PROPOSAL FORM

FIFTH CALL FOR PROPOSALS

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

Timetable: Fifth Round

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

Resources available: Fifth Round

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

Geneva, 17 March 2005

Notes:

How to use this form:

1. Ensure that you have all the documents that accompany this form—the Guidelines for Proposals, and Annexes A and B to this proposal form.
2. Please read ALL questions carefully. Specific instructions for answering the questions are provided.
3. Where appropriate, indications are given as to the approximate length of the answer to be provided. Please try to respect these indications.
4. To tick any of the boxes in the form, move the cursor to the textbox, right click and choose 'properties', then 'default value' 'checked'.
5. To avoid duplication of effort, we urge you to make maximum use of existing information (e.g., program documents written for other donors/funding agencies).
6. Instructions and guidelines are printed in blue

Annexes:

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

1 Eligibility

Proposal title Scaling up DOTS expansion in Nigeria

Name of applicant Country Coordinating Mechanism (CCM), Nigeria.

Country/countries NIGERIA

Type of application:

☒ National Country Coordinating Mechanism

☐ Sub-National Country Coordinating Mechanism

☐ Regional Coordinating Mechanism (including Small Island Developing States)

☐ Regional Organization

☐ Non-Country Coordinating Mechanism

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

Proposal components

☐ HIV/AIDS[1]

☒ Tuberculosis[2]

☐ Malaria

☐ Health system strengthening

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

Currency in which the Proposal is submitted

☒ US$

☐ Euro

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

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

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

1 Eligibility

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

Country/countries	NIGERIA

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

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

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

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

1.1.1 Counterpart financing and greater reliance on domestic resources

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

Table 1.1.1 – Counterpart Financing and Greater Reliance on Domestic Resources

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

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

1.2 CCM functioning - eligibility criteria

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

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

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

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

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

2.1 Executive Summary

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

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

Nigeria is a federation with three tiers of government: Federal, States and Local Governments Area councils (LGAs). The country has a Federal Capital Territory (FCT, Abuja) which also has a status of a state. Each of the states (average 3.5m population) and FCT is made up of between 8 to 44 LGAs (average 165,000 population). The country is divided into six geopolitical zones (between 5-7 states per zone) namely: North East, North-West, North-Central, South-East, South-West and South-South. There exists a composite relationship among all the tiers of government. Federal revenues are shared in a pre-determined proportion among the three tiers to carry out their respective functions. Statutorily, these tiers of government have concurrent responsibilities for the provision of some public services including health. In the present democratic dispensation, states also have substantial autonomy and exercise considerable authority over the budget allocation and utilization of their resources. The autonomy status of states tends to constrain the control that Federal Government can exercise over States and Local Governments in terms of resource allocation for various sectors including health and education.

TB is a major public health problem in Nigeria and as one of the 22 countries of the world with the highest burden of the disease, an estimated 380,000 cases occur annually, 60% of which are smear positive (WHO Global TB report 2005 – Annex 1). Statistics show that the age group 15-35 years is most vulnerable to TB in the country with obvious consequences on the socio-economic status of the population. The HIV epidemic in Nigeria has a significant impact on the TB epidemic as evidenced by a shift to the younger age groups (15-35 years), who have higher HIV sero-prevalence too.

The country has adopted the WHO recommended DOTS strategy as the approach to control the spread of TB through prompt detection of infectious cases and providing effective therapy with quality-assured anti-TB drugs under standard case management conditions. Currently the population access to a health facility providing DOTS services is less than 50%, and only 26% of all estimated smear positive cases are being detected and treated under DOTS. The National Tuberculosis and Leprosy Control Programme (NTBLCP) is the responsible body that coordinates TB and Leprosy control activities in the whole country. The NTBLCP operates under the Department of Public Health (DPH) of the Federal Ministry of Health (FMOH). NTBLCP is structured along the three tiers of government i.e. Federal, State and LGAs. The National level (referred to as NTBLCP

Central Unit) is responsible for facilitating policy developments regarding TB control, tertiary care, mobilization of resources, human resource development and technical support to state programmes. The State TBL programmes coordinate TB activities in the respective states, provide secondary care as well as provide technical assistance to LGA level. The LGA is the operational level of the programme based on the Primary Health Care (PHC) principle.

