dates of meetings are set by consensus, usually during preceding meetings. The Functions and Responsibilities (**Attachment IV)** and Minutes of the CCM previous meetings are herewith attached (**Attachments V, VI, & VII**).

6. Describe plans to enhance the role and functions of the CCM in the next 12 months, including plans to promote partnerships and broader participation as well as communicating with wider stakeholders, if required (1 paragraph):

The CCM has since recognized the need to improve partnership and participation and has embarked on a Public-Private Sector Summit, which has been scheduled for the last quarter of 2002. It aims at achieving two main objectives namely: enhanced publicity of CCM and stakeholder participation from the organized private sector and faith-based organizations. It also plans to raise funds complementary to the GFATM grant. The Private Sector will be mobilized to match any grant from the GF ATM with *ExxonMobil* already actively engaged in championing this crusade. GFATM. A proposed work plan for a one-year time cycle is attached (**Attachment VIII**).

7. **Members of the CCM** (*Guidelines para. II.16 – 22)*: see attached signed forms, please

> *Please note: All representatives of organizations included in the CCM must sign this page to be included in the original, hard-copy proposal sent to the Secretariat. The signatures must reach the Secretariat before the deadline for submitting proposals.*
>
> *Please print additional pages if necessary, including the following statement:*

"We the undersigned hereby certify that we have participated throughout the CCM process and have had sufficient opportunities to influence the process and this application. We have reviewed the final proposal and are happy to support it. We further pledge to continue our involvement in the CCM if the proposal is approved and as it moves to implementation"

Table II.7

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Main role in CCM				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Main role in CCM				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Main role in CCM				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Main role in CCM				

E.g. People living with HIV/ TB/ malaria, NGOs/ Community-based organisation, Private Sector, Religious/ Faith groups, Academic/ Educational Sector, Government Sector.

"We the undersigned hereby certify that we have participated throughout the CCM process and have had sufficient opportunities to influence the process and this application. We have reviewed the final proposal and are happy to support it. We further pledge to continue our involvement in the CCM if the proposal is approved and as it moves to implementation"

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Main role in CCM				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Main role in CCM				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Main role in CCM				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Main role in CCM				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Main role in CCM				

*E.g. People living with HIV/ TB/ malaria, NGOs/ Community-based organisation, Private Sector, Religious/ Faith groups, Academic/ Educational Sector, Government Sector.

7.1 Provide as attachment the following documentation for private sector and civil society CCM members:

- **Statutes of organization** (official registration papers)
- **A presentation of the organization, including background and history, scope of work, past and current activities**
- **Reference letter(s), if available**
- **Main sources of funding**

7.2 If a CCM member is representing a broader constituency, please provide a list of other groups represented.

N/A

8. Chair of the CCM and alternate Chair or Vice-Chair

Table II.8

	Chair of CCM	**Alternate Chair/Vice-Chair**
Name	Dr. Abdulsalami Nasidi	Prof. Tekena Harry
Title	Chairman	Vice-Chairman
Address	Room 4A. 334, Floor 3; Federal Secretariat, Maitama, Abuja.	Dept. of Microbiology, Univ. of Maiduguri Teaching Hospital, Maiduguri.
Telephone	+234-9-6701666;	+234-76-235668
Fax	+234-9-5238363, +234 8037006849	+234-76-235668
E-mail	ccmnigeria@hotmail.com nasidia@hotmail.com	maiduguri-lab@who-nigeria.org tekenaharry@hotmail.com ccmnigeria@hotmail.com
Signature		

9. Contact persons for questions regarding this proposal (please provide full contact details for two persons – this is necessary to ensure expedient and responsive communications):

Please note: The persons below need to be readily accessible for technical or administrative clarification purposes by the Secretariat or the TRP members.

Table II.9

	Primary contact	**Second contact**
Name	Prof J. Idoko	Dr. P. Matemilola
Title	Consultant Physician	Coordinator, Network of NPLWHAs
Address	Department of Medicine, University Teaching Hospital, Jos	24/26 MaCarthy Street, Onikan, Lagos
Telephone	+234 7646 0380, +234 8033215961	+234 1 2600047, +234 8033046872
Fax		
E-mail	jonidoko@yahoo.com ccmnigeria@hotmail.com	matemilolalsaca@yahoo.com ccmnigeria@hotmail.com

10. For coordinated regional proposals and Small Island States proposals describe how submitting this regional proposal adds value beyond the national level / what a national proposal could achieve *(Guidelines para. II.24),* (1 paragraph):

NOT APPLICABLE

10.1. For coordinated regional proposals, provide evidence of support from the national CCM or, if there is none, from other relevant national authority as attachment (e.g, letter of endorsement from Chair/Alternate of CCM or equivalent documentation).

NOT APPLICABLE

11. Sub-national Proposal from Large Countries

NOT APPLICABLE

11.1. Explain why a sub-national CCM mechanism has been chosen(1 paragraph):

NOT APPLICABLE

11.2. Describe how this proposal is consistent and fits with nationally formulated policies and/or how it fits with the national CCM plans *(Guidelines para. II.27),* (1 paragraph):

NOT APPLICABLE

11.3. Provide evidence of support from the national CCM or, if there is none, from other relevant national authority as attachment *(Guidelines para. II.27),* (e.g, letter of endorsement or equivalent documentation).

NOT APPLICABLE

Non-CCM applicant

12. Name of applicant: NOT APPLICABLE

13. Representative of organization applying:

Table II.13

	Representative	**Alternate**
Name		
Title		
Address		
Telephone		
Fax		
E-mail		

14. Contact persons for questions regarding this proposal (please provide full contact details for two persons – this is necessary to ensure expedient and responsive communications):

Please note: The persons below need to be readily accessible for technical or administrative clarification purposes by the Secretariat or the TRP members.

Table II.14

	Primary contact	**Secondary contact**
Name		
Title		
Address		
Telephone		
Fax		
E-mail		

15. Description of applying organization

15.1. Indicate what type of organization the applicant is (mark with X):

Table II.15.1

	Non-Governmental Organization (NGO) or network of NGOs
	Community based Organization (CBO) or network of CBOs
	Private Sector
	Academic/ Educational Sector
	Faith-based Organization
	Regional Organization
	Other (please specify):

15.2. Provide as attachment the following documentation:

- **Statutes of organization** (official registration papers)
- **A presentation of the organization, including background and history, scope of work, past and current activities**
- **Reference letter(s), if available**
- **Main sources of funding**

16. Justification for applying outside the CCM

16.1. Indicate reasons for not applying through the CCM (Explain clearly the circumstances, conditions and reasons; *Guidelines para. II.28–29*), (1–2 paragraphs):

NOT APPLICABLE

16.2. Have you been in contact with the CCM in your country or other relevant governmental agencies (e.g. Ministry of Health, National AIDS Council)**? If so, what was the outcome? If not, why?**

NOT APPLICABLE

16.3 Include letters from supporting organizations (e.g. human rights groups, NGO networks, bilateral or multilateral organizations, etc) supporting your reasons for not applying through a CCM as attachment.

NOT APPLICABLE

17. For regional proposals from Regional Organizations or International Non Governmental Organizations, describe how submitting this regional proposal adds value beyond the national level / what a national proposal could achieve *(Guidelines para. II.24),* (1 paragraph):

NOT APPLICABLE

17.1. Provide signed letters of endorsement from the national CCMs or, if there is none, from other relevant national authority for the countries covered by the proposal as attachment.

NOT APPLICABLE

SECTION III: General information about the country setting

*Please note: For **regional proposals**, the information requested in this section should reflect the situation in all countries involved, either in an aggregated form or by individual country.*
*For **sub-national proposals**, the information requested should reflect the situation in the particular sub-national area within the overall country context.*

18. Describe the burden or potential burden of HIV/AIDS, TB and /or Malaria:
(Describe current epidemiological data on prevalence, incidence or magnitude of the epidemics; its current status or stage of the epidemics; major trends of the epidemics disaggregated by geographical locations and population groups, where this data is available and/or relevant; *Guidelines para. III.37 – 38),* (1 – 2 paragraphs per disease covered in proposal):

Nigeria, the most populous nation in the African continent is among the most affected countries of the World by the three diseases. The HIV/AIDS prevalence in the country has exceeded 5% amongst adult population. The prevalence has grown from 1.8% in 1991 to 5.8% in 2001of the total population. With a population of 120 million, Nigeria has 3.5 million HIV infected persons; the third highest in the world. The most affected group are the reproductive and economically viable segment of the society. In the year 2001 about 170,000 died from HIV/AIDS in Nigeria (UNAIDS, 2002). Currently Nigeria is estimated to have 1 million AIDS orphans, the highest number globally. The geographical spread of the infection in the country is as follows: South East – 5.8%; South West – 4.0%; North West – 3.3%; North Central – 5.5%; North East – 5.4% and the South South – 7.7%. This shows that all parts of the country are affected. Unlike most other countries the rural populations are more affected. The Female: male ratio in young adults (15 – 24 years) is about 2:1 (UNAIDS 2002). It is estimated that AIDS related death will account for over 30% of mortality in adults aged 15 to 49 presently and could increase to 50% by the year 2005(AIDS in Nigeria: an overview see attach. 10).

An estimated 300,000 patients including all forms of tuberculosis cases occur in Nigeria annually (305/100,000 population) placing the country 4th among 22 highest TB burden countries in the world (WHO, 2002). The total TB notifications in 2000 and 2001 are 26,641 and 30,767 respectively giving a case detection efficiency of about 15%. TB case detection rate varies among the states from less than 5/100,000 to 118/100,000. Of all TB cases detected 68% are the infectious smear positive type capable of increasing transmission of TB disease within the community. Recent HIV sentinel survey shows that 19.1% of TB cases are also co-infected with HIV. Zonal differences have also been observed in HIV sero-prevalence among PTB patients in Nigeria, which fairly correlates with the HIV infection pattern in the general population (NASCP, FMOH, 2001 see Attach. II)). 21 out of the 36 States of Nigeria and the Federal Capital Territory are implementing the DOTS strategy leaving 16 states uncovered. Nevertheless treatment success rate of 77% has been achieved

Results from the Situation analysis in the year 2000 (see Attach. 12) show that malaria accounts for 25% of infant mortality, 30% childhood mortality and 11% maternal mortality. Malaria alone or in combination with other diseases is responsible for most (75-100 %) of illness episodes in under-five in all communities in the 6 geo-political zones of Nigeria. Up to 70.5% of pregnant women surveyed within communities had malaria (48.2%) and malaria with other diseases (22.3%). Malaria accounted for 63.4% of all reported diseases in Nigerian health facilities and also a reported prevalence of 47.4% in pregnant women (FMOH, 2000, see Attach. 13). Less than 1% of the total population use ITNs. However, current situation analysis data showed wide zonal variation ranging from 0% to 22.1%, with awareness of effectiveness of ITNs being less than 2% among the general population. The economic burden of malaria is substantial. Every year, the nation losses over N132 billion annually due to absenteeism from work, school, farm and cost of treatment as a result of malaria. The direct impact of this economic burden impedes human development and consequent underdevelopment

19. Describe the current economic and poverty situation (Referring to official indicators such as GNP per capita, Human Development Index (HDI), poverty indices, or other information on resource availability; highlight major trends and implications of the economic situation in the context of the targeted diseases; *Guidelines para. III.39),* (1–2 paragraphs):

Nigeria ranks as one of the poorest countries in the world with a GNP per capita of $280 in 1999 (World Bank Report). According to this report, Nigeria ranked 187th amongst all nations. About 57 % of Nigerians are currently living below the poverty line with a Human Development Index of 151 (Nigerian Human Development Report, UNDP 1998). The illiteracy rate is about 48% for males and about 58% for women. The population access to clean drinking water is about 30 % in rural and 50% in urban areas.The poverty level increased from 42.7% in 1992 to 65.6% in 1996 with over 42.7millon people living below the official poverty line. The Human Poverty Index of 37.6 ranks Nigeria as 54th amongst 78 poorest countries of the world. Compounding these, the country has a total external debt of $30,315millon, making it difficult for the country to provide adequate funding for dealing with health problems. All these data indicate a poor economic and poverty level; this is indeed one of the major driving forces of the HIV/AIDS epidemic. Definitely, the continued spread of HIV/AIDS in Nigeria is capable of compounding these problems and has the potential of harming Nigeria's economic, social, and political structure.

Nigeria has a population of 126 million people. The main source of revenue receipts is mainly from crude oil exports. The total GDP is $10b per annum, and a GNP per capita of $280 (FGN). The infant mortality rate is 90/1,000, while the maternal mortality rate 8/1,000 with a life expectancy at birth of 55 years (National Health Policy Document, FMOH 1996). This viscous cycle of poverty, illiteracy and debilitating diseases like tuberculosis and HIV/AIDS is of grave concern to Nigeria.

20. Describe the current political commitment in responding to the diseases (indicators of political commitment include the existence of inter-sectoral committees, recent public pronouncements, appropriate legislations, etc.; *Guidelines para. III.40),* (1–2 paragraphs):

There is high commitment of the President of Nigeria to the fight against HIV/AIDS and he is the current chairman of the multisectoral Presidential Committee on AIDS (PAC). In Nigeria, the President has facilitated the creation of structures for the fight against HIV/AIDS which include a Presidential council on AIDS with him as the Chairman, the National Action Committee on AIDS (NACA) which is a multi-sectoral approach having drawn its membership from all sectors of the government and civil society including the lines ministries (Education, Defence, Health, Women Affairs and Youth Development, Agriculture, Internal Affairs, etc), PLWHAs, NGOs and the civil society. This action committee has been put in place, to ensure a broad-based expanded response to HIV/AIDS in Nigeria. Following its establishment NACA developed a national working document on HIV/AIDS called the HIV/AIDS Emergency Action Plan (HEAP) which is providing the country with needed strategies and direction for fighting against this disease. Additionally, the government of Nigeria contributed over $5 million to the ART programme in the year 2002 to kick-start the first most elaborate ART project in the African continent. It also contributed USD 10 million to the Global Fund. In April 2001, the Nigerian government hosted the all African Heads of States Summit HIV/AIDS, TB and other related infectious diseases where the creation of the Global Fund to Fight AIDS, TB and Malaria was pronounced by the Secretary General of the United Nations, Mr. Kofi Annan.

Recognising that tuberculosis is a major public health problem in the country Nigeria launched the National TB and Leprosy Control Programme (NTBLCP) in 1991. Furthermore, TB/HIV control is very closely linked to the overall Poverty eradication strategy of the present Government. The Federal Government still maintains policy of

free tuberculosis treatment and in June 2002, the Minister of Health inaugurated a multi-sectoral National TB Inter-agency Committee.

The political commitment and support is very high leading to the hosting of African Summit on Roll Back Malaria (RBM) on April 25, 2000 at Abuja, Nigeria. At the Summit a reduction of taxes and tariffs on imported bed nets to 5% and concessional import duty of zero percent on approved public health insecticides for the treatment and retreatment of nets was pronounced. The success of hosting the First African Malaria Day on April 25, 2001 which attracted both WHO Director General and UNICEF Executive Director as well as some African Heads of states. Also the Strategic Plan for RBM in Nigeria (2001-2005) was launched by the President, Chief Olusegun Obasanjo in the year 2001 in Abuja. This was followed by the Presidential intent to make ITNs available to all children under five years and pregnant women in Nigeria by end of June 2002. To this end the FMOH together with RBM Partners have initiated the ITNs Massive Promotion & Awareness Campaign (IMPAC) Initiative, improvement in case management, initiating IPT with use of SP in Nigeria, which had already commenced at the community levels, with an initial financial commitment of $7.5 million by the Federal Government. The campaign aims at soliciting the support of all Chairmen of the 774 Local Government Councils (LGAs) in Nigeria through demand creation and priming the local and international market for ITNs. Meanwhile, since the RBM Summit in 2000, the Government had budgeted $1,000,000 for the year 2000, $1,000,000 for 2001 and $7,500,000 for 2002 for the implementation of RBM in the country, the annual increase in funding demonstrating political support and commitment of government. This is further underlined and strengthened by the adoption of the National Health Policy, National Malaria Control Policy, Anti-malaria Treatment Policy and the ITN policy to which government has been lending support, with full sectoral partnership and strong Stakeholder collaboration. However, because of the large population of the country and the low HDI, Nigeria requires additional external support to meets its goal for the RBM programme.

21. Financial context

21.1. Indicate the percentage of the total government budget allocated to health*:

Government budget allocated to Health is 4% for the year 2002

21.2. Indicate national health spending for 2001, or latest year available, in the Table III.21.2*:

Table III.21.2

	Total national health spending Specify year: **2001** (USD)	**Spending per capita** (USD)
Public	197,670,000	0.39
Private	324,881,302	2.7
Total	522,551,302	3.1
From total, how much is from external donors?	55,442,260	2.3

21.3. Specify in Table III.21.3, if possible, earmarked expenditures for **HIV/AIDS, TB and/or Malaria** (expenditures from the health, education, social services and other relevant sectors)**:

Table III.21.3

Total earmarked expenditures from government, external donors, etc. Specify Year:2001	In US dollars:
HIV/AIDS	7,000,000
Tuberculosis	4,916,641
Malaria	26,000,000
Total	37, 916,641

21.4. Does the country benefit from external budget support, Highly Indebted Poor Countries (HIPC) initiatives[*], Sector-Wide Approaches? If yes, how are these processes contributing to efforts against HIV/AIDS, TB and/or malaria? (1–2 paragraphs)[**]:

Nigeria does not benefit from HIPC or other such initiatives.

22. National programmatic context

22.1. Describe the current national capacity (state of systems and services) that exist in response to HIV/AIDS, TB and/or Malaria (e.g., level of human resources available, health and other relevant infrastructure, types of interventions provided, mechanisms to channel funds, existence of social funds, etc.), (*Guidelines para. III.41 – 42*), (2–3 paragraphs):

The current national response to HIV/AIDS is focused towards prevention of HIV transmission and enhancing access to affordable, efficient and quality care and support services to people living with HIV/AIDS. These will be achieved through a comprehensive and well-packaged 3-year short term HIV/AIDS emergency plan (HEAP). The plan is designed to reduce the medical and socio-economic effects of HIV/AIDS, by focusing on high impact interventions. Such interventions include the creation of an enabling environment, specific HIV/AIDS interventions, care and support for PLWHAs and PABAs. There is inadequate technical capacity in both the public and private sector to provide services that will curb the epidemic and ameliorate its effects. These deficiencies are being addressed currently through training and retraining of health and non-health workers by the government in collaboration with development partners to build and strengthen existing capacity to develop and integrate HIV/AIDS control activities into all other sectors, including the private sectors, NGOS and civil societies.

The NTBLCP is organized at the three tiers of Government i.e Federal, State and LGA levels. A Central Unit exists at the Federal level headed by a Consultant Public Health Physician and assisted by three other Public Health Medical Officers. The CU also has 12 administrative support staff including a logistics officer. At the State level, each of the 37 State programmes are headed by a Medical Officer assisted by 2-4 Senior Community Health Officers. The LGA level is usually headed by Community Health Officers who supervise activities at the health facility level. The main interventions provided include detection of tuberculosis cases and providing effective treatment to achieve cure. Other interventions include health promotional activities in respect of TB and HIV/AIDS. The State programmes operate separate bank accounts at all levels through which funds are channeled for programme activities on quarterly basis. The operations of these accounts are not influenced by the administrative bureaucracy of the ministries. Same channels are used to channel donor funds currently from the ILEP member organizations. Efforts are being made to establish same financial mechanism at the Central Unit level, which currently

[*] HIPC is a debt-relief initiative for highly indebted poor countries through the World Bank
[**] Optional for NGOs

operates using the ministry's channel. The Government of Nigeria at all levels has re-vitalized the malaria control units in all States, Local Government Areas and Community level with manpower put in place.
At the national level, there is the National Malaria Control Programme with competent staff. All States and Local Government also have Malaria Control Programme units with focal persons in place in a decentralized manner for effective implementation. The on-going Health Services System Reform will greatly enhance the effective implementation of this project. The RBM programme already has an existing public-private sector partnership jointly responsible for funding, implementation, demand creation, monitoring and evaluation. The RBM programme is also in partnership with Mosquito net manufacturers and insecticide dealers to ensure constant availability of ITNs; as well as being in partnership with Pharmaceutical Manufacturers Group of Manufacturers Association of Nigeria (PMG - MAN), which produce the prepackaged anti-malarial drugs for better compliance to treatment. The RBM adopts a multi-sectoral approach in its implementation strategy to create a synergised convergence of efforts. This brings along the ministries of Agriculture, Environment, Women Affairs and Youth Development, Information, Industries, Works and Housing and the Oil producing sector, among others. The programme implementation is guided by the following existing policies: the National Health Policy, National Malaria Control Policy, Strategic Plan, Anti-malaria Treatment Policy and the ITN Policy. The scaling of the RBM programme to cover additional twelve states (222 LGAs) identified the material and human resources gaps in the proposed response strategies. Capacity development will satisfy the human resource gap while funding procurement will ensure availability of the material resources. The programme plans to work with the existing infrastructure at the primary health facilities and communities as well as strengthen the private sector component for the Community response strategies regarding the ITNs and Prepackaged drugs. The channeling of funds will be as described within the fiduciary framework of the CCM with direction to the Principal Recipient (PR).

22.2. Name the main national and international agencies involved in national responses to HIV/AIDS, TB and/or Malaria and their main programmes[**]:

Table III. 22.2

Name of Agency	**Type of Agency** (e.g., Government, NGO, private, bilateral, multilateral, etc.)	**Main programs** (for example, comprehensive HIV/AIDS prevention; DOTS expansion over 3 years, etc.)	**Budget** (Specify time period)
National Action Committee on AIDS	Government	Basic HIV/AIDS enlightenment activities	$50,000.00 (6 months)
UNAIDS	Bilateral	Office space/equipment	$30,000 On-going
Policy Project/Futures Group International	NGO	Capacity Building	$13,000 On-going
Family Health International	NGO	Capacity Building	$50,000 On-going
World Health Organization (WHO)	Bilateral	HIV/AIDS (Technical Assistance)	Technical support
United Nations Children Education Fund (UNICEF)	Bilateral	HIV/AIDS (Mother and child)	Technical support
Canadian International Development Agency (CIDA)	Bilateral/Multilateral	Support to HIV/AIDS and DOTS expansion in Nigeria from 2002.	900,000 (2002)
Damien Foundation Belgium (DFB)	NGO	DOTS expansion since 9 years in two (2) states in Nigeria.	251,738 (2002-2005)

[**] For NGOs, specify here your own partner organizations

UK Department For International Development (DFID)	Bilateral	Support to Comprehensive HIV/AIDS prevention and DOTS pilot project in 4 States, use of ITNs for Malaria prevention.	$2,000,000 2002-2005
German Leprosy Relief Association (GLRA)	NGO	DOTS expansion since 9 years in 14 states of Nigeria.	977,869 (2002-2007)
Netherlands Leprosy Relief (NLR)	NGO	DOTS expansion since 5 years in 4 States in Nigeria.	245,000 (2002-2007)
World Health Organization (WHO)	Multinational	Technical support to the DOTS expansion and HIV/AIDS prevention.	Continuous
Christian Health Association of Nigeria (CHAN)	Local NGO	Comprehensive HIV/AIDS prevention programme and DOTS implementation over 10 years in Nigeria.	Continuous
German Bank for Reconstruction (KFW)	Bilateral	DOTS expansion since 9 years in 14 states of Nigeria.	1,417, 890 (2002-2004)
National Primary Health Care Development Agency	National	Currently putting in place minimal health package including the DOTS delivery	Continuous
National Tuberculosis and leprosy control programme (NTBLCP)	National	Implementing DOTS expansion activities in Nigeria.	1,124,144 Continuous
National	Government	ITNs use, home management of malaria, prevention of malaria in pregnancy, monitoring, research, IEC, evaluation etc	19,500,000
Unicef	UN / Multilateral	Use of ITNs for Malaria Prevention, HIV/AIDS (PMTCT)	1,800,000
WHO	UN / Multilateral	Comprehensive Malaria Control	1,603,000
DFID	Bilateral	Use of ITNs for Malaria Prevention	2,000,000
USAID (BASICS)	Bilateral	Community-based malaria control.	100,000
USAID (NetMark)	Bilateral	Promotion of use of ITNs for Malaria Prevention	2,000,000
UNDP	UN / Multilateral	Community Empowerment and development	Partnership
WORLD BANK(IDA/IBRD)	UN / Multilateral	Capacity Building, Community development and empowerment,HIV/AIDS	Partnership
MACOA (Malaria Care Organisation in Africa)	NGO	Research, Community-based malaria control, Schools malaria control etc	Self sponsored/partnership
Malaria Society of Nigeria	NGO	Research, Community-based malaria control.	Self-sponsored/ partnership
Pharmaceutical Manuf. Group (of MAN)	Private	Partnership in antimalarial drug provision.	Partnership
Insecticide and Net Manuf. Assoc.	Private	Partnership in Insecticide and Net provision and distribution.	Partnership
NAOC	Private	Partnership in community malaria control.	Partnership
Mobil Producing	Private	Partnership in community malaria control.	Partnership

NB: Please check similar table in care and support which is more complete

22.3. Describe the major programmatic intervention gaps and funding gaps that exist in the country's current response to HIV/AIDS, TB and/or Malaria (*Guidelines para. III.41 – 42*), (2–3 paragraphs):

HIV/AIDS

The total estimated need over a 3-year period is $500 million; there is an estimated available fund of $224 million with a funding gap of $226 million over a 3-year period. Though a plan of action has been formulated in the HEAP, many programmatic gaps exist in Nigeria's current response to HIV/AIDS. They include a large training gap for all cadres of health workers and community volunteers to facilitate the national response to HIV/AIDS especially in the delivery of community and home based care for AIDS patients. Though the country has begun elaborate PMTCT and ART programs these are poorly monitored due to lack of adequately equipped and staffed laboratories. There is also a major gap in the protection of rights of PLWHAs and PABAs which still needs to be tackled, including the removal of stigmatisation and discrimination. Nigeria has now the largest number of orphans currently in the world according to a UNAIDS report and yet orphan care is still very inadequate and will require further attention.