The Nigerian TB control effort has been substantially supported by development partners since its launch in 1991. From 1993 to date, KfW funds have been utilized to establish DOTS services in 14 states (Abia, Akwa-Ibom, Anambra, Bayelsa, Cross river, Delta, Ebonyi, Edo, Ekiti, Enugu, Imo, Ondo, Ogun, Rivers) mainly in the south-east, south-south and south-west zones. The KfW funding is channeled to the 14 beneficiary states through the German Leprosy and Tuberculosis Relief Association (GLRA). The funds covers anti-TB drugs, laboratory equipment, reagents/consumables, training, technical assistance, and provision of transport facilities (4-Wheel Drive (4WD) vehicles, motorbikes and speed boats). The Damien Foundation Belgium (DFB) provides support in 2 states (Oyo and Osun) in the south-west since 1994 and this support covers anti-TB drugs, laboratory equipment, reagents/consumables, training, technical assistance, and provision of transport facilities (4WD and motorbikes). Netherlands Leprosy Relief (NLR) supports DOTS in 4 states (Kaduna, Plateau, Bauchi and Gombe).

By 2002 twenty states of the federation were effectively supported in DOTS implementation, leaving a funding gap for TB control in 16 states and FCT.

The DOTS expansion strategic plan 2001-2005 (Annex 2) which was developed, reflected a total funding gap of $10m annually to execute the plan of establishing DOTS in the 16 states and FCT (Adamawa, Benue, Borno, FCT, Jigawa, Kano, Katsina, Kebbi, Kogi, Kwara, Lagos, Nasarawa, Niger, Sokoto, Taraba, Yobe and Zamfara) lacking external support. The plan also includes scaling up intervention in the others. CIDA and USAID assistance came in 2002 and 2003 respectively to reduce this funding gap. The total contribution of both agencies amounted to $2.1m annually. The specific activities reflected in the $10m annual funding gap are: strengthening laboratory services including MDR surveillance, involving private care providers in DOTS (PPM), improving patient management through community-based TB care, strengthening the technical and managerial capacity of the programme to implement effective TB/HIV collaborative activities.

Through the CIDA and USAID grants, the capacity of the Central Unit was strengthened with 4 experienced National Professional Officers recruited by WHO. In addition, the capacity of 190 laboratories and 400 general health care facilities was developed through training of staff, supervision and provision of drugs, reagents and equipment for provision of TB diagnostic and treatment services in 187 LGAs. There are presently, 547 TB microscopy centres in 505 LGAs (1/230,000 population) and 1,929 health facilities provide TB treatment (1/70,000 population). This should increase to 1468 microscopy centres (1/100,000 pop.) and 5,677 treatment centres (1/25,000 pop.) by 2010.

The overall goal of this proposal is to reduce significantly the burden, socio-economic impact, and transmission of TB in Nigeria. The impact indicators include:

1. Increased detection of the estimated TB cases under DOTS
2. Increase proportion of detected TB cases that are successfully treated
3. Reduced number of TB-related deaths
4. Reduced proportion of TB-related deaths among diagnosed patients
5. Reduced incidence of active TB among PLWHA
6. Increased % of adult population that practise healthy behaviour that contributes to reduced transmission and incidence of TB.

To attain the goal, the following objectives will be pursued:

1. To strengthen the technical and managerial capacity of the National TB and Leprosy Control Programme at all tiers to ensure achievement of at least 80% implementation rate of programme activities by 2010.

2. To promote behaviour change in the community about TB such that 70% of adult population know about TB, its prevention and free treatment, TB services and at risk groups are motivated to seek prompt care by 2010;
3. To increase TB case detection rate from 26% to 70% by 2010;
4. To treat at least 85% of all TB cases detected successfully by 2010;
5. To reduce by at least 25% the incidence of TB among PLWHA by 2010

The Key service delivery areas include: Human resource strengthening, advocacy, expansion of laboratory network, intensified TB case finding in congregate settings and among People Living With HIV/AIDS (PLWAs), treatment with DOTS, M&E and community DOTS.

Thus, the proposal aims to further increase access to DOTS facilities and to improve quality of care for TB patients, achieving the targets of 70% Case Detection Rate and of 85% Treatment Success Rate by 2010 and maintain the achievements thereafter. The expected outcome is the DOTS services available to the whole population of Nigeria (130 million) in an equitable manner, detecting on average 70,000 new SM+ TB cases (50% of the estimated total incidence) annually by 2008 and curing about of 60,000 of them.