T.B

The major programmatic and funding gaps for effective DOTS coverage in Nigeria had been: the lack of resources to provide the anti-tuberculosis drugs for the 16 non-DOTS states, training of general health care staff including laboratory staff, upgrading of laboratory system, equipment and reagents. Other gaps include the inadequacy of resources to ensure effective monitoring and supervision of field activities. The Global Drug Facility has now, in the interim, reduced the gap for anti-TB drugs by awarding drugs for 33,000 patients. The Government has pledged increased budgetary allocation for the coming years. If the other non-drug gaps are closed by the GFATM, it will ensure achievement of country wide DOTS coverage with effective tuberculosis and HIV/AIDS care.

MALARIA

Government has expressed strong political commitment to the control of malaria through financial allocation and advocacy campaigns including the budget of US$19.5million from 2000 to 2003 to RBM implementation and scaling up the use of ITNs. Partners have also contributed to malaria control activities for the same period as follows: WHO (1,603,000), UNICEF (US$1,800,000), DFID (US$ 2,000,000) USAID/BASIC (US$100,000). These commitment amounts to US$ 26,000,000 but US $41,000,000 are needed for year 2003 and US$ 33,700,000 for year 2004 (as in the Strategic plan) for the big size of the country. A funding gap of US$ 15,000,000 is needed for the year 2003 alone. The proposal is therefore seeking funds from the Global Fund to scale up the implementation of proposed interventions in 222 LGAs in twelve additional states.

SECTIONS IV – VIII: Detailed information on each component of the proposal

PLEASE COMPLETE THE FOLLOWING SECTIONS FOR EACH COMPONENT
Please copy sections IV – VIII as many times as there are components

Please note: a component refers to a disease, i.e. your proposal will have more than one component only if it covers more than one disease. There should only be 1 component per disease.

If there are any objectives or broad activities within a particular component that are of a system-wide/cross-cutting nature such as capacity building or infrastructure development that may go beyond the scope of that particular component, please indicate those aspects clearly and specify how they would relate to other components of the proposal when detailing them in Question 27. (Guidelines para. IV.47 – 49)

If this is a fully integrated proposal, where two or more components are linked in such a way which would not make it realistic or feasible to separate, mark the boxes in Table IV.23 to identify all diseases which would be directly affected by this integrated component. (Guidelines para. 50)

SECTION IV – Scope of proposal

23. Identify the component that is detailed in this section (mark with X):

Table IV.23

Component (mark with X)**:**	**X**	**HIV/AIDS**
		Tuberculosis
		Malaria
		HIV/TB

24. Provide a brief summary of the component **(Specify the rationale, goal, objectives, activities, expected results, how these activities will be implemented and partners involved) (2–3 paragraphs):**

Rationale:

The prevalence of HIV/AIDS in Nigeria is increasing at an alarming rate - from 0.09% in 1986 to 4.5% in 1996 and 5.8% in 2001. This calls for an urgent scaling-up of response activities to reduce the transmission of HIV/AIDS through preventive interventions. The high burden of disease as illustrated by the 170,000 persons estimated to have died of AIDS in 2001confirms the need for increased care and support for the infected and the sick. Presently, there is a high level of denial, stigmatization and discrimination of PLWHAs in the Nigerian society due to lack of accurate information on HIV/AIDS amongst leaders and the general public. Furthermore, it is established that religious and cultural factors play key role in our countries in facilitating the spread of the disease. Therefore, our national response must at this stage consider boosting the role of religious and traditional leaders in our communities. In addition, the relatively weak supportive and enabling environment for HIV/AIDS control activities particularly at state, local government and community levels creates a barrier for intervention, which calls for immediate attention.

In 2001, the Federal Government of Nigeria (FGN) developed a HEAP document to guide the national response to fight HIV/AIDS This shows adequate attention at the highest level, with the President of the country personally involved through the supervision of activities of the National Action Committee on AIDS (NACA) Despite these efforts, interventions still remain concentrated at the centre. This creates a major gap at the grass root level where the majority of the population lives. There is therefore an urgent need to further decentralize HIV/AIDS control activities and ensure greater involvement of all key players particularly the civil society organizations (CSOs)

and PLHWAS in implementing these interventions. It is expected that this proposal with a focus on both preventive interventions and support for PLWHAs at the grassroots will help in reducing the occurrence of new cases and mitigate the impact of HIV/AIDS on the country and its citizenry. The strengthening of support groups is a major mechanism for reaching the affected and strengthening them. Networks of PLWHAs exists and are coordinating mechanisms for support groups at community and state levels in the country. With recent emphasis on greater involvement of affected persons in the decision-making process and program development and implementation, it is believed that strengthening the networks will enable PLWHAs to play a greater role in improving the quality of life of PLWHAs in Nigeria.

The present low availability of ARV drugs, high rate of poverty and the relatively poor state of the health system to absorb all AIDS patients means that most PLWHAS will rely on receiving treatment at home. Others, as a result of poverty, will not be able to afford hospital based care. This explains the need for increased provision of home-based care as the epidemic progresses. Except adequate efforts are made, Nigeria's HIV/AIDS infection rate will continue to grow and this will have severe consequences for the African region and the World as whole since Nigeria ranks amongst the most populated and high density countries in the World that has the potential of swelling the global HIV/AIDS infected population. Recent estimates show that Nigeria's HIV/AIDS population could reach 10- to 15- million by the year 2010 if adequate actions are not taken.

GOAL: To reduce the transmission of HIV/AIDS in Nigeria by 30% by the year 2007, increase the population of PLWHAs receiving adequate treatment and mitigate the impact of HIV/AIDS in Nigeria.

OBJECTIVES:

1. To create an enabling and supportive environment for the implementation of HIV/AIDS preventive and care and support interventions in the country by the year 2004.
2. To reduce the present level of discrimination and stigmatization of PLWHAs by the general public and health care providers by 50% by 2007.
3. To increase awareness and provide the entire population with accurate information on HIV/AIDS by the year 2007.
4. To increase condom usage by 80% by the year 2007.
5. To establish additional 200 voluntary counselling and confidential testing (VCCT) centres throughout the country by the year 2007.
6. To provide access to quality home and community based care services to at least 30% of communities in Nigeria by 2007
7. To provide income generating activities to PLWHA and PABAs and establish linkages with support groups and the Poverty Eradication Programmes (PEP) within each state of the Federation by 2007.
8. To provide care and support for orphans and vulnerable children (OVC) in at least 20% of the LGAs by the year 2007.
9. To strengthen capacity of health workers, community members including PLWHAs; health and non-health workers, faith based organizations, NGOs to implement preventive and care and support interventions by the year 2007.
10. To provide Nigeria with laboratory capacity to monitor and evaluate patients on the national anti-retroviral therapy (ART) program.

BROAD ACTIVITIES:

1. Enhance advocacy, sensitization and mobilization activities on HIV/AIDS at all levels including (policy and law makers (federal, state and local government levels), professional bodies, community and religious leaders and private sector.
2. Educate and sensitise the general public, health workers and employers of labour on the rights of PLWHAs.
3. Expand and strengthen public enlightenment campaigns on HIV prevention to the general population including vulnerable and high-risk groups.

4. Scale-up behaviour change and communication interventions amongst high-risk groups and general population and empower women and youth with skills for negotiating safer sex.
5. Provide voluntary counselling and confidential testing (VCCT) services to the general population.
6. Establish support groups for PLWHAs and PABAs at community level.
7. Empower PLWHAs economically through skills acquisition and income generating activities.
8. To provide education and health services and nutritional support for orphans and vulnerable children.
9. Train and retrain health workers, non-health workers including PLWHAs, volunteers, community, non-governmental and governmental organizations involved in HIV preventive and community care interventions in the country.
10. Establish HIV/AIDS response groups within the Christian Association of Nigeria (CAN) and Supreme Islamic Council of Nigeria (SICN).
11. Establish six additional zonal reference laboratories which are adequately equipped to monitor all patients on ART.
12. Equip and train and retrain laboratory personnel and provide them with skills for laboratory monitoring of patients on ART.

EXPECTED RESULTS:

1. Informed HIV/AIDS policies and legislations enacted at all levels (federal, state and local government and private sector).
2. A reduction in the stigma and discrimination of PLWHAs and the creation of a conducive environment for open discussion on HIV/AIDS and related issues.
3. An increased knowledge on HIV/AIDS prevention amongst the general population.
4. A reduction in high-risk behaviour in the general population.
5. An increased accessibility and uptake of VCCT services in the country.
6. An improved capacity of health and non-health workers including volunteers, community, civil society, non-governmental and governmental organizations and private sector to implement HIV/AIDS preventive and care and support interventions.
7. An improved quality of life for PLWHAs and PABAs.
8. An improved quality of life for OVC.
9. Adequately equipped laboratories with well trained personnel to monitor the expanded ART program in Nigeria.
10. Established Faith-Based response groups on AIDS with improved capacity to design, plan and implement and evaluate programs.

PARTNER INVOLVEMENT:

In Nigeria, through NACA, all partners are involved and this include the network of PLWHAs, Civil Society Organizations (CSO) including FBOs, CBOs, women, governmental and non-governmental organizations, private sector as well as research institutes and universities. The activities of these important partners are fully supported by the Developmental partners existing in the country. These partners help design, plan, implement and evaluate interventions strategies in their various areas of specialization.

25. Indicate the estimated duration of the component: 5 years

Table IV.25

From (month/year):	**January 2003**	**To** (month/year):	**December 2007**

26. Detailed description of the component for its FULL LIFE-CYCLE:

Please note: Each component should have ONE overall goal, which should translate into a series of specific objectives. In turn each specific objective should be broken-down into

a set of broad activities necessary to achieve the specific objectives. While the activities should not be too detailed they should be sufficiently descriptive to understand how you aim to achieve your stated objectives.

***Indicators**: In addition to a brief narrative, for each level of expected result tied to the goal, objectives and activities, you will need to identify a set of indicators to measure expected result. Please refer to Guidelines paragraph VII.77 – 79 and Annex II for illustrative country level indicators.*

***Baseline data**: Baseline data should be given in absolute numbers (if possible) and/or percentage. If baseline data is not available, please refer to Guidelines paragraph VII.80. Baseline data should be from the latest year available, and the source must be specified.*

***Targets**: Clear targets should be provided in absolute numbers (if possible) and percentage.*

For each level of result, please specify data source, data collection methodologies and frequency of collection.

An example on how to fill out the tables in questions 26 and 27 is provided as Annex III in the Guidelines for Proposals

Nigeria ranks among the countries with high level of HIV/AIDS and the high burden of disease as illustrated has the great potential to destroy the gains the country made in the recent past. In 2001, the Federal Government of Nigeria (FGN) developed a HEAP document to guide the national response to fight HIV/AIDS Despite these efforts, interventions still remain concentrated at the centre. This creates a major gap at the grass root level where the majority of the population lives. The present low availability of ARV drugs, high rate of poverty and the relatively poor state of the health system to absorb all AIDS patients means that most PLWHAS will rely on receiving treatment at home. Others, as a result of poverty, will not be able to afford hospital based care. This explains the need for increased provision of home-based care as the epidemic progresses. Except adequate efforts are made, Nigeria's HIV/AIDS infection rate will continue to grow and this will have severe consequences for the African region and the World as whole since Nigeria ranks amongst the most populated and high density countries in the World that has the potential of swelling the global HIV/AIDS infected population. Recent estimates show that Nigeria's HIV/AIDS population could reach 10- to 15- million by the year 2010 if adequate actions are not taken.

The above is the reason why the proposal focuses on both preventive interventions and support for PLWHAs at the grassroots will help in reducing the occurrence of new cases and mitigate the impact of HIV/AIDS on the country and its citizenry. With recent emphasis on greater involvement of affected persons in the decision-making process and program development and implementation, it is believed that strengthening the networks will enable PLWHAs to play a greater role in improving the quality of life of PLWHAs in Nigeria.

See below for the details (26.1 ands 27) for more detailed presentation of the overview and the

26.1. Goal and expected impact (Describe overall goal of component and what impact, if applicable, is expected on the targeted populations, the burden of disease, etc.), (1–2 paragraphs):

Please note: the impact may be linked to broader national-level programmes within which this component falls. If that is the case, please ensure the impact indicators reflect the overall national programme and not just this component.

Please specify in Table IV.26.1 the baseline data. Targets to measure impact are only required for the end of the full award period.

The overall goal of the proposal is to reduce the transmission of HIV infection in the population and increasing care and support services provided to the PLWHAs. This dual goal is based on the fact that all should have access to health care in the country. The provision of knowledge to the general population on behaviour that protects from HIV infection is as important as the provision of care for those already affected. The goal is linked to the national main objective of reducing the prevalence of HIV in Nigeria by the year 2010 (draft of National policy on HIV/AIDS and STI).

Table IV.26.1

Goal:	**To reduce the prevalence of HIV/AIDS in Nigeria by 30% by the year 2007 and mitigate the impact of HIV/AIDS in Nigeria.**	
Impact indicators *(Refer to Annex II)*	**Baseline** **Year: 2001**	**Target** (last year of proposal) **Year: 2007**
Prevalence of HIV infection in Nigeria	**5.8% (2001)**	**4.0%**
Prevalence of HIV amongst young population aged 15-24 in Nigeria	**6.0% (2001**	**2.5%**
An increase in survival rate of PLWHAS	1 year (presumed: based on research in developing countries)	3 years

27. Objectives and expected outcomes (Describe the specific objectives and expected outcomes that will contribute to realizing the stated goal), (1 paragraph per specific objective): *Table IV.27*

OBJECTIVE 1 This objective is aimed at creating an enabling and supportive environment for carrying out effective HIV interventions. It requires that leaders in the community at all levels are in support of the programs and the methodology for their implementation. They therefore need to be consulted at the early stages to garner their support for strategies to be adopted and help in designing intervention programs

Objective 1:	**To create an enabling and supportive environment for the implementation of HIV/AIDS preventive and care and support interventions in the country by the year 2004.**				
Outcome/coverage indicators *(Refer to Annex II)*	**Baseline** **2003**	**Targets** **2004**	**2005**	**2006**	**2007**
No. of political, religious, traditional leaders openly discussing and supporting HIV/AIDS program	*	20%	50%	25%	100%
Amount of resources allocated to HIV/AIDS programs	**$7,000,000**	$15,000,000	$15,000,000	$15,000,000	$15,000,000
No. Of institutions (government, CSOs and private) developing HIV/AIDS policies	*	12	18	24	37
No. of HIV/AIDS legislation enacted by law makers at federal and state level (36 states + federal govt)	3 (10%)	10 (33%)	20 (50%)	24 (66%)	37 (100%)

*** Baseline information to be determined by survey**

OBJECTIVE 1 ACTIVITIES: The persons targeted are the leaders at all levels of the government and community including opinion leaders, religious leaders and professional groups. It will be necessary to develop advocacy packages that target these various groups. These packages will include handbills, posters, booklets, and books, e.t.c. It will also include presentations, and advocacy visits and the organizations of seminars and workshops especially for professional groups. Special efforts will be made to develop such sessions for policy makers and legislators to inform them on the key issues in the present HIV/AIDS epidemic.

Table IV.27.1

Objective 1:	**To create an enabling and supportive environment for the implementation of HIV/AIDS preventive and care and support interventions in the country by the year 2004.**				
Broad activities	**Process/Output** **Indicators** (indicate one per activity) *(Refer to Annex II)*	**Baseline** **2003**	**Targets** **2004**	 **2005**	**Responsible/Implementing agency or agencies**
1. Develop advocacy packages for use by policy makers, law makers, private sector, community leaders at various levels	Number and type of advocacy packages developed	**0**	100,000 posters/hand bills/booklets	200,000 posters / handbills/booklets	National assembly response to AIDS (NASSRA) CBOs, FBOs and NGOs
2. Sensitize policy and law makers, private sector and community leaders at federal and state levels on HIV/AIDS	Number of sensitization visits	**0**	274	274	NASSRA CBOs, FBOs and NGOs
3. Sensitize community and religious leaders at the community level	Number of sensitization visits	**0**	370	370	NASSRA CBOs, FBOs and NGOs

OBJECTIVE 2: This objective aims at reducing the negative attitudes expressed to PLWHAs and reduce the stigma which leads to concealment and fear dissipates. This will allow for a positive attitude towards those affected by HIV/AIDS. The expected outcome is a conducive environment for open discussion on AIDS, increased uptake of VCCT services and a better uptake the PMTCT /ARV programme. This should lead to the general population having more positive attitudes towards PLWHAs and the PLWHAs also openly admitting their HIV status.

Table IV.27

Objective: 2	**To reduce the stigmatisation and discrimination against people living with HIV/AIDS by 30% by 2007 years**				
Outcome/coverage indicators	**Baseline**	**Targets**			
(Refer to Annex II)	**2003**	**2004**	**2005**	**2006**	**2007**

Percent of people expressing positive attitudes towards PLWHAs	50% (SFH study)	60%	70%	75%	75%
Percent of PLWHAs expressing positive attitudes from the general public	To be provided through a study	50%	60%	65%	70%

OBJECTIVE2 ACTIVITIES: This objective aims at reducing stigmatisation and this is intended to be achieved through the use of effective IEC materials. Initially a survey shall be undertaken by a consultant to determine the major areas of discrimination and the reasons for this. meetings with policy makers, legislators, community leaders, health care workers, employees of labour and their representative bodies. Open discussion on the rights of PLWHAs and PABAs will be encouraged and mass media campaigns that address this same issue will be pursued rigorously. The mass media campaign strategy will use all media tools such as the television, radio and newspapers. Religious leaders will be encouraged to talk about AIDS and PLWHAs and to stress the rights of PLWHAs. Campaigns including rallies will be undertaken to raise awareness of PLWHAs' rights. Lastly handbills and posters will be designed to advocate for the rights of PLWHAs

Table IV.27.1

Objective 2	**To reduce the stigmatisation and discrimination against people living with HIV/AIDS**				
Broad activities	**Process/Output indicators** (indicate one per activity) *(Refer to Annex II)*	**Baseline**	**Targets**		**Responsible/Implementing agency or agencies**
		2002	**2003**	**2004**	
Survey of level of stigmatisation and discrimination expressed towards PLWHAs	Results of study	**0**	1	0	NNPLWHAS FMOH
Advocacy meetings to policy and law makers, community, and religious leaders, on HIV/AIDS and human rights	No of visits to community and religious leaders	**0**	140	140	NELA, NPHCDA SMLAS FMOH
Advocacy meetings to employers of labour	No of visits to companies and employers of labour	**0**	37	37	CRH FMOL&P FMOH
Advocacy meetings to health care providers and their professional bodies	No of visits to health of providers and their professional bodies	**0**	37	37	CRH
The development of IEC materials for the general public	No of handbills/brochures/booklets that are developed	**0**	4	2	NELA, CRH, Nigeria Baptist Convention, Mass Media
The distribution of IEC materials to the general public	No of brochures that are distributed	**0**	100,000	100,000	NELA, CRH, Nigeria Baptist Convention
Mass media campaign over radio/TV	No of programmes that are held	**0**	15	15	Media houses, NELA,
Outreaches into communities through door-to-door campaigns	No of outdoor campaigns held	**0**	36	36	Nigeria Baptist convention,
Training of health care providers on HIV issues	# of health care providers that attend training sessions	**0**	8	8	ROH

OBJECTIVE 3: The major drive of this objective is to ensure that the general public is empowered with the accurate knowledge to protect themselves against getting infected with HIV/AIDS. It is believed that through mass media campaigns it will be possible to adequately inform the public on HIV/AIDS issues. The outcome should be an informed public on HIV/AIDS issues.

Table IV.27

Objective 3:	**To increase the awareness and knowledge of the general population with accurate information on HIV/AIDS**				
Outcome/coverage indicators *(Refer to Annex II)*	**Baseline**	**Targets**			
	2003	**2004**	**2005**	**2006**	**2007**
1. Percentage of population who both correctly identify ways of transmitting HIV/AIDS (by age and gender)	*	60%	70%	80%	90%
2. Percentage of population who both correctly identify ways of preventing HIV/AIDS (by age and gender)	*	60%	70%	80%	90%
3. Percentage of population who reject major misconceptions about HIV/AIDS transmission (by age and gender)	*	60%	70%	80%	90%

***Baseline data to be derived from behaviour sentinel survey which is to be done by the end of the year 2002/2003 by the Government**

OBJECTIVE 3 ACTIVITIES: The objective will be achieved through the conduction of mass media campaigns and the targeting of high risks groups such as youths, long distance drivers, and the military and para-military through outdoor dramas, lectures and campaigns including seminars. Studies will be undertaken by consultants to determine the areas of ignorance and misinformation. This will then be used to develop IEC materials that will be distributed widely to achieve the desired level of knowledge.

Table IV.27.1

Objective 3	**To increase the awareness and knowledge of the general population with accurate information on HIV/AIDS**				
Broad activities	**Process/Output** **Indicators** (indicate one per activity) *(Refer to Annex II)*	**Baseline**	**Targets**		**Responsible/Implementing agency or agencies**
		2002	**2003**	**2004**	
1. Conduct public enlightenment campaign through drama, lectures, seminars	Number of public campaigns	*	820	1640	CBOs, FBOs, NGOs, and Government agencies Media NGOs
2. Conduct public enlightenment campaign through multi media approaches e.g. radio, TV	(airtime on radio) (Air time TV programmes)	*	**4 hours/week** **2 hours/week**	**4 hours/week** **2 hours/week**	Media NGOs
3. Develop, print and distribute IEC materials	Number of IEC materials developed and distributed	*	370,000	555,000	CBOs, FBOs, NGOs, and Government agencies

*** Baseline to be determined by study**

Objective 4: The reduction in the transmission of HIV/AIDS transmission. While targeting the general public particular attention will be made to focus on high risk groups such as youths (15 – 24 years). The main focus of the behaviour change activities will be to delay the onset of sexual intercourse and the ability to negotiate safe sex.

Table IV.27

Objective 4:	**To increase behaviour changes towards safer sexual practices by 20% in the general population and in high-risk groups 30% by the year 2007.**				
Outcome/coverage indicators *(Refer to Annex II)*	**Baseline**	**Targets**			
	2003	**2004**	**2005**	**2006**	**2007**
Percentage of young population aged (15-24) that have delayed first sexual contact	*	5%	10%	15%	20%

Percentage of young population aged 15-24 reporting the use of condom during sexual intercourse with a non-regular partner	*	5%	10%	15%	20%
Percentage of female sex workers (FSWs) reporting use of condom with most recent client	*	5%	10%	15%	20%

*** Baseline information to be obtained from proposed BSS (Federal Ministry of Health)**

27.3.2 Broad activities related to each specific objective and expected output

Objective 4 ACTIVITIES: The main focus of the behaviour change activities will be to delay the onset of sexual intercourse amongst the youths , increase the ability of youths especially females to negotiate safe sex and the teaching of safe sex practices, including the use of condoms. Though targeting the general public particular attention will be made to focus on high risk groups such as youths (15 – 24 years) and women.

To achieve this, a KABP survey will be undertaken to determine the present practices in the communities. The results will then be used to develop curricula for peer education programmes, training of females and males to negotiate safe sex.
The use of condoms will be emphasised to other high risk groups. This will include the creation of a distribution channel for obtaining condoms for the persons at the grassroots using voluntary health workers.

Table IV.27.1

Objective 4:	**To increase behavioural changes towards safer sexual practices by 20% in the general population especially in high-risk groups by the year 2007.**				
Broad activities	**Process/Output** **Indicators** (indicate one per activity) *(Refer to Annex II)*	**Baseline** **2003**	**Targets** **2003**	**2004**	**Responsible/Implementing Agency or agencies**
1. Knowledge, attitudes, behaviour and practice (KABP) survey amongst general population	Survey report (population survey)	*	*	completed	FMOH
2. Establishment of training programme for peer education	Number of peer educators trained	*	15000	30000	CBOs, FBOs, NGOs, Youth and Government Agencies
3. Training of women, girls and youths in life skills and negotiating safe sex	Number of women, girls trained in life skills	*	15000	30000	CBOs, FBOs, NGOs, Youth and Women organizations, Government Agencies
4. Distribution of condoms to the community	Number of condoms distributed	*	77,083,375	77,083,375	CBOs, FBOs, NGOs, Youth and Women organizations, Government Agencies

*** Baseline information to be obtained**

27.4.1 Objectives and expected outcomes (Describe the specific objectives and expected outcomes that will contribute to realizing the stated goal), (1 paragraph per specific objective):

OBJECTIVE 5: The aim of VCCT centres will be to ensure that persons desiring to know there HIV status may easily do so with adequate pre- and post testing counselling. It will also increase the uptake for ARV/PMTCT programme.

Objective 5:	**To establish 200 voluntary counselling and testing (VCCT) centres by the year 2007.**				
Outcome/coverage indicators	**Baseline**	**Targets**			
(Refer to Annex II)	**2003**	**2004**	**2005**	**2006**	**2007**
Number of VCCT centres established	40	80	120	160	200
Number of clients counselled	144,000	288,000	432,000	576,000	720,000
Number of counselled clients accepting to be tested for HIV	14,000	28,800	43,200	57,600	72,000

27.4.2 Broad activities related to each specific objective and expected output
(Describe the main activities to be undertaken, such as specific interventions, to achieve the stated objectives) (1 short paragraph per broad activity):

OBJECTIVE 5 ACTVITIES:
The setting up of VCCT centres will commence with identification of institutions that will be used for the VCCT activities. The staff from these institutions will then be trained in the art of counselling. Furthermore, the laboratories will be equipped with adequate equipment and specific reagents supplies for conducting the necessary tests. The laboratory staff will also be trained to conduct the these tests.

Objective 5:	**To establish 200 voluntary counselling and testing (VCCT) centres by the year 2007.**				
Broad activities	**Process/Output Indicators** (indicate one per activity) *(Refer to Annex II)*	**Baseline**	**Targets**		**Responsible/Implementing Agency or agencies**
		2003	**2004**	**2005**	
Training of counsellors in VCCT	Number of counsellors trained	1,200	2,400	3,600	CSOs, NGOs, FBOs, AGPMPN, NNPLWHA, NPHCDA,
Training of laboratory staff on HIV testing	Number of lab staff trained	300	600	900	NGOs, FBOs, AGPMPN, NNPLWHA, NPHCDA
Provision of HIV test kits	Number of HIV test kit supplied	120,000	240,000	360,000	NGOs, FBOs, AGPMPN, NNPLWHA, NPHCDA
Provision of counselling services	Number of clients counselled	40,000	80,000	120,000	CSOs, NGOs, FBOs, AGPMPN, NNPLWHA, NPHCDA
Provision of testing services	Number of counselled clients testing for HIV	30,000	60,000	90,0000	NGOs, FBOs, AGPMPN, NNPLWHA, NPHCDA
Awareness creation activities on VCCT services	Number of awareness activities	400	600	800	CSOs, NGOs, FBOs, AGPMPN, NNPLWHA, NPHCDA

N/B – Additional counsellors will be trained by CBOs, NGOs, FBOs etc from within the community and counselled clients will be referred to VCCT centres.

OBJECTIVE 6: This objective intends to increase access of PLWHAs to community and home based health care services. This will include the setting up of support groups and the provision of home based health care services using these groups working in

partnership with the local government health care services (primary health care centres). The expected outcome is the increase of survival rate of PLWHAs as access to healthcare is increased.

Table IV.27

Objective: 6	**To provide access to quality home-based care services to PLWHAs in at least 30% of LGAs in Nigeria by 2007**				
Outcome/coverage indicators	**Baseline**	**Targets**			
(Refer to Annex II)	2003:	**2004**	**2005**	**2006**	**2007**
% of local government areas with effective home-based care services	22 (3%)	100(13%)	150(19%)	200 (26%)	250 (30%)
No of support groups formed	22 (3%)	100(13%)	150(19%)	200 (26%)	250 (30%)

OBJECTIVE 6: ACTIVITIES:

The implementation of this objective will start with a baseline survey on the access of PLWHAs to health care. This will then be used to develop both the curricula for teaching the home care providers and the planning and mapping out of the programme.
The home based care providers will be trained mainly by the National Primary Healthcare Development Agency (NPHCDA) and NGOs. They will include PHC workers and volunteer workers in the community and members of CBOs and NGOs.
The setting up of home based care services will then be undertaken including the provision of home based kits, creating awareness on the availability of the services.
The services will gradually be scaled-up and will include the provision of treatment for opportunistic infections, provision of nutritional supplements and regular home visits.

Table IV.27.1

Objective 6	**To provide access to quality home-based care services to at least 30% of communities in Nigeria by 2007**				
Broad activities	**Process/Output indicators** (indicate one per activity) *(Refer to Annex II)*	**Baseline**	**Targets**		**Responsible/Implementing agency or agencies**
		2003	**2004**	**2005**	
Baseline survey on health care needs and access of PLWHAs to home-based care services	Result of study to be carried out	*	completed	completed	NPHCDA, NNPLWHAS
Training of care providers on home based care	# of care providers trained	1750	3500	3500	UACO, NELA, WACOP NPHCDA, FMOH, NACA, CISGHAN, UN agencies. Catholic ACA SMLAS
Provision of home–based care kits	# of kits provided	100,000	100,000	100,000	UACO, NNPLWHAS SMLAS
Creating awareness of availability of home – based care	# of awareness-creating sessions	100	200		SMLAS, UACO, WACOP, Catholic ACA
Home visits	# of home visits	*	*	*	NELA, NNPLWHAS, WACOP

Provision of nutritional supplements for PLWHAs	# of PLWA receiving nutritional supplements	**1000**	2000	3000	Catholic ACA, Baptist convention, SMLAS
Treatment of opportunistic infections (OI)	# of PLWHAs receiving treatment for OIs	**10000**	20,000	30,000	SMLAS, NNPLWHAS,

OBJECTIVE 7:
The aim of this proposal is to increase the ability of PLWHAs and PABAs to cope with the economic burden of HIV/AIDS. This will be addressed by equipping the PLWHAs and PABAs with skills to ensure that, to a certain extent, they are self sufficient. Poverty is a known factor that worsens the plight of PLWHAs and therefore this objective intends to attain the reduction of the effects of poverty on these groups.

Table IV.27

Objective:7*	**To provide income generating activities to PLWHAs and PABAs and establish linkages with support groups and Poverty Eradication Programmes (PEP) within each state of the Federation by 2007.**				
Outcome/coverage indicators	**Baseline**	**Targets**			
(Refer to Annex II)	**2003**	**2004**	**2005**	**2006**	**2007**
# of local governments with IGAs established	*	4 (10%)	12 (33%)	24 (66%)	36.(100 %)

OBJECTIVE 7: ACTIVITIES:
PLWHAs will be trained and retrained based on their skills to engage in income generating activities to ensure a degree of self sufficiency. The implementation of this activity will start with a baseline study in communities to determine the best form of activities that could suit individuals as well as skills possessed in the community. Skills that can be learnt will be taught. Later micro credit schemes will be started where possible. In other income generating activities, seed grants will be used to commence the activities. At the same time to ensure a positive attitude to life counselling and skills for living will be undertaken.

Table IV.27.1

Objective:7	**To provide income generating activities to PLWHA and PABAs and establish linkages with other support groups and Poverty Eradication Programmes (PEP) within each state of the Federation by 2007.**				
Broad activities	**Process/Output indicators** (indicate one per activity) *(Refer to Annex II)*	**Baseline**	**Targets**		**Responsible/Implementing agency or agencies**
		2003	**2004**	**2005**	
Baseline study on skills of PLWHAS	Report of study	*			UACO, NNPLWHAs
Baseline inventory of LGAs with IGAs for PLWHAS	Report of study	*	*	*	NPHCDA, NNPLWHAs
Income generating activities identified and established	# of IGAs identified that PLWHAs that easily engage in	*	18	18	NNPLWHAs, Children of Hope,
Skills acquisition training	# of PLWHAs trained to acquire new skills	**6000**	12000	18000	, UACO, WACOP, ROH, SMLAS
Micro credit scheme established for the purpose of starting IGAs	# of people who benefit from micro credit scheme	**12950**	25900		NNPLWHAs, SMLAS
Training of PLWHAS on life skills on living with HIV	# of PLWHAs who receive counselling for positive living	*	350	650	NNPLWHAs

OBJECTIVE 8:
Though it is possible to make some PLWHAs and PABAs self sufficient, it is not possible in all cases and certainly not immediately. Therefore it is important to provide support for them; for some temporarily and for others on a long term basis. This objective aims to reduce the effects of the epidemic on the PABAs especially vulnerable children. The

outcome should be a reduction in the street children, orphans and the social ills associated with this.

Table IV.27

Objective 8:	**To provide education and health services and nutritional support for orphans and vulnerable children within 2 LGAs per state by the year 2007.**				
Outcome/coverage indicators *(Refer to Annex II)*	**Baseline**	**Targets**			
	2003	**2004**	**2005**	**2006**	**2007**
a reduction in the number of orphans and street children	result of baseline study* obtained	Completed			
a reduction in the % of malnourished children (0 – 4 years)	Baseline				
A reduction in the school absentee rate/dropouts	result of study				

***Baseline study**

OBJECTIVE 8: ACTIVITIES

The provision of support for the needy is an inherent activity in most Faith based institutions and usually this could include the provision of resources to improve survival. This objective shall be supported mainly by the faith based organisations by using funds available to them to support the education of the needy children; the provision of food supplements to the needy and shelter for the homeless.

Table IV.27.1

Objective 8	**To provide education and health services and nutritional support for orphans and vulnerable children within 2 LGAs per state by the year 2007.**				
Broad activities	**Process/Output indicators** (indicate one per activity) *(Refer to Annex II)*	**Baseline**	**Targets**		**Responsible/Implementing agency or agencies**
		2003	**2004**	**2005**	
Provision of school fees, uniform and books	# of OVC receiving educational support		400	1200	Faith Based Community Action Committee on AIDS (CACA)
Provision of nutritional support	# of OVC receiving educational support		500	1000	Faith Based Community Action Committee on AIDS (CACA)

OBJECTIVE 9: One of the greatest hindrances to the country's fight against HIV/AIDS is the scarcity of technical personnel capable of designing, implementing, controlling and monitoring programmes efficiently and effectively at the State and local government level, in particular. Therefore this objective aims to develop the in-country capacities to improve this situation. The staff of the various organizations in the country, including government workers, health personnel, NGOs, CBOs, FBOs, Networks of PLWHAs, Women and youth organizations will therefore be trained to carry out their respective functions efficiently. With recent emphasis on greater involvement of PLWHAs in the decision-making process and program development and implementation, it is believed that strengthening the networks will enable them play their role in contributing to improvement of quality of life of PLWHAs in Nigeria

Objective 9:	To strengthen capacity of health and non-health workers, including PLWHAs, community based, faith based, non-governmental and governmental organizations to implement HIV interventions by the year 2007.

Outcome/coverage indicators	Baseline	Targets			
(Refer to Annex II)	2003	2004	2005	2006	2007
% OF LGA in which PHC workers are trained to carrying out HIV interventions	*	25%	50%	75%	100%
No. of non-health workers carrying out HIV interventions	300	450	600	900	1,200

***Baseline study to be carried out**

OBJECTIVE 9 ACTIVITIES:
The development of the curricula will be developed by the NGOs in collaboration with developmental partners, consultants and NGOs after studies to determine the needs of the various organisations. Then training sessions will be undertaken to initially train trainers who will then train other workers. Retraining will occur 2-yearly to ensure that gains made are not lost.

Objective 9	To strengthen capacity of community members including PLWHAs, health and non-health workers community based, faith based, non-governmental and governmental organizations to implement preventive and care and support interventions by the year 2007.

Broad activities	Process/Output	Baseline	Targets		Responsible/Implementing
	Indicators (indicate one per activity) (Refer to Annex II)	2002	2003	2004	Agency or agencies
Development of curricula for training of health and non-health personnel	No of curricula developed	*			
Training of health workers in preventive interventions	No. of health workers trained	*	8,750	17,500	NGOs, FBOs, NNPLWHA, NPHCDA, AGPMPN
Training of non-health workers in preventive interventions and program management	No. of non-health workers trained	*	600	1200	CSOs, NGOs, FBOs, NNPLWHA, NPHCDA, AGPMPN

*** Baseline year**

Objective 10:

The monitoring of the ART program requires an effective laboratory service. This objective aims to acquire this through ensuring access of effective laboratory services in each of the six zones of the country.

Table IV.27

Objective 9:	**To provide Nigeria with the capacity to assess and monitor patients on the national anti-retroviral program (ART) program**				
Outcome/coverage indicators *(Refer to Annex II)*	**Baseline**	**Targets**			
	2003	**2004**	**2005**		
Number of reference centres with adequate facilities and well trained personnel for assessment and monitoring of ART.	**2**	5	8		

OBJECTIVE 10 ACTIVITIES:
The main activities will be the upgrading of the 2 existing laboratories and establish 6 reference laboratories. The staff will be trained in the use of the modern methodologies and techniques. The laboratories will be chosen to reflect the six zones of the country for equity and spread and will be based on the technical capacity of the present staff, the state of the laboratories and the burden of HIV in the community. This will improve the quality of the ART project approved by the GF ATM.

Table IV.27.1

Objective 10	**To provide Nigeria with the capacity to assess and monitor patients on the national anti-retroviral program (ART) program**				
Broad activities	**Process/Output indicators** (indicate one per activity) *(Refer to Annex II)*	**Baseline**	**Targets**		**Responsible/Implementing agency or agencies**
		2003	**2004**	**2005**	
Upgrade 2-National reference centres (NIPRD&NIMR)	Number of reference centres upgraded	**2**	2	2	NIPRD, Abuja NIMR, Lagos and four University Teaching Hospitals laboratories
Establish 6 additional zonal reference centres	Number of reference centres established	**0**	3	6	NIPRD, Abuja NIMR, Lagos and four University Teaching Hospitals laboratories
Provide laboratory equipment and reagent.	Number of centres adequately equipped	**0**	3	6	NIPRD, Abuja NIMR, Lagos and four University Teaching Hospitals laboratories
Train laboratory personnel on CD4/CD8 and viral load	Number of laboratory personnel trained	**2**	10	16	NIPRD, Abuja NIMR, Lagos and four University Teaching Hospitals laboratories
Monitor patients on ART program for CD4/CD8 and viral load	Number of patients on ART program monitored for CD4/CD8 and viral load	**30%**	40%	60%	NIPRD, Abuja NIMR, Lagos and four University Teaching Hospitals laboratories

28. Describe how the component adds to or complements activities already undertaken by the government, external donors, the private sector or other relevant partner: (e.g., does the component build on or scale-up existing programs; does the component aim to fill existing gaps in national programs; does the proposal fit within the National Plan; is there a clear link between the component and broader development policies and programmes such as Poverty Reduction Strategies or Sector-Wide Approaches, etc.), (*Guidelines para. III.41 – 42*),(2–3 paragraphs):

The Federal Government designed a 3-year HIV AIDS Emergency Action Plan (HEAP) ***(See attachment 14)*** launched in 2001 with strategies that include the removal of socio–cultural and systemic barriers, catalyzing community-based response, preventive, and care and support interventions. However despite on-going efforts by the government and external donors, there are gaps in its implementation as activities are yet to reach the grass root level due to inadequate funds and technical capacity at the grass root level. Additionally Nigeria has obtained a grant from the GF ATM to expand ART programme and a World Bank loan to support its HIV/AIDS interventions. These programmes require adequate funding to make them effective. However, the funds available currently are insufficient to make a significant impact.
This proposal is designed to include strategies for advocating for a supportive environment at all levels and from donors of HIV/AIDS prevention and control activities. It aims at increasing the capacity of the CBOs and NGOs to effectively scale up existing HIV/AIDS interventions in line with the HEAP. This proposal therefore seeks to scale up the interventions and also bring activities closer to the grassroots thereby addressing existing inequalities. To guide the national response and implementation of the HEAP several Thematic Technical Support Groups have been formed at National level and this is comprised of NACA, Ministries, Donors, NGOs, as well as PLWHAs. This proposal will consult and collaborate with the responsible groups to ensure a nationwide harmonization in the implementation of activities and ensure a minimum standard of practice. Therefore, all components will be in line with and based on the national policy and guidelines.

The current ART in Nigeria is presently supported by two reference laboratories which are being funded solely by the Nigerian Government. With the ongoing expansion of Nigeria's ART program there is need to establish additional reference laboratories to effectively support the programme's expansion.

The Nigerian government has established a well articulated National Agency on Poverty Eradication Programme. (NAPEP) ***(See attachment 15).*** The NAPEP program aims at reducing poverty in the community through, amongst other strategies, a youth empowerment scheme which includes a capacity acquisition programme, a mandatory attachment programme and a credit delivery programme. Though the program does not target PLWHAs, they represent a considerable number of persons living below the poverty level. The income generating activities provided, in this proposal therefore will complement the government's efforts to address poverty.

29. Briefly describe how the component addresses the following issues (1 paragraph per item):

29.1. The involvement of beneficiaries such as people living with HIV/AIDS:
The main beneficiaries are the general population, PLWHAs and the vulnerable groups of women and children. Implementing partners include support groups of network of PLWHAs within the communities and many women organizations. Many of the CBOs and NGOs in Nigeria already have PLWHAs and women as active members. In addition organizations work very closely with women, youth, and high-risk groups in the implementation of activities. PLWHAs and women's organizations were involved in the proposal development and through wide consultation on priority areas, will be involved in providing services at the support group level and in the overall planning, implementation and evaluation of activities incorporated in the proposal.

29.2. Community participation:

Most of the implementing partners are community-based and draw their membership from volunteers within the communities. Advocacy targeted at community and religious leaders and legislators will assure active involvement of these leaders. Women and youth groups will involve their members in the implementation of their projects. Using culturally acceptable and religion sensitive preventive programs, the communities will be encouraged to actively participate will be involved in the design, implementation and evaluation of the project.

29.3. Gender equality issues (*Guidelines paragraph IV.53*):
This proposal addresses gender equality issues through activities that target young girls and women. Advocacy and sensitization activities will include issues on how gender inequalities put women at high risk especially as regards their ability to negotiate safe sex in a polygamous setting, the burden of women as health care providers for family members and effective heads of households due to incapacity of spouses, the discrimination of women who are care-providers for PLWHAs and the inheritance rights of widows as a result of premature death of breadwinners. These issues will be raised during advocacy visits to leaders and suggestions proposed on how to address them. It also aims at challenging gender stereotypes and attitudes, improving safe sex negotiating and decision making skills of men and women and encouraging the active involvement of young men and women in this process. It will aim at reducing the effects of peer pressure which compels adolescents into early sex while the IGA will help to reduce the effects of poverty associated with early death of heads of households leading to social vices such as prostitution and crime. Finally a conscious effort will be made to encourage increased female participation.

29.4. Social equality issues (*Guidelines paragraph IV.53*):
The vulnerable groups in the community will be targeted and the provision of support for OVCs will increase the ability of the community to cope with the increasing number of OVC. The larger part of this proposal is aimed at the hard-to-reach and under-served areas thereby increasing accessibility of the community to services and preventive activities. Through the income generating activities the rural dwellers and vulnerable groups will have access to better living conditions and through the numerous training activities their capacity will be strengthened.