To reach these set targets, it is strategic to enhance the technical and managerial capacity of the NTBLCP and other implementing partners in strengthening the existing services and establishing new peripheral DOTS centers in areas at present not covered. To improve the quality of treatment, the program will continue to ensure a regular supply of drugs and laboratory supplies to all DOTS centers, provide training to health staff, strengthen supervision, monitoring and evaluation activities. TB partnership will be strengthened to work in close collaboration with the NTBLCP so to advocate for governments' commitment and ownership of the program, hence the need for intensive ACS as an integral part of this proposal. Other important strategies include involvement of the private health care providers and community to deliver DOTS services.

The systematic implementation of TB/HIV collaborative activities planned in this proposal is expected to result into synergies that will help mitigate the impact both diseases on each other leading to an overall improvement of the health system. These synergies are in the areas of capacity building, partnership strengthening and advocacy, joint monitoring of TB and HIV/AIDS activities at all levels, availability of VCT services to all TB patients, TB care as part of HIV counselor training and INH preventative therapy as part of TB care. The overall impact of these synergies will be in reduction of deaths among people suffering from both of the diseases through timely detection and treatment of TB disease in PLWA, and reduction of HIV impact among TB patients.

The proposal if approved and funded will be directed at scaling up the existing DOTS efforts to reach uncovered LGAs within the context of the WHO Expanded DOTS Framework. This entails scaling up new initiatives of PPM, TB/HIV, CBTC and MDR surveillance to reach the population with quality-assured services. The scaling up effort will draw on lessons learnt in the previous 2 years of DOTS expansion and ongoing pilot project in the areas TB/HIV and PPM by German Leprosy and TB Relief Association (GLRA) and community patient care for leprosy patients by the Christian Health Association of Nigeria (CHAN), Netherlands Leprosy Relief (NLR) and The Leprosy Mission Nigeria (TLMN).

A total amount of $105,439,20 is required to successfully implement effective TB control in Nigeria for the 5 year period, of which $37,173,708 is expected to be met by Government and existing Development partners. The unmet need amounts to a total of $68,265,522, which is expected to be met by the GFATM.

2.2 Component and Funding Summary

Table 2.2 – Total Funding Summary

	Total funds requested in Euro / US$					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
HIV/AIDS						
Tuberculosis	13,670,413	11,899,648	13,370,972	13,897,622	15,426,868	**68,265,522**
Malaria						
Health systems strengthening						
Total						

Table 3 – Type of Application

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

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

3.1 National Country Coordinating Mechanism

Table 3.1 – National CCM: Basic Information

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

3.1.1	Describe how the National CCM operates—in particular, the extent to which the CCM acts as a partnership between government and other actors in civil society, including non-governmental organizations, the private sector and academic institutions, and how it coordinates its activities with other national structures (such as National AIDS Councils) (2 paragraphs). [For example, decision-making mechanisms, constituency consultation processes, structure of subcommittees, frequency of meetings, implementation oversight, etc. Provide statutes of the organization, organizational diagram and terms of reference as attachments.]
	The Organisational Structure of the CCM Nigeria includes a democratically elected Chairman, and a focal Secretary who operates the CCM Secretariat

with its staff compliment. Six Sub-committees are set up with their specific Terms of Reference (TOR) to address specific areas namely: Financial Management, Technical, Monitoring and Evaluation, Drug and Procurement, Technical, Fund Raising and Constitution (Annex E). The CCM operates standard and transparent procedures in its conduct of meetings and business; and maintains democratic channels for its decision – making processes on most matters of concern to the CCM, GFATM and Nigeria at large. The CCM meets every other month, or as emergent issues may dictate with dates of meetings set by consensus, usually during preceding meetings. The Functions and Responsibilities (Annex F) and Minutes of the CCM previous meetings are herewith attached (Annex G) have also been attached.

The CCM membership is drawn from eight constituencies, with each of which it maintains effective linkages through a very open communication channel. The membership also reflects effective partnership between government, NGOs, Civil Society Organizations and Organized Private Sector. While the CCM is not an organ of government, relevant government organs are adequately and fully represented on the Mechanism. By this means, the CCM Nigeria has created an atmosphere of full and equal participation of members. The CCM Nigeria thus depends on the constituency consultations that inform the in put of representatives to the CCM meeting and its entire processes. An annual work plan and budget for the activities is in place.