29.5. Human Resources development:
This proposal focuses on strengthening the capacity of implementing partners including faith based organizations, government and non governmental organizations to carry out quality preventive, and care and supportive activities. This includes development of individual and institutional capacities in order to develop human resources as the project progresses. The empowering of PLWHAS to live positively and the acquisition of skills by PLWHAS is also a prime objective. The capacities of the beneficiaries, the project team and the management structure of the coordinated country proposal structure will also be built to facilitate proper and effective project management, and evaluation of the activities. Several health religious workers will be trained

29.6. For components dealing with essential drugs and medicine, describe which products and treatment protocols will be used and how rational use will be ensured (i.e. to maximize adherence and monitor resistance), *(Guidelines para. IV.55),* (1–2 paragraphs):

Opportunistic infections will be treated using mainly over-the-counter drugs. Volunteer nurses using existing standard of practice (SOP) guidelines of the FMOH will administer drugs for opportunistic infection. Drugs used will include oral

rehydration salts, paracetamol, chloroquine, anti-diarrhoeals such as mist kaolin and multivitamin preparations and first-line antibiotics such as trimethoprim and tetracycline, others include antifungal; antivirals; antiT.B. prophylaxis.
The firstline antibiotics such as co-trimaxazole will serve prophylaxis purposes, while a wider range of antibioticsn is proposed for treatment purposes.
Other categories of drugs required for the treatment of opportunistics infections include antifungals, antivirals(e.g. herpes), anti-T.B. prophylaxis as well as full complement of drugs for the treatment of T.B using DOTS.
Rational use shall be ensured by education, encouragement and monitoring as is emphasized in the standard of practice protocol. When improvement is not noticed after 2 – 3 days PLWHAs will be referred to doctors who will be also trained and will be available on a part-time basis. Drugs will be stored at nearest health centre to the support groups and a drug and commodity logistic system will be put in place

SECTION V – Budget information

30. Indicate the summary of the financial resources requested from the Global Fund by year and budget category, (Refer to *Guidelines paragraph V.56 – 58*):

Table V.30

Resources needed (USD)	**2003**	**2004**	**2005**	**2006**	**2007**	**Total**
Human Resources	1,220,000	1,403,000	1,403,000	1,403,000	1,403,000	6,832,000
Infrastructure/ Equipment	3,096,780	3,561,297				6,658,077
Training/ Planning	22,190,591	25,519,180	25,519,180	25,519,180	25,519,180	124,267,311
Commodities/ Products	13,507,083	15,533,145	15,533,145	15,533,145	15,533,145	75,639,663
Drugs						
Monitoring and Evaluation	715,166	822,441	822,441	822,441	822,441	4,004,930
Administrative Costs	100,000	115,000	115,000	115,000	115,000	560,000
Other (Please specify)	0	0	0	0	0	0
Total	40,829,621	46,954,064	43,392,766	43,392,766	43,392,766	217,961,981

The budget categories may include the following items:
Human Resources: *Consultants, recruitment, salaries of front-line workers, etc.*

Infrastructure/Equipment: *Building infrastructure, cars, microscopes, etc.*
Training/Planning: *Training, workshops, meetings, etc.*
Commodities/Products: *Bednets, condoms, syringes, educational material, etc.*
Drugs: *ARVs, drugs for opportunistic infections, TB drugs, anti-malaria drugs, etc.*
Monitoring & Evaluation: *Data collection, analysis, reporting, etc.*
Administrative: *Overhead, programme management, audit costs, etc*
Other (please specify):

30.1. For drugs and commodities/products, specify in the table below the unit costs, volumes and total costs, for the FIRST YEAR ONLY:

Table V.30.1

Item/unit	**Unit cost** (USD	**Volume** (specify measure)	**Total cost** (USD)
CD4/CD8 Kits	8.3	2000 units	16, 667
Roche amplicor for cobas version 1.5 kit	2,178	10,000units	453,062
HIV Test Kits	2.5	500,000	1,250,000
*IEC Materials	*	*	1,250,000
Condoms	0.08	77,083,375	6,166,670
**Home based kit	4.17	100,000	416,667

*IEC package includes various materials needed for an outing
**Home based Kits includes First AID Materials and drugs for opportunistic infections

30.2. In cases where Human Resources (HR) is an important share of the budget, explain to what extent HR spending will strengthen health systems capacity at the patient/target population level, and how these salaries will be sustained after the proposal period is over (1 paragraph):

Care and support interventions are capital intensive in view of the fact that its provision requires relatively high number of effective manpower. The salaries of project staff will be sustained through the annual subvention from the the various Governments at Federal, State and local government levels and by the various partners involved.
Though human resources constitute a significant part of the budget, salaries of staff is not a major component. Only the programme managers are engaged on a full time basis. The major percentage of the human resources component is for resource persons and consultants who are paid per activity rather than on regular salaries. In future it is expected that a strengthened network of NGOs, PLWHAs and support groups will have the capacity to develop proposals and advocate for continued support from government, public, private and donor organizations to sustain the project. Also, income generating activities will be set up by the CSOs to generate additional resources

31. If you are receiving funding from other sources than the Global Fund for activities related to this component, indicate in the Table below overall funding received over the past three years as well as expected funding until 2005 in US dollars (*Guidelines para. V.62*)**:**

Table V.31.1

	1999	2000	2001	2002	2003	2004	2005
Domestic (public and private)	100,000	83,333	385,852	8,450,000	9,000,000	10,000,000	12,000,000
External	1,100,000	750,000	1,000,000	692,308	800,000	1,000,000	1,200,000
Total	**1,200,000**	**833,333**	**4,851,852**	**9,142,308**	**9,800,000**	**11,000,000**	**13,200,000**

NB: Please see Care and Support table and add

Please note: The sum of yearly totals of Table V.31.1 from each component should correspond to the yearly total in Table 1.b of the Executive Summary. For example, if Year 1 in the proposal is 2003, the column in Table 1.b labeled Year 1 should have in the last row the total of funding from other sources for 2003 for all components of the proposal.

32. Provide a full and detailed budget as attachment, which should reflect the broad budget categories mentioned above as well as the component's activities. It should include unit costs and volumes, where appropriate.

See attachment for detailed Budget

33. Indicate in the Table below how the requested resources will be allocated to the implementing partners, in <u>percentage</u> (Refer to *Guidelines para. V.63*):

Resource allocation to implementing partners* *(%)*	**2003**	**20004**	**2005**	**2006**	**2007**	**Total**
Government	**25%**	22%	18%	14%	10%	*
NGOs / Community-Based Org.	**42%**	38%	46%	46%	54%	*
Private Sector	**8%**	9%	10%	13%	12%	*
People living with HIV/ TB/ malaria	**10%**	13%	12%	12%	11%	*
Academic / Educational Organizations	**7%**	8%	5%	5%	5%	*
Faith-based Organizations	**6%**	6%	7%	8%	6%	*
Others *(please specify)NGOs for profit*	2%	2%	2%	2%	2%	*
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Total in USD	40,829,621	46,954,064	27,267,571	22,276,030	19,859,306	157,186,538

***Not applicable as column totals are not additive.**

Please note: The following three sections (VI, VII and VII) are all related to proposal/component <u>implementation arrangements</u>.

If these arrangements are the same for all components, you do not need to answer these questions for each component. If this is the case, please indicate clearly in which component the required information can be found.

<u>SECTION VI – Programmatic and Financial management information</u>

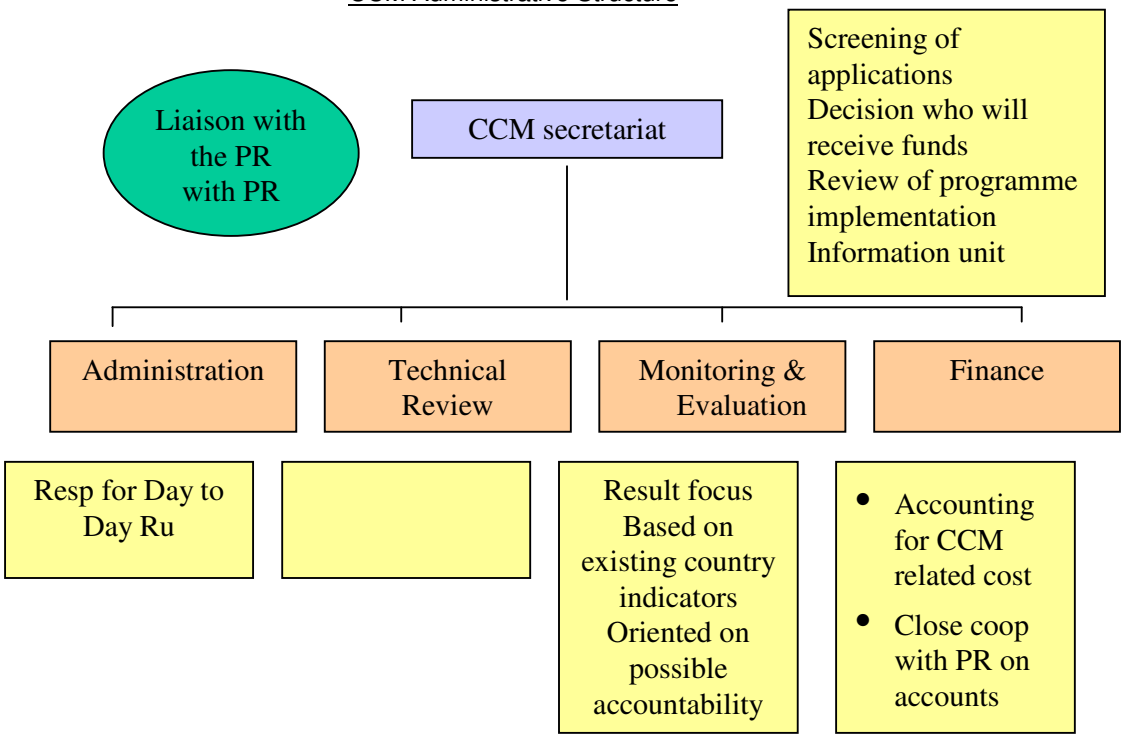
Please note: Detailed description of programmatic and financial management and arrangements are outlined in Guidelines para. VI. 61 – 73, including the main responsibilities and roles of the Principal Recipient (PR).

34. Describe the proposed management arrangements (outline proposal implementation arrangements, roles and responsibilities of different partners and their relations), *(Guidelines para. VI.64),*(1–2 paragraphs)**:**

The implementers are the various implementing partners which include governmental and non-governmental organisations. A forum will be developed to ensure that collaboration exists between partners. This will be actively be encouraged by regular meetings at zonal and national levels to ensure a synergy between the various partners. The CCM will act as the main coordinator that will ensure the

implementation of the project jointly with the PR and that services provided are qualitative and target oriented. The role of the government will be to ensure the provision of policy guidelines and allocating counterpart funding in the nations budget for this programme. It will also ensure that the training curricula are standardised and used in the training of trainers and other relevant governmental staff. The NGOs will be responsible for training of frontline staff, planning, supervision of service delivery and projects at the peripheral level. The Local community-based CSOs are also involved in direct service delivery and project implementation at both primary and secondary care levels. The administrative structure support the project implementation the CCM and PR relationship is provided in the figure below.

CCM Administrative Structure



34.1 Explain the rationale behind the proposed arrangements (e.g., explain why you have opted for that particular management arrangement), (1 paragraph)**.**

Nigeria is a large country with 37 semi-autonomous states, which are zoned according to geo-political characteristics. There is the need to ensure that partners are able to maximize each others strengths in the delivery of services and the planning and implementation of preventive initiatives. A forum for partners should achieve this goal as well as build up partnerships between government and non-governmental organisations.

35. Identify your first and second suggestions for the Principal Recipient(s) (Refer *to Guidelines para. VI.65–67)*:

Table VI.35

	First suggestion	**Second suggestion**
Name of PR	GTZ (German Technical Corporation)	UNOPS/WHO
Name of contact	Heiner Woller	Dr. B. T. Costantinos Dr. Abdou Moudi
Address	Plot 954A, Idejo Street, P.O.Box 56106, Victoria Island Lagos Nigeria	United Nations Building, Aguinyi Ironsi Way, Maitama, Abuja.
Telephone	+234-1-618 542	+234-9-4135671
Fax		As Above
E-mail	Woller_gtz@ghana.com	unaids@linkserve.com admin@who-nigeria.org

Please note: If you are suggesting to have several Principal Recipients, please copy Table VI.35 below.

35.1. Briefly describe why you think this/these organization(s) is/are best suited to undertake the role of a Principal Recipient for your proposal/component (e.g. previous experience in similar functions, capacity and systems in place, existing contacts with sub recipients etc), *(Guidelines para. VI.66–67),* (1–2 paragraphs):

Both the GTZ and UNOPS/WHO are well established in Nigeria and both have a functional financial and auditing system that meet international requirements. Each of the organizations has programme implementation mechanisms, which are well tested and are specific on the diseases targeted by this grant. Adequate manpower is also on ground and are conversant with Nigeria's Medical and Financial mechanisms.

The two organizations also have an effective surveillance and Monitoring and Evaluation Mechanism systems tested in the field for various diseases. It is expected that the Mission from GFATM will be able to assess these capabilities and during which further information will be made available. This is with special regard to the performance records in the areas of Programme Management, Procurement and Fiduciary matters.

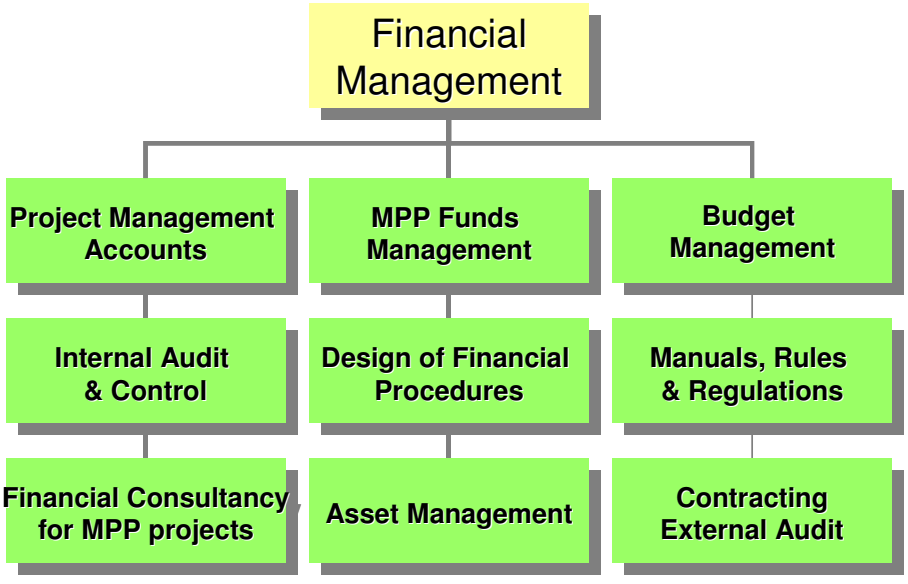
35.2. Briefly describe how your suggested Principal Recipient(s) will relate to the CCM and to other implementing partners (e.g., reporting back to the CCM, disbursing funds to sub-recipients, etc.), (1 paragraph)**:**

The Principal Recipient will be a member of the CCM and will directly relate to the sub-recipients under the supervision of the CCM. The CCM is developing a Disbursement Manual, which will form the basis for the implementation of all fiduciary functions and which will be based on the GF ATM requirements

36. Briefly indicate links between the overall implementation arrangements described above and other existing arrangements (including, for example, details on annual auditing and other related deadlines)**. If required, indicate areas where you require additional resources from the Global Fund to strengthen managerial and implementation capacity**, (1–2 paragraphs)**:**

The fiduciary arrangement endorsed by the CCM, Nigeria is based on the structure recommended by the GF ATM.

Additionally, the Monitoring and Evaluation subcommittee of the CCM has the mandate to ensure programme implementation as designed, with proper information-sharing mechanism. There will thus be linkages with the sub recipients, the CCM and disease sub groups / partners to enable appropriate assessment of implementation. The CCM plans to engage the services of External Auditors who will be independent in function and responsibility, while ensuring the adequate bookkeeping for CCM. Additional resources will be required from Global Fund to strengthen the managerial capacity of the Principal Recipient and the CCM, especially with regard to the geographic expanse of Nigeria and the multiplicity of sector responses and subprojects that challenge the limits of the present infrastructure of the CCM. The following financial management structure which links the various functions will be instituted jointly with the PR.



SECTION VII – Monitoring and evaluation information

37. Outline the plan for conducting monitoring and evaluation including the following information, (1 paragraph per sub-question).

37.1. Outline of existing health information management systems and current or existing surveys providing relevant information (e.g., Demographic Health Surveys, Living Standard Measurement Surveys, etc.), (*Guidelines para. VII.76)***:**

- Demographic health survey (DHS, 1999) ***(See attachment 16)***
- Technical Report on a Sero-prevalence amongst antenatal care attendees (FMOH, 2001) ***(See attachment 17)***
- The prevalence of HIV, Syphilis and STD syndromes among PTB/STD patients and Drug users in Nigeria (FMOH, 2000) ***(See attachment 18)***
- HIV/AIDS in Nigeria - Overview of the epidemic (POLICY Project, 2002) ***(See attachment 9)***
- Report on the global HIV/AIDS epidemic (UNAIDS 2002) **(see attachment 7)**
- Epidemiologic Fact Sheet on Nigeria (UNAIDS, 2000) ***(See attachment 8)***

37.2. Suggested process, including data collection methodologies and frequency of data collection (e.g., routine health management information, population surveys, etc.)**:**

In order to come to a manageable system for the project and the partners agency(ies), it is required to build on existing M & E AND ADJUSTMENT elements or procedures. As far as possible, available secondary data sources, information gathering methods/experiences and known reporting procedures/formats will be used.

Information gathering/reporting procedures used by the local project authorities/institutions will serve as basis and integrated when setting up/refining an M & E AND ADJUSTMENT system for this project. The first step is to define the organisational structure of the project in order to determine the information requirements and tailor the flow of information to the decision making competencies. The following activities will be carried out:

- Data will be collected from the various HIV/AIDS interventions using existing Health Management Information system and the national integrated disease surveillance and response (IDSR) jointly developed with the WHO
- Secondary data will be used as baseline information where available.
- Project specific baseline assessment using both qualitative and quantitative will be carried out by implementing partners.
- Existing data collection forms will be utilized to obtain routine service statistics on a monthly and quarterly basis.
- Achievement of results shall be determined by the output and outcome indicators stated in section IV.
- Output indicators will be communicated on a monthly basis to the CCP through the channel stated below. The various projects are expected to make monthly progress reports to the CCM Secretariat through their project staff.
- Outcome indicators will be determined by the CCP office which will collate the data to determine coverage achieved.
- The coverage will be communicated to the CCM on a quarterly basis.
- Effect indicators will be determined by secondary data and regular surveys conducted by various organisations. These will include the behaviour sentinel surveys, demographic health surveys, fertility sentinel surveys, research work done by academic institutions. Where the information is not available surveys can be commissioned by the CCM to determine the state

of the indicator being sought. This may be done in consonance with the midterm and final evaluation scheduled to be undertaken by consultants.
- The impact will be determined using the impact indicators. This will be assessed twice during the duration; at the mid-term and at the end term. Use will be made of the 2 yearly sero-prevalence studies done once every two years by the National AIDS control Programme of the FMOH
- Establishing a central monitoring system for collating of output/coverage indicators for various sub-projects.
- A mid-term and final evaluation will be carried out by an independent evaluator/Consultant who will assess progress and make necessary modifications whenever necessary.

Additionally, data will be collected from:

- Assessment reports
- Service statistics
- Training reports
- Monthly reports of projects-
- Quarterly reports of projects
- Passive and active surveillance
- National surveys

37.3. Timeline:

- Baseline assessment (Project onset)
- Monthly supervision (Monthly)
- Quarterly monitoring (Quarterly)
- Mid term project review (Mid point)
- End of project review (End of project)

NB: see Attachment Timeline Table

37.4. Roles and responsibilities for collecting and analyzing data and information:

- The M&E officer from each sub-project will be responsible for collecting service and training statistics from task team leaders and report to the project coordinator of the implementing partner on a monthly basis.
- The project/zonal coordinators of each implementing partner will be responsible for reporting service, training statistics and reports to the CCM on a quarterly basis. The CCM or the PR will employ staff for the purpose of monitoring the indicators of projects.
- The Country Coordinating Mechanism (CCM)/PR will collate and analyze data at national level and generate outcome indicators for the country. They will also provide feedback to the implementing partners and Global Fund.
- Independent consultants will be responsible for a mid-term and final evaluation.

37.5. Plan for involving target population in the process:

The target populations include the general uninfected population, PLWHAs, PABAs, vulnerable and high-risk population. These groups in collaboration with implementing partners will assist in collecting data and monitoring of interventions at community level and at CCM level.

37.6. Strategy for quality control and validation of data:

Internal validation of data will be carried out during supervisory and monitoring visit.
External validation of data will be carried out during mid-term and end of project review.
The quality of the M&E will be determined by the project's implementation experience, dynamic (induced or autonomous) changes in the target, population/beneficiaries, changing frame conditions and other influences.

Project Management requires a continuous flow of information in order to be able to steer the project. The CCM jointly with the PR will embark on M&E (and Adjustment) as a comprehensive Project Cycle Management (PCM) strategy which will involve obtaining adequate information for project steering and the utilisation of this information to make decisions and steer the project leading to adjustments.

37.7. Proposed use of M&E data:

M&E data will be used for the following:

- Program effectiveness (acceptance and utilization of services)
- Input into program redesign of on-going interventions
- Planning and projection for future activities
- Identify program gaps and unmet needs
- Identify best practice for scale up
- Advocacy tool
- Input into national data
- Impact assessment

38. Recognizing that there may be cases in which applicants may not currently have sufficient capacity to establish and maintain a system(s) to produce baseline data and M&E indicators, please specify, if required, activities, partners and resource requirements for strengthening M&E capacities.

Please note: As M&E activities may go beyond specific proposals funded by the Global Fund, please also include resources coming from other sources at the bottom of Table VII.38.

Examples of activities include collecting data, improving computer systems, analyzing data, preparing reports, etc.

Table VII.38

Activities (aimed at strengthening Monitoring and Evaluation Systems)	**Partner(s)** (which may help in strengthening M&E capacities)	**Resources Required** (USD)					
		Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Baseline (KAPB)	Development Partner	**328,333**	**-**	-	-	-	**328,333**
Baseline (Population based assessment)	Development Partner	**166,666**	**-**	-	-	-	**166,666**

Training in program management,	Development Partner	**66,700**	**66,700**	**66,700**	**66,700**	**66,700**	**333,500**
Training in M/E	Development Partner	**66,700**	**66,700**	**66,700**	**66,700**	**66,700**	**333,500**
Total requested from Global Fund		**628,399**	**133, 400**	**133,400**	**133,400**	**133,400**	**1,161,999**
Total other resources available		**0**	**0**	**0**	**0**	**0**	**0**

? Please calculate these totals

SECTION VIII – Procurement and supply-chain management information

39. Describe the existing arrangements for procurement and supply chain management of public health products and equipment integral to this component's proposed disease interventions, including pharmaceutical products as well as equipment such as injections supplies, rapid diagnostics tests, and commodities such as micronutrient supplements, condoms and bed nets (Refer to *Guidelines paragraph VIII.86*)**.**

Table VIII.39

Component of procurement and supply chain management system	Existing arrangements and capacity (physical and human resources)
How are suppliers of products selected and pre-qualified?	Suppliers of products are selected on the basis of competitive bidding with due regard to economy, quality and transparency. Managerial and technical qualification, experience and financial capabilities of the supplier to carry out the arrangements
What procurement procedures are used to ensure open and competitive tenders, expedited product availability, and consistency with national and international intellectual property laws and obligations?	This is to be achieved through advertising for competitive bids and provision of bidding documents containing sufficient information to enable prospective bidders to respond appropriately. Suppliers of products will be chosen by open tender of registered contractors. The procurement unit of the PR/CCM will be responsible for recommending the most appropriate contractor of each bid. All procurement actions are initiated by the procurement unit/officer and are to be carried out after the approval of the Project Managers (CCM and PR)
What quality assurance mechanisms are in place to assure that all products procured and used are safe and effective?	All imported drugs and reagents are subjected to quality analysis by the National Agency for Food, Drugs, administration and Control (NAFDAC) and IDA will also be involved from time to time
What distribution systems exist and how do they minimize product diversion and maximize broad and non-interrupted supply?	Each implementing partner has its own in house method of distribution however drugs and materials bought directly through the CCM shall be distributed through the government channels. Drugs received directly by the central unit are stored at the central medical store in Lagos and Kano from where they are distributed to the states. Groups requesting restocks will need to show evidence of how previous stocks were used. A 50% drop in stocks should be enough justification for re stocking stores of implementing partners. Established distribution networks of partners will also be used to minimize leakages while ensuring delivery to the beneficiaries. **A software will be used to track….**

40. Describe the existing arrangements for procurement of services (e.g., hiring personnel, contracts, training programs, etc.), (1–2 paragraphs)**:**

In the public service, the civil service commission of the 3-tiers of government (federal, State and local) are responsible for employment of personnel according to laid down regulations and procedures.
In the non governmental sector, the implementing partners do hire personnel according to their organizational statutes.
due honorarium.
The CCM however will determine required levels of qualification for various categories of staff working with it or through the implementing partners and use as consultants as a prerequisite for engaging in activities. Where these are not available hiring shall be done through interviews after advertising in national newspapers. s

41. Provide an overview of the additional resources (e.g., infrastructure, human resources) required to support the procurement and distribution of products and services to be used in this component, (2–3 paragraphs):

A procurement unit will have to be established in the CCM or the PR. A channel of distribution will have to be setup that involves the government authorities at the various levels. A machinery will be set in place to ensure effective distribution of products and commodities once procured.

There is the need to renovate the storage facilities at the federal, State and LGA levels and provide facilities such as
- Air - conditioners for stores
- Zonal offices
- Fund for logistics

There is also need to recruit a Pharmacist for managing the drug procurement at the National level and training of stores personnel at the periphery

42. Detail in the table below any additional sources from which the applicant plans to obtain products relevant to this component, whether additional requests have been requested or granted already. (For each source, indicate a contact person at the program in question, the volume of product in the request of grant, and the duration of support. Examples of such programmes are the Global TB Drug Facility or product donations from pharmaceutical manufacturers), (*Guidelines para. VIII.88*):

Table VIII.42

Programme name	Contact person (with telephone & email information)	Resources requested (R) or granted (G)	Timeframe and duration of request or grant

42.1. Explain how the resources requested from the Global Fund for the products relevant to this component will be complementary and not duplicative to the additional sources, if any, described above (1 paragraph):

The resources requested from the global fund are supplementary to the resources already provided by development partners and government. They are actually gap identified in the provision of HIV/AIDS interventions programmes in the country

SECTIONS IV – VIII: Detailed information on each component of the proposal

PLEASE COMPLETE THE FOLLOWING SECTIONS FOR EACH COMPONENT
Please copy sections IV – VIII as many times as there are components

Please note: a component refers to a disease, i.e. your proposal will have more than one component only if it covers more than one disease. There should only be 1 component per disease.

If there are any objectives or broad activities within a particular component that are of a system-wide/cross-cutting nature such as capacity building or infrastructure development that may go beyond the scope of that particular component, please indicate those aspects clearly and specify how they would relate to other components of the proposal when detailing them in Question 27. (Guidelines para. IV.47 – 49)

If this is a fully integrated proposal, where two or more components are linked in such a way which would not make it realistic or feasible to separate, mark the boxes in Table IV.23 to identify all diseases which would be directly affected by this integrated component. (Guidelines para. 50)

SECTION IV – Scope of proposal

23. Identify the component that is detailed in this section (mark with X):

Table IV.23

Component (mark with X):		HIV/AIDS
	X	Tuberculosis
		Malaria
		HIV/TB

24. Provide a brief summary of the component (Specify the rationale, goal, objectives, activities, expected results, how these activities will be implemented and partners involved) (2–3 paragraphs):

Rationale
Nigeria ranks 4th among the 22nd highest TB burden country in the world (WHO, 2002). An estimated 300,000 of all forms of tuberculosis occur annually. Thus, tuberculosis is a major public health problem in the country and has been recognized as such, which informed the launching of the National Tuberculosis and Leprosy Control Programme in 1991. Currently, 21 of the 36 states (55% of population covered) and FCT are implementing the DOTS Strategy for tuberculosis control. However DOTS coverage ranges between 25% and 75% depending on the extent of expansion among the LGAs within the states.

The main goal is achieve 100% DOTS coverage in Nigeria by 2005 and sustained through to 2007. The specific objectives include: expansion of DOTS to 16 non-DOTS states by 2003, 100% LGA DOTS coverage by 2005, increase case detection from 15% to 70% by 2005 and achieve cure rate of 85% for TB smear positive patients by 2005.

These activities will be implemented in a phased manner establishing one microscopy centre in each of 5 LGAs per State in the non-DOTS states, and establishing at least 2 treatment centres per LGA annually. Consideration will be given to the contiguity of the LGAs in the course of expansion of both microscopy and treatment services. A number of LGAs will be started off together considering the availability of human resources at that

level. In the DOTS implementing states, further expansion of diagnostic and treatment network will also take place. It is expected that by 2005, each of the 774 LGAs have at least 2 microscopy centres and at least 10 treatment centers. This will ensure the availability of DOTS services in all the 5,000 major Primary Health Care centres throughout the country. The major expected results will be increased access to diagnosis and treatment leading to increased TB case detection and cure.
The major partners include: CIDA, DFB, DFID, GLRA/KFW, NLR, TLMI, WHO, IUATLD, Stop TB, Local NGOs, National Primary Health Care Development Agency and private practitioners.

25. Indicate the estimated duration of the component:

Table IV.25

From (month/year):	January 2003	To (month/year):	December 2007

26. Detailed description of the component for its FULL LIFE-CYCLE:

Please note: Each component should have ONE overall goal, which should translate into a series of specific objectives. In turn each specific objective should be broken-down into a set of broad activities necessary to achieve the specific objectives. While the activities should not be too detailed they should be sufficiently descriptive to understand how you aim to achieve your stated objectives.

Indicators: In addition to a brief narrative, for each level of expected result tied to the goal, objectives and activities, you will need to identify a set of indicators to measure expected result. Please refer to Guidelines paragraph VII.77 – 79 and Annex II for illustrative country level indicators.

Baseline data: Baseline data should be given in absolute numbers (if possible) and/or percentage. If baseline data is not available, please refer to Guidelines paragraph VII.80. Baseline data should be from the latest year available, and the source must be specified.

Targets: Clear targets should be provided in absolute numbers (if possible) and percentage.

For each level of result, please specify data source, data collection methodologies and frequency of collection.

An example on how to fill out the tables in questions 26 and 27 is provided as Annex III in the Guidelines for Proposals

26.1. Goal and expected impact (Describe overall goal of component and what impact, <u>if applicable</u>, is expected on the targeted populations, the burden of disease, etc.), (1–2 paragraphs):

Please note: the impact may be linked to broader national-level programmes within which this component falls. If that is the case, please ensure the impact indicators reflect the overall national programme and not just this component.

Please specify in Table IV.26.1 the baseline data. Targets to measure impact are only required for the end of the full award period.

Table IV.26.1

Goal:	*To reduce transmission of tuberculosis in Nigeria by 25% by 2007*	
Impact indicators	*Baseline*	*Target (last year of proposal)*
(Refer to Annex II)	*Year: 2002*	*Year: 2007*
No of new smear positive cases per 100,000 population	132 per 100,000 population	100 per 100,000 population

27. Objectives and expected outcomes (Describe the specific objectives and expected outcomes that will contribute to realizing the stated goal), (1 paragraph per specific objective):

Question 27 must be answered for each objective separately. Please copy Question 27 and 27.1 as many times as there are objectives.

Please note: the outcomes may be linked to broader programmes within which this component falls. If that is the case, please ensure the outcome/coverage indicators reflect the overall national programme and not just this component.

Specify in Table IV.27 the baseline data to measure outcome/coverage indicators. Targets are only required for Year 2 onwards.

Table IV.27

Objective 1:	To increase the LGA DOTS coverage from 45% to 100% by the end of 2005 and sustained through 2007					
Outcome / coverage indicators	Baseline	Targets				
(Refer to Annex II)	Year:	Year 1	Year 2	Year 3	Year 4	Year 5
	2002	2003	2004	2005	2006	2007
No of states implementing DOTS	21	37	37	37	37	37
No of LGAs implementing DOTS	350	498	646	774	774	774
No of Microscopy centers for DOTS	417	615	1,002	1,326	1,548	1,548
No of Treatment centers implementing DOTS	1,605	2233	3,426	4,314	5,202	5,202
No. of Private and NGO hospitals delivering DOTS services	20	57	94	131	168	205

Explanatory note:

The Local Government Area level is the closest to the grass root and the field of operation for TB Control activities. Presently 350 Local Government Areas (LGA's) out of 774 are implementing DOTS through 417 microscopy centers and 1605 treatment centers. Thus DOTS expansion in the country will follow a systematic addition of new microscopy centers and treatment centers in the LGA's annually until all LGA's are covered by 2005. All sectors will be involved including the private sector and NGO's.

27.1. Broad activities related to each specific objective and expected output (Describe the main activities to be undertaken, such as specific interventions, to achieve the stated objectives) (1 short paragraph per broad activity):

Please note: Process/output indicators for the broad activities should directly reflect the specified broad activities of THIS component.

Specify in Table IV.27.1 below the baseline data to measure process/output indicators. Targets need to be specified for the first two years of the component.

For each broad activity, specify in Table IV.27.1 who the implementing agency or agencies will be.

Objective 1:	*To increase the LGA DOTS coverage from the 45% to 100% by the end of 2005 and sustained trough to 2007*				
Broad activities	*Process/Output indicators (indicate one per activity)* (Refer to Annex II)	*Baseline (Specify year) 2002*	*Targets*		*Responsible/Implementing agency or agencies*
			Year 1 2003	*Year 2 2004*	
a)To sensitize State and LGA Governments on the DOTS strategy	*Number of States/LGAs visited and advocacy meetings held.*	*7*	*16*	*14*	*NTBLCP, ILEP, WHO*
b)To establish microscopy centers at LGAs, State Zonal and National levels	*Number of microscopy centers established.*	*417*	*198*	*387*	*STATE GOVERNMENTS, LGA, NTBLCP, ILEP, WHO, DFID*
c)To develop capacity of health staff to deliver DOTS services	*Number of general health staff trained on DOTS*	*3,210*	*1256*	*2386*	*NTBLTC, ZARIA, ILEP, WHO, DFID AND OTHER DEVELOPMENT PARTNERS*

d)To train laboratory technicians and microscopists on Sputum microscopy for DOTS.	*Number of laboratory technicians and microscopists trained on Sputum microscopy*	*834*	*396*	*774*	*NTBLCP, ILEP, WHO, DFID*
e) Procurement and distributions of packages of anti-TB drugs as follows:	*No. of Packages of anti-TB drugs available at base.*				*NTBLCP, ILEP, WHO, DFID, STOP TB.*
(i) SCC for Cat. 1	*(i) SCC for Cat. 1*	*57,422*	*108,934*	*163,877*	
(ii) Cat. 1 for children	*(ii) Cat. 1 for children*	*6,153*	*12,255*	*23,411*	
(iii) INH prophylaxis for children	*(iii) INH prophylaxis for children*	*74,000*	*131,214*	*213,040*	

Explanatory note:

a) The Federal Ministry of Health (FMOH) will conduct advocacy visits to sensitize policymakers in the States and LGA's to ensure concept of DOTS is understood and support enlisted.

b) The Medical laboratory scientist of the FMOH currently undertakes assessment of the laboratories. WHO on behalf of the FMOH will procure microscopes, reagents and other lab consumables. FMOH will distribute the items to all the states from the Central Medical Stores, Lagos.

c) In the initial take-off of DOTS at least 2 health workers will be trained per treatment center. Trainings will be organized in the States.

d) In the initial take-off of DOTS at least 2 lab scientists will be trained per microscopy center. Trainings will be organized in the States.

e) FMOH will collaborate with partners to estimate the national anti-TB drug requirements State by State on an annual basis (including INH prophylaxis for children under 6 years of age). This will be ordered from the GDF. On clearance the drugs will be stored at the Central Medical Stores, Lagos. FMOH will distribute the drugs to the partners Stores at the Zonal level. The States will arrange to move the drugs from the Zonal Stores to the LGA's.

(see attached detailed narration of proposal attached)

27. 2ND OBJECTIVE ***Table IV.27***

Objective 2:	*To increase the case detection rate from 15% to 70% by the end of 2005 and to 80% by the end of 2007*					
Outcome/coverage indicators	***Baseline***	***Targets***				
(Refer to Annex II)	***Year: 2002***	***Year 1: 2003***	***Year 2 : 2004***	***Year 3: 2005***	***Year 4: 2006***	***Year 5: 2007***
Proportion of all estimated new smear positive cases detected under DOTS.	*15%* *18,097*	*35%* *42,226*	*45%* *54,391*	*70%* *84,452*	*75%* *90,484*	*80%* *96,517*

Explanatory Note:
Case detection will be increased by systematic establishment of laboratory diagnostic centers in each LGA, training and retraining of health staff, examination of contacts of smear positive patients, improved health education of the populace and improvement in the health information system of the programme.

27.2.1. Broad activities related to each specific objective and expected output (Describe the main activities to be undertaken, such as specific interventions, to achieve the stated objectives) (1 short paragraph per broad activity):

Table IV.27.1

Objective: 2	*To increase the case detection rate from 15% to 70% by the end of 2005 and to 80% by the end of 2007*				
Broad activities	*Process/Output indicators (indicate one per activity)* (Refer to Annex II)	*Baseline (Specify year) 2002*	*Targets Year 1 2003*	*Year 2 2004*	*Responsible/Implementing Agency or agencies*
a) Prepare communication strategy and advocacy package on TB and HIV.	TB/HIV advocacy package developed & distributed	0	1000	0	Central Unit, NACA, STBLCP & health education unit
b) Update, reproduce & distribute TB/HIV advocacy package	No. of updated Advocacy package produced.	0	0	2000	Central Unit, NACA, STBLCP & health education unit
c) Develop, print and distribute TB /HIV IEC materials in local languages.	Number of IEC materials distributed.	0	136,000	150,000	Central Unit, NACA, STBLCP & health education unit
d) Increase diagnostic laboratory network at LGAs, State Zonal and National levels	Number of new microscopy centers established.	417	148	387	State governments, local governments, NTBLCP, ILEP, WHO
e) Improve Contact Examination and reporting (formats developed and distributed).	Number of new contact examinations reported by state.	0	250	500	State governments, local governments, NTBLCP, ILEP, WHO
f) Organize World TB Day to create public awareness and re-invigoration of efforts among stakeholders	No. of States observing World TB day.	21	37	37	FMOH, WHO, STBLCO and TB Supervisors, NGOs

Explanatory Note:

a) FMOH in collaboration with other partners will employ the expertise of a consultant in order to prepare and develop a communication and advocacy strategy and package to be used all levels of the Control Programme.
b) FMOH will ensure the reproduction and distribution of updated TB/HIV advocacy materials to the peripheral level.
c) FMOH in collaboration with other partners will employ the expertise of a consultant in order to prepare and develop TB/HIV IEC materials in local languages to be used all levels of the Control Programme.
d) Systematically new laboratory diagnostic centers will be established so that by 2007 all LGA's have at least 2 microcopy centers. 6 Zonal referral laboratories and one national referral laboratory will be established.
e) Contact examination of smear positive patients will be improved and reported using standardized formats.
f) Yearly World TB Day will be celebrated to create public awareness and re-invigoration of efforts among stakeholders, especially among the policy makers.

(see attached narrative of the proposal)

27. 3RD OBJECTIVE

Table IV.27

Objective 3:	*To increase cure rate from 66% to at least 85% by the year 2005 and 90% by the end of 2007*					
Outcome/coverage indicators	*Baseline*	*Targets*				
(Refer to Annex II)	*Year: 2002*	*Year 1: 2003*	*Year 2: 2004*	*Year 3: 2005*	*Year 4: 2006*	*Year 4: 2007*
Proportion of smear positive TB cases getting cured out of those registered for chemotherapy under DOTS	*66%*	*75%*	*80%*	*85%*	*85%*	*90%*

Explanatory Note:
The cure rate in the 21 currently DOTS implementing States is 66%. This will be increased to 85% by 2005. This objective will be achieved by providing uninterrupted anti TB drugs to all categories of TB patients, under proper case management conditions. In addition health education to patients and relatives will be undertaken to facilitate treatment compliance and therefore enhance cure rate. Furthermore recording and reporting materials will be provided to ensure that quarterly statistical reports are made for programme monitoring and evaluation.

27.3.1. Broad activities related to each specific objective and expected output (Describe the main activities to be undertaken, such as specific interventions, to achieve the stated objectives) (1 short paragraph per broad activity):

Table IV.27.1

Objective: 3	*To increase cure rate from 66% to at least 85% by the year 2005 and 90% by the end of 2007*				
Broad activities	*Process/Output*	*Baseline*	*Targets*		*Responsible/ Implementing agency or agencies*
	Indicators (indicate one per activity) (Refer to Annex II)	*(Specify year) 2002*	*Year 1 2003*	*Year 2 2004*	
a) Produce and distribute adequate recording and reporting materials	No. of recording materials distributed to centers.	200,000	**432,500**	**432,500**	NTBLCP Central Unit, ILEP Orgs. WHO.
b) Provide un-interrupted anti-TB drugs to patient. SCC for Cat 1:	No. of anti-TB drug packages provided.	57,422	108,934	163,877	NTBLCP, ILEP, WHO, DFID
c) Provide un-interrupted anti-TB drugs to patient. Cat 1 for Children:	No. of anti-TB drug packages provided.	6,153	12,255	23,411	As above
d) Provide un-interrupted anti-TB drugs to patient. Cat 2	No. of anti-TB drug packages provided.	4,112	13,617	46,822	As above
e) Provide health education to patients and the relatives.	No. of health education sessions for patients at center.	1605	2233	3426	PHC supervisors, PHC workers
f) Perform follow up smear examinations at 2, 5, end 7 months.	Proportion of patients with all smear results at end 7 months.	66%	75%	80%	PHC Supervisors, PHC workers
g) Compile quarterly & annual TB Statistical report from LGAs with DOTS.	Number of LGAs submitting complete reports.	350	498	646	State TBL Control Officers, PHC supervisors, PHC workers

Explanatory Note:

a) FMOH will print adequate sets of NTBLCP recording and reporting materials (Central TB Register, Laboratory Register, patient cards, sputum request forms, appointment cards, quarterly report forms on case-finding and treatment results, drug supply form) and distribute to all States. This will enable us to monitor the progress and to estimate the number of drugs and other materials required for the programme.

b-d) FMOH will collaborate with partners to estimate the national anti-TB drug requirements State by State on an annual basis (including INH prophylaxis for children under 6 years of age). This will be ordered from the GDF. On clearance the drugs will be stored at the Central Medical Stores, Lagos. FMOH will distribute the drugs to the partners Stores at the Zonal level. The States will arrange to move the drugs from the Zonal Stores to the LGA's.

e) All health workers will provide a session of health education at each Health Center to patients and relatives on a daily basis to ensure adequate patient motivation to complete full course of treatment.

f) Pulmonary smear positive patients will have follow up smear examinations at 2nd, 5th and 7th month to monitor their progress.

g) Quarterly and annually all the statistical data will be compiled from the health facilities in each LGA and forwarded to the State TB Control Programme Manager. He will compile all these data and forward them to the FMOH for further compilation and provide feedback.

27. 4TH OBJECTIVE

Objective 4:	*To develop capacity of health staff in the 37 states to deliver DOTS services by the end of 2007*					
Outcome/coverage indicators	*Baseline*	*Targets*				
(Refer to Annex II)	*Year: 2002*	*Year 1: 2003*	*Year 2: 2004*	*Year 3: 2005*	*Year 4: 2006*	*Year 5:2007*
No. of health staff trained on DOTS	*3,760*	*5,966*	*8407*	*10,208*	*12,108*	*13,500*

Explanatory Note:
Capacity of staff at all levels will be improved by continuous training and retraining of all general health workers on current DOTS strategies. This will be carried out using standardized training modules developed by FMOH and partners to ensure uniformity in the whole country.

27.4.1. Broad activities related to each specific objective and expected output (Describe the main activities to be undertaken, such as specific interventions, to achieve the stated objectives) (1 short paragraph per broad activity):

Table IV.27.1

Objective: 4	*To develop capacity of health staff in the 37 states to deliver DOTS services by the end of 2007*				
Broad activities	*Process/Output*	*Baseline*	*Targets*		*Responsible/ Implementing agency or agencies*
	Indicators (indicate one per activity) (Refer to Annex II)	*(Specify year)* 2002	*Year 1* 2003	*Year 2* 2004	
a) Revise, produce and distribute the national TB Worker's Manual.	No. of revised National TB Manuals distributed.	0	10,000	5,000	Central Unit NTBLCP, NTBLTC Zaria
b) Integrate TB Control Programme into Medical and para-medical training institutions' curricula.	No. of institutions integrating TB Control into Curricula.	30	18	10	Central Unit NTBLCP, Training Institutions
c) Development of training materials for volunteers in community DOTS.	No. of training materials developed.	0	2, 000	3, 000	Central Unit, NTBLTC, NPHDA
d) Conduct orientation of health workers on DOTS	No of health workers trained.	3,210	1256	2386	FMOH, NTBLTC, STBLCO.
e) Conduct training of new LGA PHC supervisors.	No. of newly trained PHC supervisors.	350	148	150	NTBLCP, STBLCO and NTBLTC
f) Training of Trainers on Community DOTS volunteers	No. of community volunteers trained	0	700	1400	NTBLCP, STBLCO, NPHDA
g) Orientation State Officers & Senior PHC Supervisors on new TB management guidelines	No. of State TBL Control Officers & Senior PHCS trained.	Nil	37	Nil	FMOH State, WHO
h) Training of STBLCOs and CU Medical Officers in an international TB Course, organized either by WHO or IUATLD	No. of state TBL CO trained.	24	7	6	NC, NTBLCP, ILEP

Explanatory Note:

a) The Technical Planning Cell will expedite action on the review of the National TBL Workers Manual, which is currently in draft. Revised manual to be finalized by 3rd quarter 2002, printed and disseminated.
b) The FMOH in collaboration with the Medical Training Institutions both at National and State levels will continue to review and update the current training curriculum for all categories of health staff.
c) Training materials on DOTS for community volunteers are currently being developed with the aim of improving DOTS delivery services.
d) In the initial take-off of DOTS at least 2 health workers per treatment centers will be trained on DOTS using standardized training materials.

e) There is need to train the PHC supervisors of LGA's in tuberculosis control with the view of incorporating TB in the overall PHC supervision at that level. In each LGA one PHC supervisor will be trained.
f) There is need to train the PHC supervisors and TBL supervisors on how to train the community volunteers on DOTS.
g) State officers and Senior PHC supervisors will be regularly reoriented on new TB management guidelines, including TB/HIV joint activities.
h) New State Control Officers and Medical Officers of the FMOH will be trained in an international TB course, organized either by WHO or IUATLD.

27. 5TH OBJECTIVE

Table IV.27

Objective 5:	*To put in place a functional TB/HIV collaboration for integrated management and support of TB/HIV infected persons at all levels by the end of 2007.*					
Outcome/coverage indicators	*Baseline*	*Targets*				
(Refer to Annex II)	*Year: 2002*	*Year 1: 2003*	*Year 2: 2004*	*Year 3: 2005*	*Year 4: 2006*	*Year 4: 2007*
No of Joint TB/HIV activities carried out.	*1*	*Establish baseline value*	*Implementation of joint TB/HIV activities in care of support of HIV/TB patients at the peripheral level*	*Implementation of joint TB/HIV activities in care of support of HIV/TB patients at the peripheral level*	*Implementation of joint TB/HIV activities in care of support of HIV/TB patients at the peripheral level*	*Implementation of joint TB/HIV activities in care of support of HIV/TB patients at the peripheral level*

Explanatory Note:

TB and HIV create an unwholesome alliance. To break the alliance there is need to integrate functionally the control of both diseases. In order to achieve this functional TB/HIV collaboration, TB/HIV working groups at State and LGA levels have to be established. A working group has already been established at the Federal level.

27.5.1. Broad activities related to each specific objective and expected output (Describe the main activities to be undertaken, such as specific interventions, to achieve the stated objectives) (1 short paragraph per broad activity):

Table IV.27.1

Objective: 5	*To put in place a functional TB/HIV collaboration for integrated management and support of TB/HIV infected persons at all levels by the end of 2007*				
Broad activities	*Process/Output*	*Baseline*	*Targets*		*Responsible/ Implementing agency or agencies*
	Indicators (indicate one per activity) (Refer to Annex II)	*(Specify year)*	*Year 1*	*Year 2*	
		2002	*2003*	*2004*	
a) Establish TB/HIV working group at the State/ LGA levels.	No. of established working group at State/ LGA levels	0	21	37	FMOH, NACA
b) Production of communication strategy and advocacy package on TB and HIV.	No. of TB/HIV advocacy package.	0	2000	2000	Consultant, FMOH, NACA, WHO
c) Produce & distribute guidelines for TB/HIV integrated mngnt.	No. of guidelines printed and distributed.	0	2,000	5,000	FMOH NACA
d) Conduct orientation of health workers on DOTS and management of HIV/AIDS opportunistic and nosocomial infections.	No. of health workers trained.	0	2,000	2,000	FMOH, NACA, STBLCO and National TBL Training Center
e) Appropriate management of HIV/ TB dually infected patients.	No. of appropriately managed patients.	N/A	1,000	2,000	NACA, STBLCO
f) Produce and distribute IEC materials to community members local languages.	Number of local languages IEC materials.	0	10,000	20,000	FMOH, NASCP, NACA, STBLCP
g) Sensitization seminars for mass media organizations on TB/HIV	No. of Seminars for print and electronic media organizations.	0	2	2	FMOH, NASCP, NACA.

Explanatory Note:

a) A TB/HIV working group will be established at State and LGA level.
b) A consultant will be hired to prepare appropriate communication strategy and advocacy package on TB and HIV.
c) The FMOH and partners will develop and print guidelines for management and support of TB/HIV infected patients. This will be distributed by FMOH to all peripheral levels.
d) The General Health Workers need to be reoriented on DOTS and management of HIV/AIDS related infections.
e) Appropriate management of dual infection of TB/HIV means treatment of TB with anti-TB drugs, HIV with Anti Retroviral Drugs and management of other opportunistic infections. It also includes voluntary testing and counseling.

f) FMOH in collaboration with all partners will develop and print IEC materials on TB and HIV in selected local languages to be distributed to community members.
g) FMOH, NACA and other partners will organize seminars to sensitize mass media organizations on TB/HIV in order to promote and enhance information and communication on the Control Activities of the two diseases.

28. Describe how the component adds to or complements activities already undertaken by the government, external donors, the private sector or other relevant partner: (e.g., does the component build on or scale-up existing programs; does the component aim to fill existing gaps in national programs; does the proposal fit within the National Plan; is there a clear link between the component and broader development policies and programmes such as Poverty Reduction Strategies or Sector-Wide Approaches, etc.), (*Guidelines para. III.41 – 42*),(2–3 paragraphs):

At present DOTS services are being provided in 350 LGAs in 21 states of the federation with 774 LGAs and 36 States and FCT, Abuja.
This component is to enable us expand DOTS to all the remaining LGAS in all states by the end of 2005.

It is to complement the financial support from the Government, NGOs and ILEP organizations.

There is a national DOTS expansion strategic plan for 2001-2005 for which this request is based. The proposal is meant to fill in the existing gap in the National strategic plan.

29. Briefly describe how the component addresses the following issues (1 paragraph per item):

29.1. The involvement of beneficiaries such as people living with HIV/AIDS:

The beneficiaries such as TB patients will be involved in public awareness, treatment support, case finding activities.

29.2. Community participation:

Community will be involved in awareness creation and patients' treatment compliance on TB.

29.3. Gender equality issues (*Guidelines paragraph IV.53*):

Both sexes will have equal access to DOTS services,

29.4. Social equality issues (*Guidelines paragraph IV.53*):

Poverty alleviation programme is in place by the Government to help improve the economic statutes and well being of Nigerians.

29.5. Human Resources development:

Various cadres of the health providers will have requisite training which would enhance good DOTS service delivery.

29.6. For components dealing with essential drugs and medicine, describe which products and treatment protocols will be used and how rational use will be ensured (i.e. to maximize adherence and monitor resistance), *(Guidelines para. IV.55),* (1–2 paragraphs):

The NTBLCP adopted the WHO and IUATLD recommended Short Course chemotherapy for the DOTS strategy.
The regimens and the category of patients are;

1. 2RHZE/6EH for New Smear Positive and Negative cases
2. 2S3RHZE/6RHZE for retreatment cases.

The 4Fixed dose combination RHZE will be used.
Health workers or a trained family/community member will administer the drugs under direct observation.
The WHO/IUATLD recording and reporting formats will be used to monitor drug intake, compliance and treatment progress at the health facility level.
Monitoring of drug stock will also be conducted from the facility to the LGA, State and national levels.

SECTION V – Budget information

30. Indicate the summary of the financial resources requested from the Global Fund by year and budget category, (Refer to *Guidelines paragraph V.56 – 58*):

Table V.30

Resources needed (USD)	Year 1	Year 2	Year 3 (Estimate)	Year 4 (Estimate)	Year 5 (Estimate)	Total
Human Resources	54,609	0.00	0.00	0.00	0.00	54,609
Infrastructure/ Equipment	2,080,522	246,804	246,804	246,804	246,804	3,067,738
Training/ Planning	856,696	883,087	883,087	883,087	883,087	4,389,044
Commodities/ Products	458,210	515,581	592,918	681,856	784,134	3,032,699
Drugs	0.00	0.00	0.00	0.00	0.00	0.00
Monitoring and Evaluation	1,880,977	1,880,977	1,880,977	1,880,977	1,880,977	9,404,885
Administrative Costs	315,078	352,104	352,104	352,104	352,104	1,723,494
Other (Please specify) Advocacy and operational research	166,689	130,732	174,210	130,732	174,210	776,573
Total	5,812,780	4,009,285	4,130,100	4,175,560	4,321,316	22,449,042

The budget categories may include the following items:
Human Resources: Consultants, recruitment, salaries of front-line workers, etc.

Infrastructure/Equipment: Building infrastructure, cars, microscopes, etc.
Training/Planning: Training, workshops, meetings, etc.
Commodities/Products: Bednets, condoms, syringes, educational material, etc.
Drugs: ARVs, drugs for opportunistic infections, TB drugs, anti-malaria drugs, etc.
Monitoring & Evaluation: Data collection, analysis, reporting, etc.
Administrative: Overhead, programme management, audit costs, etc

Other (please specify):

30.1. For drugs and commodities/products, specify in the table below the unit costs, volumes and total costs, for the FIRST YEAR ONLY:

Table V.30.1

Item/unit	Unit cost (USD	Volume (specify measure)	Total cost (USD)
Laboratory reagents	2.17	79,333	172,153
Patient leaflets	0.09	136,000	12,240
Treatment cards	0.2	200,000	34,7823
LGA TB central registers	1.7	5,000	8,696
TB quarterly report forms	0.9	2,000	9,939
Sputum examination request forms	0.9	20,000	17,391
TB laboratory register	0.9	2,000	173.9
TB appointment cards	0.005	200,000	1,739
TB cohort forms	0.9	2,000	1,739
Transfer forms	0.06	1,500	1,304
Bulbs for microscopes	.8	1,500	1,200
Objectives X 100	1.1	1,500	1,650

30.2. In cases where Human Resources (HR) is an important share of the budget, explain to what extent HR spending will strengthen health systems capacity at the patient/target population level, and how these salaries will be sustained after the proposal period is over (1 paragraph):

31. If you are receiving funding from other sources than the Global Fund for activities related to this component, indicate in the Table below overall funding received over the past three years as well as expected funding until 2005 in US dollars (*Guidelines para. V.62*):

Table V.31.1

	1999	2000	2001	2002	2003	2004	2005
Domestic (public and private)	404,470	687,599	1,100,158	1,617,878	2,235,347	2,682,416	3,218,900
External	1,751,507	2,102,951	1,594,175	2,564,083	2,679,291	3,349,114	4,186,392
Total	2,157,976	2,792,550	2,869,634	4,183,963	4,916,641	6,033,534	7,407,297

Please note: The sum of yearly totals of Table V.31.1 from each component should correspond to the yearly total in Table 1.b of the Executive Summary. For example, if Year 1 in the proposal is 2003, the column in Table 1.b labeled Year 1 should have in the last row the total of funding from other sources for 2003 for all components of the proposal.

32. Provide a full and detailed budget as attachment, which should reflect the broad budget categories mentioned above as well as the component's activities. It should include unit costs and volumes, where appropriate.

Please, see attached Detailed Budget

33. Indicate in the Table below how the requested resources will be allocated to the implementing partners, in <u>percentage</u> (Refer to *Guidelines para. V.63*):

Table V.33

Resource allocation to implementing partners (%)*	Year 1	Year 2	Year 3 (Estimate)	Year 4 (Estimate)	Year 5 (Estimate)	Total
Government	40%	25%	25%	20%	20%	
NGOs / Community-Based Org.	35%	30%	25%	25%	25%	
Private Sector	5%	10%	15%	15%	15%	
People living with HIV/ TB/ malaria	0%	5%	5%	10%	10%	
Academic / Educational Organizations	10%	15%	15%	15%	15%	
Faith-based Organizations	10%	15%	15%	15%	15%	
Others (please specify)						
Total	100%	100%	100%	100%	100%	100%
Total in USD						

** If there is only one partner, please explain why.*
Please note: The following three sections (VI, VII and VII) are all related to proposal/component <u>implementation arrangements</u>.

If these arrangements are the same for all components, you do not need to answer these questions for each component. If this is the case, please indicate clearly in which component the required information can be found.

<u>SECTION VI – Programmatic and Financial management information</u>

Please note: Detailed description of programmatic and financial management and arrangements are outlined in Guidelines para. VI. 61 – 73, including the main responsibilities and roles of the Principal Recipient (PR).

34. Describe the proposed management arrangements (outline proposal implementation arrangements, roles and responsibilities of different partners and their relations), *(Guidelines para. VI.64),*(1–2 paragraphs):

The implementers are the NTBLCP; State and LGA TBL programmes; Universities, Local and community-based NGOs involved in frontline TB/HIV activities also to be referred to as Sub-recipients. The role of the NTBLCP is mainly dealing with provision of policy guidelines, supervision and coordination of partners in collaboration with the National TB inter-agency committee. The State programmes are responsible for training of frontline staff, planning and supervision at that level, while the LGA programmes are responsible for DOTS services delivery at the health facility level as well as planning and supervision at the LGA level. The Local community-based NGOs are also involved in direct DOTS service delivery at both primary and secondary care levels.

34.1 Explain the rationale behind the proposed arrangements (e.g., explain why you have opted for that particular management arrangement), (1 paragraph).

The rationale behind the above management arrangements lies in the fact that the proposed PRs have reputable efficient financial disbursement system for administration of external donor funding to States and LGA implementers with many years of experience. The proposed PRs are also known to have the human and managerial capacity to perform the task. Moreover Nigeria is a large country with 37 semi-autonomous states, which are zoned according to geographical location.

35.Identify your first and second suggestions for the Principal Recipient(s) (Refer *to Guidelines para. VI.65–67)*:

Table VI.35

	First suggestion	Second suggestion
Name of PR	GTZ (German Technical Cooperation)	UN OPS (UNDP/WHO)
Name of contact	Heiner Woller	Dr. B. T. Costantinos Dr. Abdou Moudi
Address	95A Idejo Dtreet, Victoria Island, Lagos, P.O.Box 56 106 Nigeria	United Nations Building, Aguinyi Ironsi Way, Maitama, Abuja.
Telephone		+234-9-4135671
Fax	+234-9-4135671	As Above
E-mail	Woller_gtz@ghana.com	unaids@linkserve.com

Please note: If you are suggesting to have several Principal Recipients, please copy Table VI.35 below.

35.1. Briefly describe why you think this/these organization(s) is/are best suited to undertake the role of a Principal Recipient for your proposal/component (e.g. previous experience in similar functions, capacity and systems in place, existing contacts with sub recipients etc), *(Guidelines para. VI.66–67),* (1–2 paragraphs):

See HIV/AIDS Component

Both the GTZ and UNOPS/WHO are well established in Nigeria and both have a functional financial and auditing system that meet international requirements. Each of the organizations has programme implementation mechanisms, which are well tested and are specific on the diseases targeted by this grant. Adequate manpower is also on ground and are conversant with Nigeria's Medical and Financial mechanisms.

The two organizations also have an effective surveillance and Monitoring and Evaluation Mechanism systems tested in the field for various diseases. It is expected that the Mission from GFATM will be able to assess these capabilities and during which further information will be made available. This is with special regard to the performance records in the areas of Programme Management, Procurement and Fiduciary matters.

35.2. Briefly describe how your suggested Principal Recipient(s) will relate to the CCM and to other implementing partners (e.g., reporting back to the CCM, disbursing funds to sub-recipients, etc.), (1 paragraph):

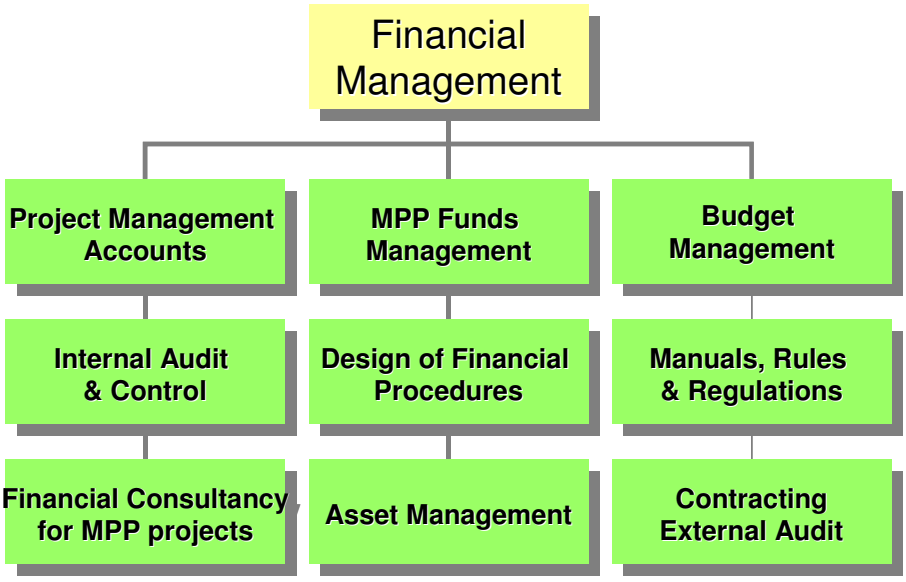
The Principal Recipient will be a member of the CCM and will directly relate to the sub-recipients under the supervision of the CCM. The CCM is developing a Disbursement Manual, which will form the basis for the implementation of all fiduciary functions and which will be based on the GF ATM requirements.

36. Briefly indicate links between the overall implementation arrangements described above and other existing arrangements (including, for example, details on annual auditing and other related deadlines). If required, indicate areas where you require additional resources from the Global Fund to strengthen managerial and implementation capacity, (1–2 paragraphs):

See HIV/AIDS Component

The fiduciary arrangement endorsed by the CCM, Nigeria is based on the structure recommended by the GF ATM.

Additionally, the Monitoring and Evaluation subcommittee of the CCM has the mandate to ensure programme implementation as designed, with proper information-sharing mechanism. There will thus be linkages with the sub recipients, the CCM and disease sub groups / partners to enable appropriate assessment of implementation. The CCM plans to engage the services of External Auditors who will be independent in function and responsibility, while ensuring the adequate bookkeeping for CCM. Additional resources will be required from Global Fund to strengthen the managerial capacity of the Principal Recipient and the CCM, especially with regard to the geographic expanse of Nigeria and the multiplicity of sector responses and subprojects that challenge the limits of the present infrastructure of the CCM.



SECTION VII – Monitoring and evaluation information

37. Outline the plan for conducting monitoring and evaluation including the following information, (1 paragraph per sub-question).

The National Tuberculosis and Leprosy control programme is structured along the 3 tiers of government, Federal, state and Local Governments.

The Central unit (CU) is involved with policy formulation, securing support and supervision of the implementation at the state level, while the state is responsible for the monitoring and supervision of the programme at the LGA level. The LGA level is the area of programme implementation.

The Central Unit and Partners are involved in bi-annual monitoring and supervision of all states, while the state conducts quarterly monitoring and supervision at the LGA levels using checklists. The LGA supervisors monitor and supervise the programme at the health facilities.

The project will be subjected to comprehensive evaluation at all stages of the programme. A Situational analysis has already been carried out and the results will serve as a baseline for use in future evaluations..
A mid-term evaluation will be conducted with participation of all partners, mid-way through the project period and at the end of project, an Independent end evaluation has been scheduled.
During the intervals of the evaluation periods, regular monitoring will be done to ensure that project activities are implemented according to plan. Regular interpretation of epidemiological indicators will serve as a basis for continuous improvement in the programme. Regular feedback between the various levels of the programme will be ensured to ensure proper coordination and technical guidance.

37.1. Outline of existing health information management systems and current or existing surveys providing relevant information (e.g., Demographic Health Surveys, Living Standard Measurement Surveys, etc.), (*Guidelines para. VII.76)*:

The programme adopted the WHO/IUATLD recommended recording and reporting formats, which include; TB patient treatment card, LGA Central Register, Laboratory registers, Quarterly case finding / annual reporting formats, Quarterly Sputum conversions forms, and the Quarter reports on the treatment outcomes of smears positive.

37.2. Suggested process, including data collection methodologies and frequency of data collection (e.g., routine health management information, population surveys, etc.):

A TB suspect (persistent cough for 3 weeks or more) is subjected to 3 sputum examinations, and is confirmed a Tuberculosis case with 2 smear positive smears. A TB patient treatment card is opened for the case, and the TBL Supervisor subsequently registers him in the LGA TB Central Register.
The daily anti-TB drug administration under direct supervision is entered in the patients' treatment card. The patients response to treatment is monitored by sputum examination and weight at 2nd, 5th and end of 7th month, which is entered into the LGA Central Register from where the Quarterly / Annual case finding, sputum conversion and the treatment outcome data are collated.

37.3. Timeline:

Routine data are collected quarterly i.e case finding and sputum conversion.
The analysis will be done yearly for treatment outcome.
Progress reports will be done half yearly.
A mid- term evaluation of the project will be done, while an end term evaluation will be carried out at the end of the project.

- Case finding and sputum conversion to be done quarterly
- Treatment outcome to done annually
- External monitoring to be done quarterly and annually
- Evaluation to be done midterm and end-term
- Reports to be done half yearly

37.4. Roles and responsibilities for collecting and analyzing data and information:

The LGA TBL Supervisors collect and collate the TB data from the heatlh facilities on weekly basis and compile for the LGA on quarterly basis, which he forwards to the state TBL Control Programme officer.

The State TBL Control officers collate and analyse all the LGA quarterly reports and forward the state reports to the NTBLCP Central Unit.

The NTBLCP Central Unit collate and analyse all the State quarterly reports and give annual feedback to the control officers.

37.5. Plan for involving target population in the process:

The patients and the community are involved in case finding and defaulter retrieval and plans are on the way for involving the community members in community DOTS drug administration.

37.6. Strategy for quality control and validation of data:

Quarterly meetings are held at the state level for all the LGA TBL supervisors during which the data collated from the variously health facilities by the LGA TBL supervisors are validated in line with their LGA TB Central register

Quarterly supervisory visits are made by the state TBL Control officers from the state level to the LGA level to validate data. Also, frequent visits are made by the Medical advisers of the NGO/ Partners to the states and LGA levels to validate the data collected.

Slides are picked quarterly for quality control at first, second and third level quality assurance.

See Section 37.7 of HIV/AIDS Component

37.7. Proposed use of M&E data:

1. For monitoring the trends of the disease
2. For planning purposes (i.e, for logistics etc)

3. For monitoring the efficacy of interventions.
4. As a powerful advocacy tool.
5. For policy formulation

38. Recognizing that there may be cases in which applicants may not currently have sufficient capacity to establish and maintain a system(s) to produce baseline data and M&E indicators, please specify, if required, activities, partners and resource requirements for strengthening M&E capacities.

Please note: As M&E activities may go beyond specific proposals funded by the Global Fund, please also include resources coming from other sources at the bottom of Table VII.38.

Examples of activities include collecting data, improving computer systems, analyzing data, preparing reports, etc.

Table VII.38

Activities (aimed at strengthening Monitoring and Evaluation Systems)	Partner(s) (which may help in strengthening M&E capacities)	Resources Required (USD)					
		Year 1	Year 2	Year 3	Year 4	Year 5	Total
National lab. Quality assurance monitoring	FMOH, SMOH, CIDA, ILEP, WHO, LGA	10,435	10,435	10,435	10,435	10,435	52,175
State lab. Quality control monitoring	FMOH, SMOH, CIDA, ILEP, WHO, LGA	51,217	51,217	51,217	51,217	51,217	256,085
Undertake at least one supervisory visits per year to each state programme	FMOH, SMOH, CIDA, ILEP, WHO, LGA	23,478	23,478	23,478	23,478	23,478	117390
Supervision from Zone to State 3 times per year	FMOH, SMOH, CIDA, ILEP, WHO, LGA	7,826	7,826	7,826	7,826	7,826	39,130
Conduct supervisory visits to each LGA.	SMOH, CIDA, ILEP, WHO, LGA	381,130	381,130	381,130	381,130	381,130	1,905,650
Conduct supervisory visit of each health facility involved in TB control.	CIDA, ILEP, WHO, LGA	805,148	805,148	805,148	805,148	805,148	4,025,740

Conduct joint WHO/IUATLD monitoring of NTBLCP quarterly and annually in collaboration with technical partners	WHO, IUATLD, ILEP, FMOH, SMOH, LGA, KIT	8,870	8,870	8,870	8,870	8,870	44,350
Midterm review	WHO, IUATLD and KIT	2,087	2,087	2,087	2,087	2,087	10,435
End term review	WHO, IUATLD and KIT	2,087	2,087	2,087	2,087	2,087	10,435
Hold twice yearly State TBL Control Officers meetings	CU, NASCP STBLCO and Medical Advisors	28,357	28,357	28,357	28,357	28,357	141,785
Quarterly meetings of state TBL workers including laboratory scientists with facility laboratory scientists / technicians	STBLCO State lab scientists and LGA lab. Scientists	560,343	560,343	560,343	560,343	560,343	2,80,1715
Total requested from Global Fund		1,880,977	1,880,977	1,880,977	1,880,977	1,880,977	9,404,885
Total other resources available		306,873	306,873	306,873	306,873	306,873	1,534,365

** Exchange rate used is N115.00 to $1.00

SECTION VIII – Procurement and supply-chain management information

39. Describe the existing arrangements for procurement and supply chain management of public health products and equipment integral to this component's proposed disease interventions, including pharmaceutical products as well as equipment such as injections supplies, rapid diagnostics tests, and commodities such as micronutrient supplements, condoms and bed nets (Refer to *Guidelines paragraph VIII.86*).

Table VIII.39

Component of procurement and supply chain management system	Existing arrangements and capacity (physical and human resources)
How are suppliers of products selected and pre-qualified?	At present, all anti-TB drugs and reagents are supplied to the programme directly by the Donor agencies, who make purchases through their home office abroad. Therefore the suppliers of products are selected and pre-qualified there.
What procurement procedures are used to ensure open and competitive tenders, expedited product availability, and consistency with national and international intellectual property laws and obligations?	Not applicable, see above.
What quality assurance mechanisms are in place to assure that all products procured and used are safe and effective?	All imported drugs and reagents are subjected to qualitative analysis by the National Agency for Food, Drugs, Administration, and Control. (NAFDAC)
What distribution systems exist and how do they minimize product diversion and maximize broad and non-interrupted supply?	The existing drug distribution system makes use of the donor agencies, which receive their supplies from their home offices. The donors in turn distribute to the state drug stores according to the reported caseload and stock position from where the peripheral health facilities receive their drug supplies. Delivery vouchers are signed by both receiving and supplying officers at all levels. In addition drugs received directly by the central unit are stored at the central medical store Oshodi from where they are distributed through the donor agencies supporting the State programmes according to the reported case load and stock position of the peripheral health facilities at the LGA level

40. Describe the existing arrangements for procurement of services (e.g., hiring personnel, contracts, training programs, etc.), (1–2 paragraphs):

In the public service, the civil service commission of the 3 tiers of government (federal, State and local) are responsible for employment of personnel according to laid down regulations and procedures. In the non-governmental sector, the donors and partners do hire personnel according to their organizational statutes.

However for organized seminars and workshops, Facilitators are invited and paid their due honorarium.

41. Provide an overview of the additional resources (e.g., infrastructure, human resources) required to support the procurement and distribution of products and services to be used in this component, (2–3 paragraphs):

Anti Tb drugs are being expected from the Global drug facility (GDF) and to this end there is the need to renovate the storage facilities at the federal, State and LGA levels and provide facilities such as

- Air - conditioners for stores
- Zonal offices
- Fund for logistics

There is also need to recruit a Pharmacist for managing the anti-TB drugs at the National level and training of stores personnel

42. Detail in the table below any additional sources from which the applicant plans to obtain products relevant to this component, whether additional requests have been requested or granted already. (For each source, indicate a contact person at the program in question, the volume of product in the request of grant, and the duration of support. Examples of such programmes are the Global TB Drug Facility or product donations from pharmaceutical manufacturers), (*Guidelines para. VIII.88*):

Table VIII.42

Programme name	Contact person (with telephone & email information)	Resources requested (R) or granted (G)	Timeframe and duration of request or grant
Global TB drug Facility	Dr T. O. Sofola 234-9-5238190 234-80-3305-1149 (Mobile) tosofola@hotmail.com	Anti-TB drugs for 33000 cases granted for 2002	2002 - 2004

42.1. Explain how the resources requested from the Global Fund for the products relevant to this component will be complementary and not duplicative to the additional sources, if any, described above (1 paragraph):

The resources requested from the global fund are supplementary to the resources already provided by development partners and government. They are actually gap identified in the provision of TB services in the country

SECTIONS IV – VIII: Detailed information on each component of the proposal

PLEASE COMPLETE THE FOLLOWING SECTIONS FOR EACH COMPONENT
Please copy sections IV – VIII as many times as there are components

Please note: a component refers to a disease, i.e. your proposal will have more than one component only if it covers more than one disease. There should only be 1 component per disease.

If there are any objectives or broad activities within a particular component that are of a system-wide/cross-cutting nature such as capacity building or infrastructure development that may go beyond the scope of that particular component, please indicate those aspects clearly and specify how they would relate to other components of the proposal when detailing them in Question 27. (Guidelines para. IV.47 – 49)

If this is a fully integrated proposal, where two or more components are linked in such a way which would not make it realistic or feasible to separate, mark the boxes in Table IV.23 to identify all diseases which would be directly affected by this integrated component. (Guidelines para. 50)

SECTION IV – Scope of proposal

23. Identify the component that is detailed in this section (mark with X):

Table IV.23

Component (mark with X)**:**		**HIV/AIDS**
		Tuberculosis
	X	**Malaria**
		HIV/TB

24. Provide a brief summary of the component (Specify the rationale, goal, objectives, activities, expected results, how these activities will be implemented and partners involved) (2–3 paragraphs):

Rationale: The purpose of this project is to contribute to an increased utilization of ITNs and insecticide re-treatment kits, improved household management of malaria and introducing the use of sulphadoxine-pyrimethamine as IPT of malaria in pregnancy by the target population.

Goal:

To contribute to reduction of Malaria mortality in children under five and pregnant women, in 12 states (222 LGAs) by 30% by the year 2007 through Scaling up the use of Insecticide Treated Nets (ITNs), Improving Home Management of Malaria and Initiating Intermittent Preventive Treatment (IPT) for pregnant women.

Objectives:

1.To increase the proportion of pregnant women and children under 5 years in 12 States of Nigeria who sleep under ITNs from 2.9% to 50% as well as from 5.7% to 55% respectively by the year 2007

2.To have 50% of total nets in households regularly retreated by 2007.

3. To increase the proportion of malaria cases among under fives that are appropriately managed at the community level through improvement in the home management by mothers and care givers from 12% to 60% by the end of 2007.

4. To increase the proportion of pregnant women that use IPT according to national guidelines from 0% to 50% in 12 states by end 2007.

Broad Activities:

1.The procurement, distribution and demand creation to ensure the appropriate use of ITNs

2.Timely re-treatment of the nets over the project time cycle.

3.The procurement and distribution of pre-packed drugs and capacity strengthening for malaria drug handlers, mothers and home-caregivers.

4.The procurement and distribution of Sulphadoxine-pyrimethamine (SP) and capacity strengthening of Health Managers on IPTs.

Expected Results:
1. Reduce morbidity and mortality due to malaria among pregnant women and children under five years.

2. Improved knowledge of mothers and other caregivers on the appropriate management of malaria cases among under fives

3. Initiate the use of Sulphadoxine –pyrimethamine (SP) for Intermittent Preventive Treatment of malaria in pregnancy

Implementation Process.:

A Procurement and Distribution (P & D) Agents will be appointed to procure and distribute commodities to the established community based outlets Media consultants used in the programme in collaboration with Public Information Services, CBOs, local information channel operators, and other private sectors will implement IEC activities. Insecticide resistance assessment will be addressed through medical research institutions within their relevant areas of comparative advantage. P & D agents are expected to be private sector Manufacturers/Dealers and NGOs.in mosquito nets, insecticides and drugs with existing distribution channels at the community levels.
They will be selected through public bidding through CCM in accordance with GFATM procurement guidelines.

Capacity strengthening through the relevant training will address orientation and re-training of Health Managers, vendors and other malaria drug handlers for prepackaged drugs for case management and IPT. This will involve using cascaded approaches and IEC strategies in line with the National Policy and guidelines. This is expected to improve compliance and ensure correct home management of malaria.

Partner Role:

Partner role will be complementary based on their areas of comparative advantage and mandate within the framework of the National RBM Strategic Plan. In addition to above, partners are networking with the private sector to ensure effective implementation and sustainability of the overall control efforts.

25. Indicate the estimated duration of the component:

Table IV.25

From (month/year)**:**	January 2003	**To** (month/year)**:**	December 2007

26. Detailed description of the component for its FULL LIFE-CYCLE:

Please note: Each component should have ONE overall goal, which should translate into a series of specific objectives. In turn each specific objective should be broken-down into a set of broad activities necessary to achieve the specific objectives. While the activities should not be too detailed they should be sufficiently descriptive to understand how you aim to achieve your stated objectives.

***Indicators**: In addition to a brief narrative, for each level of expected result tied to the goal, objectives and activities, you will need to identify a set of indicators to measure expected result. Please refer to Guidelines paragraph VII.77 – 79 and Annex II for illustrative country level indicators.*

***Baseline data**: Baseline data should be given in absolute numbers (if possible) and/or percentage. If baseline data is not available, please refer to Guidelines paragraph VII.80. Baseline data should be from the latest year available, and the source must be specified.*

***Targets**: Clear targets should be provided in absolute numbers (if possible) and percentage.*

For each level of result, please specify data source, data collection methodologies and frequency of collection.

An example on how to fill out the tables in questions 26 and 27 is provided as Annex III in the Guidelines for Proposals

26.1. Goal and expected impact (Describe overall goal of component and what impact, if applicable, is expected on the targeted populations, the burden of disease, etc.), (1–2 paragraphs):

Goal:

To contribute by 30% reduction of Malaria mortality in children under five and pregnant women, in 12 states (222 LGAs) by the year 2007 through Scaling up the use of Insecticide Treated Nets (ITNs), Improving Home Management of Malaria and Initiating Intermittent Preventive Treatment (IPT) for pregnant women.

Expected Impact on disease burden:

Situation analysis showed the enormity of the disease burden among the target groups (Section III, parag.18)

The impact, therefore, of a 30% reduction in mortality among the target groups will ultimately contribute to the overall goal of the Roll Back Malaria by the year 2010.

Please note: the impact may be linked to broader national-level programmes within which this component falls. If that is the case, please ensure the impact indicators reflect the overall national programme and not just this component.

Please specify in Table IV.26.1 the baseline data. Targets to measure impact are only required for the end of the full award period.

Table IV.26.1

Goal:		
Impact indicators (Refer to Annex II)	***Baseline*** ***Year 2002:***	***Target*** *(last year of proposal)* ***Year:2007***
<5 malaria mortality rate	***45 per thousand deaths target population***	*31 per thousand deaths target population (year 2007)*
Malaria specific maternal mortality rate	***77 per 100 thousand***	*48 per 100 thousand*

27. Objectives and expected outcomes (Describe the specific objectives and expected outcomes that will contribute to realizing the stated goal), (1 paragraph per specific objective):

1. To increase the proportion of pregnant women and children under 5 years in 12 States of Nigeria who sleep under ITNs from 2.9% to 50% as well as 5.7% to 55% respectively by 2007.

2. To have 50% of total nets in households regularly retreated by end of 2007.

3. To increase the proportion of malaria cases among under fives that are appropriately managed at the community level through improvement in the home management by mothers and care givers from 12% to 60% by end of 2007.

4. To increase the proportion of pregnant women that use IPT according to national guidelines from 0% to 50% in 12 States by end of 2007.

Question 27 must be answered for each objective separately. Please copy Question 27 and 27.1 as many times as there are objectives.

Please note: the outcomes may be linked to broader programmes within which this component falls. If that is the case, please ensure the outcome/coverage indicators reflect the overall national programme and not just this component.

Specify in Table IV.27 the baseline data to measure outcome/coverage indicators. Targets are only required for Year 2 onward

Table IV.27

Objective 1		**To increase the proportion of pregnant women and children under 5 years** ***in 12 States of Nigeria who sleep under ITNs from 2.9% to 50% and to 55% respectively by 2007.***				
Outcome/coverage indicators (Refer to Annex II)	**Baseline**	**Targets**				
	Year: 2002	**Year 1 2003**	**Year 2:** 2004	**Year 3:** 2005	**Year 4:** 2006	**Year 5:** 2007
Proportion of Pregnant women sleeping under ITNs, the previous night.	**2.9%**	15.0%	30.0%	40.0%	45.0%	50.0%
Proportion of children under five years sleeping under ITNs the previous night.	**5.7%**	20.0%	35.0%	45.0%	50.0%	55.0%

Objective: 2	**To have 50% of total nets procured regularly retreated by end of 2007.**					
Outcome/coverage indicators (Refer to Annex II)	**Baseline**	**Targets**				
	Year: 2002	**Year 1 2003**	**Year 2:** 2004	**Year 3:** 2005	**Year 4:** 2006	**Year 5:** 2007
The proportion of ITNs retreated within the last 6 months	**0%**	20%	20%	30%	40%	50%

Objective: 3	**To increase the proportion of malaria cases among under fives that are appropriately managed at the community level through Improvement in the home management by mothers and care givers From 12% to 60% by end of 2007.**					
Outcome/coverage indicators (Refer to Annex II)	**Baseline**	**Targets**				
	Year: 2002	**Year 1 2003**	**Year 2:** 2004	**Year 3:** 2005	**Year 4:** 2006	**Year 5:** 2007
Proportion of children <5 years with uncomplicated malaria getting correct treatment at home within 24 hours of unset.	**12.0%**	20.0%	30.0%	40.0%	50.0%	60.0%

Objective: 4	**To increase the proportion of pregnant women that use IPT according to national guidelines from 0% to 50% in 12 States by end 2007.**					
Outcome/coverage indicators (Refer to Annex II)	**Baseline**	**Targets**				
	Year: 2002	**Year 1 2003**	**Year 2:** 2004	**Year 3:** 2005	**Year 4:** 2006	**Year 5:** 2007
Proportion of Pregnant women who completed IPT for malaria.	**0.0%**	10.0%	20.0%	30.0%	40.0%	50.0%

27.1. Broad activities related to each specific objective and expected output (Describe the main activities to be undertaken, such as specific interventions, to achieve the stated objectives) (1 short paragraph per broad activity):

Please note: Process/output indicators for the broad activities should directly reflect the specified broad activities of THIS component.

Specify in Table IV.27.1 below the baseline data to measure process/output indicators. Targets need to be specified for the first two years of the component.

For each broad activity, specify in Table IV.27.1 who the implementing agency or agencies will be.

Table IV.27.1

Objective: 1	**To increase the proportion of pregnant women and children under 5 years in 12 States of Nigeria who sleep under ITNs from 2.9% to30% and 60% by 2004 and 2007 respectively.**				
Broad activities	**Process/Output Indicators** (indicate one per activity) (Refer to Annex II)	**Baseline (Specify year) 2002**	**Targets**		**Responsible/Implementing agency or agencies**
			Year 1 2003	**Year 2 2004**	
A. Identification of Procurement & Distribution (P & D) agents and appointment by public bidding.	No. of P & D agents identified and appointed	**0**	3	3	CCM
B. Procurement of ITNs (180 x 170 x 150)	No. of ITNs procured	219,311	805,064	938,516	CCM / P & D Agents
C. Development of appropriate distribution channels.	No. of ITNs distributed	**0**	805,064	938,516	CCM / P & D Agents, CBOs etc.
D. Implementation of IEC and media activities	No. of IEC activities implemented	**0**	25% increase		Advert Agency; Private Sector, CBOs, Public Information services
E. Monitoring vector resistance to insecticides.	Sentinel sites for insecticide resistance by vector established	**0**	6	6	Medical Research Institutions Laboratory

Explanatory Note:

A. The project team will be guided by fiduciary guidelines of the GFATM/CCM in matters concerning procurement and supplies of the ITNs to their technical specifications to assure fairness, transparency and maximum impact for costs. CCM in collaboration with the RBM Partners will appoint 3 Procurement and Distribution Agents (P&D), one for two contiguous zones in the first year of the project, and additional three agents to cover the 6 geopolitical zones (scaled up to one per zone) of the country by the end of the second year of the project.

B. Procurement and Distribution (P&D) Agents will be appointed to execute procurement and appropriate levels of distribution for established channels. A total of 1,743,580 ITN will be procured in the first 2 years of the project time cycle with 805,064 for year one, and 938,516 for year two. These figures were derived from the following values:
Current population estimates in the selected 12 states for pregnant women is 1,846,829 while that for children under five years is 7,695,131. The annual population growth rate is 3%. An increment on ITN availability from 2.9% to 15% between the baseline year and the first year and 30% for the

Second year is being proposed for pregnant women, and an increment from 5.7% to 20% and 35% for children under five years over the same period. Increments in the subsequent years of the project are as stated in Table 27 under Objectives above. The mathematical relationships for these data thus led to the derived values for the target groups for each year (See attached annex sheet on calculations).

C. As in B above. In addition, the relevant quantity of ITNs will be delivered to the end-user outlet by the P&D following the establishment of the appropriate distribution points up to the Health facility and community level.

D. An advertisement agency will implement IEC activities in collaboration with Private Sectors, CBOs and Public Information Services. An increase of 25% is targeted over the first year implementation coverage, which in itself becomes the baseline value for the activity.

E. Monitoring of insecticide resistance will be addressed through medical research institutions within their relevant areas of comparative advantage in the 6 Sentinel sites to be established by the second year. Deficiencies in baseline values will be provided for all cases from year one data when established.

Table IV.27.1

Objective: 2	**To have 50% total nets in households regularly treated by end of 2007.**				
Broad activities	**Process/Output Indicators** (indicate one per activity) (Refer to Annex II)	**Baseline (Specify year) 2002**	**Targets**		**Responsible/Implementing Agency or agencies**
			Year 1 2003	**Year 2 2004**	
A. Identification of P & D agents and appointment by bidding	No. of P & D agents identified and appointed	0	3	3	CCM
B. Procurement of Insecticide Kits	Qty. of Insecticides procured	0	161,013	915,129	CCM / P & D Agents
C. Development of appropriate distribution channels.	Qty. of Insecticides distributed	0	161,013	915,129	CCM / P & D Agents CBOs

D. Implementation of IEC activities	No. of IEC activities implemented	0	25% increase	25% increase	Advert Agency; Private Sector, CBOs, Public Information services

Explanatory Note: Procurement and distribution strategy already in place (as described above) will facilitate implementation of the activities which in-turn will address the problems inherent in challenges poised by nets re-treatment.

Objective: 3	**To increase the proportion of malaria cases among under fives that are appropriately managed at the community level through Improvement in the home management by mothers and caregivers from 12% to 60% by end of 2007**				
Broad activities	**Process/Output Indicators** (indicate one per activity) (Refer to Annex II)	**Baseline (Specify year) 2002**	**Targets**		**Responsible/Implementing agency or agencies**
			Year 1 2003	**Year 2 2004**	
A. Sensitize mothers and other care givers on home based management of malaria	% of mothers and other care givers who know correct treatment of malaria.	12%	20%	30%	Women groups, CBOs, NGOs, Public facilities and Community members
B. Procurement of Pre-packed drugs procured.	No. of outlets keeping pre-packs in stock.	0	1,585,197	2,449,129	CCM / P & D Agents
C. Distribution of Pre-packed drugs.		0	1,585,197	2,449,129	CCM / P & D Agents
D. Training of malaria drug handlers	No. of vendors, handlers trained	0	20,133	20,133	Public sector

Explanatory Note:

A. Improper information and misplaced economic values are the bane of home management practices are found to be inadequate in communities. Sensitization strategies through CBOs, NGOs, Public facilities, and community members will attempt to improve this gap in knowledge, attitude, and practice in the successive years of the project beginning from 0 baseline values.

B. Demand creation resulting from implementation of the above activities will be addressed by the Procurement & Distribution(P&D) Agent of Pre-packed drugs using the already established channels and stocking the accredited outlets. Procurement figure per year is derived from the following values:
Current population estimates of the children under five years is 7,695,131; the current baseline utilization of Chloroquine (CQ) in this group is 12% while 20% increase is proposed for year one. An annual population increase of 3% is used. The mathematical

relationship of these values provides the figure for each year of the project (see attached annex sheet on calculations)

C. Distribution to outlets is accommodated in B above as part of the Terms of Reference (TOR) of the P&D Agent.

D. The human resources involved, Vendors and other malaria drugs handlers, will have capabilities improved by the relevant package of training. This is expected to improve compliance and ensure correct home management of malaria.

Objective: 4	**To increase the proportion of pregnant women that use IPT according to national guidelines from 0% to 50% in 12 States by end 2007.**				
Broad activities	**Process/Output Indicators** (indicate one per activity) (Refer to Annex II)	**Baseline** **(Specify year)** **2002**	**Targets** **Year 1** **2003**	**Year 2** **2004**	**Responsible/Implementing Agency or agencies**
A.Procurement of 582,084 packs of IPT	No. of Sulphadoxine Pyrimethamine procured.	0	190,224	391,860	CCM / P & D Agent
B. Distribution of Sulphadoxine Pyrimethamines to Health Facilities	% of Health Facilities with no. of stock out within two weeks	0	190,224	391,860	CCM / P & D Agent, Public Facility framework
C. Orientation of Health Managers on IPT for pregnant women	% of ANC staff trained in IPT	0	2,220	2,220	NGOs etc
D. Implementation of IEC activities	No. of IEC activities implemented	0	25% increase	25% increase	Advert Agency; Private Sector, CBOs, Public Information services

Explanatory Note:

A. Consequent upon increasing resistance, circulation of fake/sub-standard products and more particularly poor compliance with existing drugs interventions, there is compelling need to initiate and sustain IPT as a management option for malaria in pregnancy. Procurement/distribution framework for Sulphadoxine Pyrimethamine (SP) will be executed by a P&D as described earlier using the already established channels to improve and sustain community-based facility stock status over the project lifetime.

B. Procurement figure per year is derived from the following values: Current population estimates in the selected 12 states for pregnant women is 1,846,829 while that for children under five years is 7,695,131. The annual population growth rate is 3%. An annual 10% increment on IPT availability from 0% baseline is proposed for pregnant women, Increments in the subsequent years of the project are as stated in Table 27 under Objectives above. The mathematical relationship of these values provides the figure for each year of the project (see attached annex sheet on calculations).

C. This initiative presumes initial orientation and the acceptance of the concept by health managers thereby requiring cascaded orientation of the personnel of various health services cadres.

D. An advertisement agency will implement IEC activities along national policy and guidelines in collaboration with Private Sectors, CBOs and Public Information Services. An increase of 25% is targeted over the first year implementation coverage, which in itself becomes the baseline value for the activity.

28. Describe how the component adds to or complements activities already undertaken by the government, external donors, the private sector or other relevant partner: (e.g., does the component build on or scale-up existing programs; does the component aim to fill existing gaps in national programs; does the proposal fit within the National Plan; is there a clear link between the component and broader development policies and programmes such as Poverty Reduction Strategies or Sector-Wide Approaches, etc.), (*Guidelines para. III.41 – 42*),(2–3 paragraphs):

The component to provides access to ITNs for pregnant women and children under 5 through ITNs Massive Promotion & Awareness Campaign (IMPAC) initiative, improve home management and introduce intermittent preventive treatments of malaria in pregnancy. This is a demand creation mechanism, which is based on a reward system to children who complete immunization schedule and pregnant women that attend antenatal clinic (ANC). Government will distribute about 1 million nets to these groups as incentive to boost immunization and ANC attendance. The component will narrow estimated 59% (national coverage gap.

The component also complements donor-supported private sector ITN initiatives. Three major social marketing initiatives will stimulate sustainable private sector ITN programme. The component where the private sector/NGOs are to be used to deliver ITN will provide additional choice of product and channel of distribution and it will

narrow potential gaps particularly at the rural and semi urban centres that have less structured and less developed channels.

The component's IEC plans will scale up ITN demand in focal states/LGAs and will complement existing generic advertising campaign by private sector initiative.

The components are properly located in the National Roll Back Malaria Programme.

By providing nets at reasonable subsidies, by targeting women and children under 5 and by locating in some of the poorest states of the nation the component has clear links to the National Poverty Eradication Programme.

29. Briefly describe how the component addresses the following issues (1 paragraph per item):

29.1. The Involvement of Beneficiaries such as People Living with HIV/AIDS:

The project is focusing on two main beneficiaries. Malaria affects every citizen of Nigeria but children under 5 and pregnant women are the most vulnerable.

29.2. Community Participation:

The Malaria component involves the already existing community based systems (Patent Medicine Vendors (PMVs), Village Development Committees (VDC), District Development Committees (DDC), Community Based Organisations (CBOs), etc) in the implementation of its activities to ensure socio-cultural acceptability and sustainability. This includes, among other things, regular meetings of stakeholders at the community level, dialogue session, Empowerment (through information sharing) and capacity building.

29.3. Gender Equality Issues (*Guidelines paragraph IV.53*):

By targeting children under 5 irrespective of sex and pregnant women with ITNs not only were they prevented from attacks of malaria but also offering them protection as a social right and demonstrating gender equalities. Since malaria in pregnancy pre-disposes to abortions, low birth weight in children and constitutes 11% of MMR in Nigeria, targeting pregnant women with ITNs and IPT will provide protection from malaria and increase the reproductive health needs of women.

Mothers sleep on the same bed with their new born babies culturally in Nigeria, thus targeting pregnant women at ANC with ITNs ensures protection to the baby early at birth.

29.4. Social Equality Issues (*Guidelines paragraph IV.53*):

Malaria remains a major killer disease among the vulnerable group i.e. children under 5 and pregnant women including persons of low social standing within our rural communities. These groups are often deprived of social amenities including opportunity for ease access to them.

This proposal seeks to address the issues of malaria prevention using ITNs, use of pre-packaged drugs for correct home management of malaria and encouraging PMVs, mothers and other care givers to have access to these drugs as near to the home as possible.

The Health facilities at the ward level will be strengthened to participate in IMPAC and deliver correct treatment of malaria including appropriate referrals. The community solidarity mechanisms through the CDCs will be encouraged using appropriate communication strategies. The Private sector dealing with both the ITNs and Drugs have demonstrated their preparedness to expand their distribution channels for their products to the communities.

The Private- Public partnership being developed will seek to ensure that the social equality issues including access and affordability are addressed.

29.5. Human Resources Development:

The proposal addresses human resources development at both the health facility and community levels. At the health facility level health workers will be trained to provide quality ANC care with emphasis on IPT to pregnant women. They will also be trained to acquire skills in data collection, analyses and interpretation for the purpose of monitoring the key intervention.

At the community level, PMVs will be trained to stock and dispense pre-packed drugs and keep relevant records for monitoring purposes.

The existing M & E officers in the States and LGAs will be adequately involved with the consultant for M & E contracted for the project.

29.5. **For components dealing with essential drugs and medicine, describe which products and treatment protocols will be used and how rational use will be ensured (i.e. to maximize adherence and monitor resistance),** *(Guidelines para. IV.55),* (1–2 paragraphs):

The ITN and Antimalaria drug policies are available in the Nigeria. The prepackaged drugs are designed to improve compliance to treatment especially in the home. The Chloroquine (CO) and Sulphadoxine – pyrimethamine (SP) packages are colour-specific for the different age groups as shown in the table below

Age	Chloroquine(CQ)
Under 1 year	Yellow
1-6 years	Blue
6-12 years	White
Above 12	Pink
Age	Sulphadoxine Pyrimethamine(SP)
2months -2 years	Yellow
2-6 years	Blue
6-12 years	White
Above 12 years	Pink

SECTION V – Budget information

30. **Indicate the summary of the financial resources requested from the Global Fund by year and budget category**, (Refer to *Guidelines paragraph V.56 – 58*):

Table V.30

Resources needed(USD)	Year 1	Year 2	Year 3 (estimate)	Year 4 (estimate)	Year 5 (estimate)	Total
Human resources	863,000	821,000	845,000	821,000	821,000	4,171,000
Training/Planning(training,workshops,meeting)	849,816	862,545	828,583	809,453	811,618	4,162,015
Infrastructure(buildings, computers,cars etc)	351,000	24,000	24,000	24,000	24,000	447,000
Monitoring and evaluation	100,000	160,000	100,000	160,000	100,000	620,000
Commodities/Products	4,944,061	5,437,834	4,550,718	3,530,902	3,657,669	22,121,183
Drugs and transportation	381,314	457,645	731,990	838,152	924,739	3,333,840
Administrative cost	15,750	15,750	15,750	15,750	15,750	78,750
Others (specify)	1,008,262	1,536,831	1,792,128	2,218,317	2,825,364	9,380,902
Total	8,513,203	9,315,605	8,888,169	8,417,573	9,180,140	[redacted]

The budget categories may include the following items:
Human Resources: Consultants, recruitment, salaries of front-line workers, etc.
Infrastructure/Equipment: Building infrastructure, cars, microscopes, etc.
Training/Planning: Training, workshops, meetings, etc.
Commodities/Products: Bednets, condoms, syringes, educational material, etc.
Drugs: ARVs, drugs for opportunistic infections, TB drugs, anti-malaria drugs, etc.
Monitoring & Evaluation: Data collection, analysis, reporting, etc.
Administrative: Overhead, programme management, audit costs, etc
Other (please specify):

30.1. For drugs and commodities/products, specify in the table below the unit costs, volumes and total costs, for the FIRST YEAR ONLY:

Table V.30.1

Item/unit	**Unit cost** (USD	**Volume** (specify measure)	**Total cost** (USD)
Insecticide treated nets	3.5	1,730,000	6,055,000
Insecticide kits	1.0	1,100,000	1,100,000
Prepackaged drugs	0.4	4,100,000	1,640,000
Sulphadoxine-pyrinethanine SP for intermittent preventive treatment (IPT)	0.4	585,000	234,000
Cost of Transportation and handling of Kits, ITNs, prepackaged drugs and IPT drugs.	-	-	2,201,300
Vehicles land cruiser(4 wheel drive)	22,000	2	44,000
Motorcycles(motorbikes)	1,000	225	225,000
Total			11, 499,300

30.2. In cases where Human Resources (HR) is an important share of the budget, explain to what extent HR spending will strengthen health systems capacity at the patient/target population level, and how these salaries will be sustained after the proposal period is over (1 paragraph):

The staff at the local government and community level will be actively involved in the project and the capacity of the other members of the community will be built to sustain the activities. The Community Development Commitees (CDCs) will be the actual actors for the community participation from the onset of the project.

31. If you are receiving funding from other sources than the Global Fund for activities related to this component, indicate in the Table below overall funding received over the past three years as well as expected funding until 2005 in US dollars (*Guidelines para. V.62*)**:**

Table V.31.1

	1999	2000	2001	2002	2003	2004	2005
Domestic (public and private)		1,000,000	1,000,000	9,500,000	10,000,000	8,000,000	8,000,000
External		0	0	8,000,000	8,000,000	8,000,000	8,000,000
Total		1,000,000	1,000,000	17,500,000	18,000,000	16,000,000	16,000,000

Please note: The sum of yearly totals of Table V.31.1 from each component should correspond to the yearly total in Table 1.b of the Executive Summary. For example, if Year 1 in the proposal is 2003, the column in Table 1.b labeled Year 1 should have in the last row the total of funding from other sources for 2003 for all components of the proposal.

32. Provide a full and detailed budget as attachment, which should reflect the broad budget categories mentioned above as well as the component's activities. It should include unit costs and volumes, where appropriate.

The full and detailed budget is as attatched. The component activities are procurement, transportation and distribution of commodities(ITN, insecticides, IEC materials, prepackaged drugs etc).Training ,monitoring and evaluation are other main component activities.

33. Indicate in the Table below how the requested resources will be allocated to the implementing partners, in <u>percentage</u> (Refer to *Guidelines para. V.63*):

Table V.33

Resource allocation to implementing partners* *(%)*	**Year 1**	**Year 2**	**Year 3 (Estimate)**	**Year 4 (Estimate)**	**Year 5 (Estimate)**	**Total**
Government	10%	10%	10%	10%	10%	10*

NGOs / Community-Based Org.	20%	30%	40%	50%	60%	42*
Private Sector	60%	50%	40%	30%	20%	38*
People living with HIV/ TB/ malaria	N/A	N/A	N/A	N/A	N/A	N/A
Academic / Educational Organizations	5%	5%	5%	5%	5%	5%*
Faith-based Organizations	5%	5%	5%	5%	5%	5%*
Others *(please specify)*	-	-	-	-	-	-
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Total in USD	**8,513,203**	**9,315,605**	**8,888,169**	**8,417,573**	**9,180,140**	**44,314,689**

- ***If there is only one partner, please explain why.***

* Not applicable as column totals are not additive

Please note: The following three sections (VI, VII and VII) are all related to proposal/component <u>implementation arrangements</u>.

If these arrangements are the same for all components, you do not need to answer these questions for each component. If this is the case, please indicate clearly in which component the required information can be found.

SECTION VI – Programmatic and Financial management information

Please note: Detailed description of programmatic and financial management and arrangements are outlined in Guidelines para. VI. 61 – 73, including the main responsibilities and roles of the Principal Recipient (PR).

GFATM

Identify steering committee with oversight of all subcontract/(ors)
and their compliance to specifications and timelines

NATIONAL CCM THROUGH ITS ESTABLISHED PROCESS
Supported by National Malaria Control Committee)

↓

STATE COORDINATING MECHANISM (Private sector, civil society, public etc supported by State malaria control committee)

↓

LGA COORDINATING MECHANISM (Private sector, civil society, public, etc supported by LGA Health Committee)

↓

WARD/COMMUNITY COORDINATING MECHANISM (supported by Community Development Committees)

VILLAGECOORDINATING MECHANISM (supported by the Village Development Committee)

The National Malaria Control Committee does not have an office and as such makes meetings of members very irregular. There will be a need to have an office for proper supervision and monitoring of the project with staff in place. This will be the coordinating office for the RBM component of the proposal especially for collation and analysis of M& E data

34. Describe the proposed management arrangements (outline proposal implementation arrangements, roles and responsibilities of different partners and their relations), *(Guidelines para. VI.64),*(1–2 paragraphs)**:**

1. All procurement requirements will be met by the Procurement and Distribution Agents to be appointed from the private sector and NGOs by the CCM in collaboration with the RBM Partners, who will ensure distribution of products to the service points of the consumer.

2. The RBM-GF ATM Project Committee will have the responsibility for the entire oversight of the project implementation processes including Supervision, Monitoring and Evaluation of all project components.

3. Capacity building and improvement of awareness are continuous processes, which will run through the entire project cycle. The awareness component will be implemented using the private, public and local facility outlets, while the capacity building framework will be addressed by NGOs with the relevant comparative advantage, in collaboration with the appropriate public sector departments.

34.1 Explain the rationale behind the proposed arrangements (e.g., explain why you have opted for that particular management arrangement), (1 paragraph)**.**

1. Partner consensus guided the decision for a contractual approach to procurement, which lends itself to easy management that, is transparent and based on economic prudence.

2. The partnership is highly stake –holder representative and the implementation options for broad activities are selected in an all-inclusive participatory process.

3. The strategies established for individual components are a utility of synergism for inter-linkage of components and overall project benefits.

35. Identify your first and second suggestions for the Principal Recipient(s) (Refer *to Guidelines para. VI.65–67)*:

The CCM will be appointing a Principal Recipient that will manage projects within its Fiduciary Framework and the GFATM Guidelines.

Table VI.35

	First suggestion	**Second suggestion**
Name of PR	GTZ	UNOPS/WHO
Name of contact	Heiner Woller	Dr. B. T. Costantinos Dr. Abdou Moudi
Address	Plot 954A, Idejo Street, P.O.Box 56106, Victoria Island Lagos Nigeria	United Nations Building, Aguinyi Ironsi Way, Maitama, Abuja.
Telephone	+234-1-618 542	+234-9-4135671

Fax		As above
E-mail	Woller_gtz@ghana.com	unaids@linkserve.com, admin@who-nigeria.org

Please note: If you are suggesting to have several Principal Recipients, please copy Table VI.35 below.

35.1. Briefly describe why you think this/these organization(s) is/are best suited to undertake the role of a Principal Recipient for your proposal/component (e.g. previous experience in similar functions, capacity and systems in place, existing contacts with sub recipients etc), *(Guidelines para. VI.66–67),* (1–2 paragraphs):

Both the GTZ and UNOPS/WHO are well established in Nigeria and both have a functional financial and auditing system that meet international requirements. Each of the organizations has programme implementation mechanisms, which are well tested and are specific on the diseases targeted by this grant. Adequate manpower is also on ground and are conversant with Nigeria's Medical and Financial mechanisms.

The two organizations also have an effective surveillance and Monitoring and Evaluation Mechanism systems tested in the field for various diseases. It is expected that the Mission from GFATM will be able to assess these capabilities and during which further information will be made available. This is with special regard to the performance records in the areas of Programme Management, Procurement and Fiduciary matters.

35.2. Briefly describe how your suggested Principal Recipient(s) will relate to the CCM and to other implementing partners (e.g., reporting back to the CCM, disbursing funds to sub-recipients, etc.), (1 paragraph)**:**

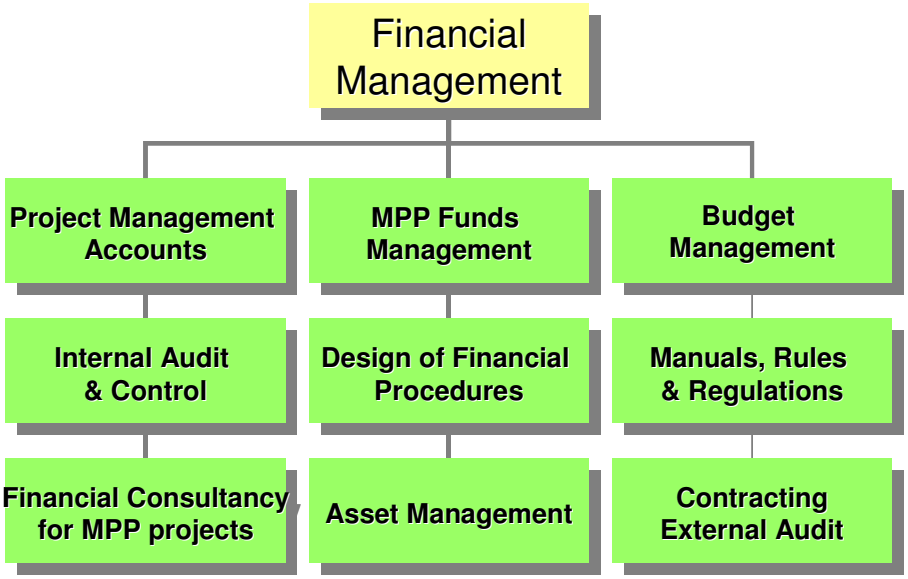
The Principal Recipient will be a member of the CCM and will directly relate to the sub-recipients under the supervision of the CCM. The CCM is developing a Disbursement Manual, which will form the basis for the implementation of all fiduciary functions and which will be based on the GF ATM requirements.

36. Briefly indicate links between the overall implementation arrangements described above and other existing arrangements

(including, for example, details on annual auditing and other related deadlines)**. If required, indicate areas where you require additional resources from the Global Fund to strengthen managerial and implementation capacity**, (1–2 paragraphs)**:**

The fiduciary arrangement endorsed by the CCM, Nigeria is based on the structure recommended by the GF ATM.

Additionally, the Monitoring and Evaluation subcommittee of the CCM has the mandate to ensure programme implementation as designed, with proper information-sharing mechanism. There will thus be linkages with the sub recipients, the CCM and disease sub groups / partners to enable appropriate assessment of implementation. The CCM plans to engage the services of External Auditors who will be independent in function and responsibility, while ensuring the adequate bookkeeping for CCM. Additional resources will be required from Global Fund to strengthen the managerial capacity of the Principal Recipient and the CCM, especially with regard to the geographic expanse of Nigeria and the multiplicity of sector responses and subprojects that challenge the limits of the present infrastructure of the CCM.



SECTION VII – Monitoring and evaluation information

37. Outline the plan for conducting monitoring and evaluation including the following information, (1 paragraph per sub-question).

37.1. Outline of existing health information management systems and current or existing surveys providing relevant information (e.g., Demographic Health Surveys, Living Standard Measurement Surveys, etc.), (*Guidelines para. VII.76)***:**

Routine data collection forms are used by health facilities, the accruing data not being processed are sent to LGAs monthly. These forms are collated and sent to the National Health Management Information System Unit through the State offices. The RBM Secretariat lacks it own in-house data management base to perform any data management function and thus relies on data supposed to be centrally analysed and feedback given downwards. Unfortunately, this has not been happening due to lack of human resources, equipment and logistics.

Information is also gathered through community surveys using the WHO Guideline on RBM for monitoring and evaluation of impact usually on a three yearly basis. The Guideline was used for baseline data collection in 2001. Other community surveys including Demographic Health surveys are conducted on a regular basis by Federal Office of Statistics (FOS), National Health Management and Information System (NHMIS) etc using other tools.

37.2. Suggested process, including data collection methodologies and frequency of data collection (e.g., routine health management information, population surveys, etc.)**:**

Routine data to measure some process and outcome indicators will be collected on monthly basis through improved NHMIS. WHO Guidelines on RBM progress monitoring and impact evaluation will be adapted and used. Annual population surveys will be carried out to monitor indicators, which require services to measure. RBM database will be established at the RBM secretariat. The proposed arrangement will involve contracting consultants and/or institutions through competitive bidding, to carry out monitoring and evaluation of the Project with the oversight of the RBM-GFATM Project Committee. The successful bidder will be expected to comply fully with the TOR to be developed by CCM regarding data collection, analysis, interpretation and dissemination of reports to the LGAs, States, RBM Secretariat and the CCM.

37.3. Timeline:

In the first quarter of the first year of the Project, the successful M& E consultant will carry out baseline data collection and analysis. He will also provide a semi- annual monitoring and evaluation report of the implementation of the activities. An annual evaluation report is expected with a full evaluation report at the completion of the Project cycle.

37.4. Roles and responsibilities for collecting and analyzing data and information:

Personnel at point of service delivery will be responsible for data collection, immediate analysis and submission to the consultant. He will be responsible for collation and further analysis of data coming from service delivery points and submission to CCM through RBM secretariat database.

37.5. Plan for involving target population in the process:

Target population will be required to keep the necessary personal/individual records/cards for verification during household surveys. Key members of the Health facility and Development Committees at village, community, ward, LGA and State levels will be involved in the monitoring and evaluation.

37.6. Strategy for quality control and validation of data:

Tools and checklists will be developed and applied to the service delivery points for process monitoring and output evaluation. NAFDAC, SON and relevant stakeholders will design and participate in the regulation of practice and quality control of supplies and products. Scheduled and unscheduled visits will be paid to personnel at service delivery points. Discussions to give feedback will hold at the end of visits. Staff will be commended on good practices and unacceptable practices will be corrected.

37.7. Proposed use of M&E data:

The data from Monitoring Reports will be used to ensure that the project processes are being complied with, and its targets being met.
Evaluation reports will be used to determine project impact and the realization of the overall objectives towards the project goal.
Results of the analysis will be deployed to timely decision making and lessons learnt from monitoring and evaluating would be used to scale up this component in the remaining 24 states.

38. Recognizing that there may be cases in which applicants may not currently have sufficient capacity to establish and maintain a system(s) to produce baseline data and M&E indicators, please specify, if required, activities, partners and resource requirements for strengthening M&E capacities.

Please note: As M&E activities may go beyond specific proposals funded by the Global Fund, please also include resources coming from other sources at the bottom of Table VII.38.

Examples of activities include collecting data, improving computer systems, analyzing data, preparing reports, etc.

Table VII.38

Activities (aimed at strengthening Monitoring and Evaluation Systems)	**Partner(s)** (which may help in strengthening M&E capacities)	**Resources Required** (USD)					
		Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Setting up of an M&E Unit for the RBM Secretariat: ➢ Data Manager (1) ➢ Data Entry Clerks (4) ➢ Computer/accessories.	WHO, DFID, USAID UNICEF	36,000 15,000 16,000 5,000	38,000 15,000 18,000 5,000	38,000 15,000 18,000 5,000	40,000 15,000 20,000 5,000	40000 15,000 20,000 5,000	192,000 75,000 92,000 25,000
Training of RBM staff at LGA level for data collection and analysis: ➢ Recruitment	WHO, Unicef, DFID, USAID (BASICS-II), Malaria Consortium.	800,000	800,000	750,000	700,000	650,000	**3,700,000**

Computerization of the HIMS at the LGA.	WHO, Unicef, DFID, USAID (BASICS-II), Malaria Consortium.	2,000,000	2,000,000	1,000,000	1,000,000	1,000,000	7,000,000
Total		2,872,000	2,876,000	1,826,000	1,780,000	1,730,000	11,084,000
Total requested from Global Fund		100,000	160,000	100,000	160,000	100,000	620,000
Total other resources available		N/A	N/A	N/A	N/A	N/A	N/A

SECTION VIII – Procurement and supply-chain management information

39. Describe the existing arrangements for procurement and supply chain management of public health products and equipment integral to this component's proposed disease interventions, including pharmaceutical products as well as equipment such as injections supplies, rapid diagnostics tests, and commodities such as micronutrient supplements, condoms and bed nets (Refer to *Guidelines paragraph VIII.86*)**.**

Table VIII.39

Component of procurement and supply chain management system	Existing arrangements and capacity (physical and human resources)
How are suppliers of products selected and pre-qualified?	Tender's Board headed by the Permanent Secretary in the FMOH selects the suppliers through open competitive bidding. The pre-qualification for selection process include: - being a reliable company - must be registered as limited liability company - must be registered as a contractor(s) with FMOH
What procurement procedures are used to ensure open and competitive tenders, expedited product availability, and consistency with national and international intellectual property laws and obligations?	Advertisement are made in the national dailies listing the required products and stating clearly the specifications including quality, quantity and timeframe in conformity with the standard required by the regulatory agencies (SON and NAFDAC). The prospective bidders in sealed envelopes to the Tender's Board then submit quotations. The Board meets regularly to consider such bids and award contracts to the lowest bidders that meet the specification without compromising quality.
What quality assurance mechanisms are in place to assure that all products procured and used are safe and effective?	Apart from meeting the requirement of the national regulatory agencies (SON and NAFDAC), the products are physically inspected by the appropriate technical officer(s) within the FMOH/SMOH/ Department of Health in LGA on delivery to the warehouse of the national/state/LGA stores respectively before payments are made.
What distribution systems exist and how do they minimize product diversion and maximize broad and non-interrupted supply?	The existing distribution system requires the beneficiary states to collect their share of the products from the Federal store in Federal Capital Territory (FCT), Abuja using a requisition which specify the quantity (ies) and timeframe within which the product(s) be collected. The same arrangements above are utilized for distribution from states to LGAs.

40. Describe the existing arrangements for procurement of <u>services</u> (e.g., hiring personnel, contracts, training programs, etc.), (1–2 paragraphs)**:**

Procurement of services are made through advertisement in the national dailies stating the kind of service(s) to be provided, qualification, competence and experience required. Responses from the prospective candidate(s)/company(ies)/Agent(s) will be examined by a constituted panel for appropriate selection.

The selected candidate(s)/company(ies)/Agent(s) will be made known to the appropriate authority for approval followed by formal documentation of the processes involved.

41. Provide an overview of the additional resources (e.g., infrastructure, human resources) required to support the procurement and distribution of products and services to be used in this component, (2–3 paragraphs):

Considering the need for timeliness, consistent quality, leakage proof, safety, appropriate storage conditions and equitable distribution of products (ITNs, Insecticide and Anti-malaria drugs) and services (IEC, M&E, etc.) it is proposed that the procurement and distribution be carried out through competent Procurement and Distribution agents (P & D Agents). P & D Agent(s) will be selected through open competitive bidding. Such agents will enter into agreement with CCM. The agreement among other things would provide for: Quality, Specification contract fee(s), Recall and Replacement of sub-standard product(s), Termination of Agreement.

At implementation sites, existing community organizations such as PMVs and CBOs will be mobilized through training and orientation to ensure effective performance.

In order to ensure effective supervision of P & D Agents and community organisations, it is proposed that consultant(s)/institution(s) be appointed with the responsibility(ies) of ensuring that products supplied are in compliance with the provision of agreement by P & D Agent(s).

42. Detail in the table below any additional sources from which the applicant plans to obtain products relevant to this component, whether additional requests have been requested or granted already. (For each source, indicate a contact person at the program in question, the volume of product in the request of grant, and the duration of support. Examples of such programmes are the

Global TB Drug Facility or product donations from pharmaceutical manufacturers), (*Guidelines para. VIII.88*):

The country has received donation of ITNs and insecticides from RBM partners (UNICEF, WHO and DFID) and also, the Federal Government is committed to the procurement of 1.184 million ITNs for distribution throughout the country out of which 5,000 have been received.

Table VIII.42

Programme name	Contact person (with telephone & email information)	Resources requested (R) or granted (G)	Timeframe and duration of request or grant
UNICEF	UNICEF Representative 234-1-2690276 ; Lagos' unicef.org	400,000 ITNs	2001 – 2003
WHO	WHO Representative 234-1-7737092	25,000 ITNs	2002 – 2003
DFID	Country Representative	100,000 ITNs	2002
FGN	Hon. Minister of Health 234-9-5238190	1,00,000 ITNs	2002 – 2003

42.1. Explain how the resources requested from the Global Fund for the products relevant to this component will be complementary and not duplicative to the additional sources, if any, described above (1 paragraph):

Out of the 530,000 ITNs above, 230,000 will be distributed throughout the country including the 12 states identified by this proposal. The remaining 30,000 will be utilized in the UNICEF – assisted states. It should be noted that the total ITNs required to cover the vulnerable groups (pregnant women and under 5 years) is currently 15 million.

LIST OF ATTACHMENTS

Please note:
The list of attachments is divided into two parts: the first part lists the attachments requested by the Global Fund as support for Sections III and IV.
The second part is for applicants to list attachments related to other Sections such as the Information on applicants (Section II), Detailed Budget (Section IV), or other relevant information.

Please note which documents are being included with your proposal by indicating a document number.

General documentation:	**Attachment #**
1. Poverty Reduction Strategy Paper (PRSP)	_____
2. Medium Term Expenditure Framework	_____
3. Sector strategic plans	_____
4. Any reports on performance	_____
HIV/AIDS specific documentation:	**Attachment #**
5. Situation analysis	
6. Baseline data for tracking progress[1]	
7. National strategic plan for HIV/AIDS, with budget estimates	_____
8. Results-oriented plan, with budget and resource gap indication (where available)	
TB specific documentation:	**Attachment #**
9. Multi-year DOTS expansion plan and budget to meet the global targets for TB control	_____
10. Documentation of technical and operational policies for the national TB programme, in the form of national manuals or similar documents	_____
11. Most recent annual report on the status of DOTS implementation, expansion, and financial planning (routine annual WHO TB Data [and Finance] Collection Form)	_____
12. Most recent independent assessment/review of national TB control activities	_____

[1] Where baselines are not available, plans to establish baselines should be included in the proposal.

Malaria specific documentation:	Attachment #
13. Situation analysis	x
14. Baseline data for the tracking of progress	x
15. Country strategic plan to Roll Back Malaria, with budget estimates	x
16. Result oriented plan, with budget and resource gap indication (where available)	x

General documentation:	Attachment #

HIV/AIDS specific documentation:	Attachment #

TB specific documentation:	Attachment #

Malaria specific documentation:	Attachment #

Crosscutting documents/activities	Attachment #