3.2 Sub-National Coordinating Mechanism

Table 3.2 – Sub-National CCM: Basic Information

Name of Sub-National CCM	Date of Composition

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

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

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

3.3 Regional Coordinating Mechanism (including Small Island Developing States)

Table 3.3 – Regional Coordinating Mechanism: Basic Information

Name of Regional CM	Date of Composition

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

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

3.4 Regional Organizations

Table 3.4 – Regional Organization: Basic Information

Name of Regional Organization

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

3.5 Non-Country Coordinating Mechanism

Table 3.5 – Non-CCM Applicant: Basic Information

Name of Non-CCM applicant

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

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

3.5.2 Rationale for applying outside an existing CCM

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

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

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

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

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

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

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

3.6 Proposal Endorsement and Membership Section

3.6.1 Representation

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

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

3.6.2 Contact information

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

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

	Primary contact	Secondary contact
Name	N/A	
Title		
Organization		
Mailing address		
Telephone		
Fax		
E-mail address		

3.6.3 Membership information

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

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

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

3.6..3.2

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

3.6.3.2

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

3.6.3.2

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

3.6.3.2

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

3.6.3.2

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

3.6.3.2

<table>
<tr><th colspan="4">National/Sub-National/Regional (C)CM member details</th></tr>
<tr><th colspan="4">Member 7</th></tr>
<tr><td>Agency/organization</td><td>National Parents-Teachers Association (NAPTAN)</td><td>Website</td><td></td></tr>
<tr><td rowspan="5">Type
(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)</td><td rowspan="5">Non-governmental-educational.</td><td rowspan="5">Sector represented</td><td>Civil Society Organisation</td></tr>
<tr><td></td></tr>
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<tr><td></td></tr>
<tr><td></td></tr>
<tr><td>Name of representative</td><td>Chief Mishael O. Nwachukwu</td><td>CCM member since</td><td>5 March 2002</td></tr>
<tr><td>Title in agency</td><td>National Vice-President, NAPTAN</td><td>Fax</td><td></td></tr>
<tr><td>E-mail address</td><td>monwachukwu@yahoo.com</td><td>Telephone</td><td>+234-803-3304112
+234-1-5894956</td></tr>
<tr><td rowspan="4">Main role in the Coordinating Mechanism and the proposal development
(proposal preparation, technical input, component coordinator, financial input, review, other)</td><td rowspan="4">Chairman, Fund-Raising subcommittee.</td><td rowspan="4">Mailing address</td><td>191 Babs Animashaun Road,</td></tr>
<tr><td>Surulere, Lagos.</td></tr>
<tr><td></td></tr>
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<tr><th colspan="4">Member 8...</th></tr>
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3.6.3.2

<table>
<tr><th colspan="4">National/Sub-National/Regional (C)CM member details</th></tr>
<tr><th colspan="4">Member 8</th></tr>
<tr><td>Agency/organization</td><td>National Action Committee on AIDS (NACA)</td><td>Website</td><td>www.naca.gov.ng</td></tr>
<tr><td rowspan="5">Type
(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)</td><td rowspan="5">Government -NACA</td><td rowspan="5">Sector represented</td><td>Government - NACA</td></tr>
<tr><td></td></tr>
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<tr><td></td></tr>
<tr><td></td></tr>
<tr><td>Name of representative</td><td>Prof. Babatunde Osotimehin</td><td>CCM member since</td><td>5 March 2002</td></tr>
<tr><td>Title in agency</td><td>Chairman, NACA.</td><td>Fax</td><td></td></tr>
<tr><td>E-mail address</td><td>osotimehin2000@yahoo.co.uk
bosotimehin@naca.gov.ng</td><td>Telephone</td><td>234-9-2904410-19
234-803-315-4600
234-804-418-4949</td></tr>
<tr><td rowspan="4">Main role in the Coordinating Mechanism and the proposal development
(proposal preparation, technical input, component coordinator, financial input, review, other)</td><td rowspan="4">Principal Recipient-HIV (PMTCT & ARV) Projects, and member, M & E subcommittee.</td><td rowspan="4">Mailing address</td><td>Chairman</td></tr>
<tr><td>NACA, The Presidency</td></tr>
<tr><td>Plot 823 Ralph Shodeinde Street</td></tr>
<tr><td>Central Business District, Abuja.</td></tr>
<tr><td colspan="4"></td></tr>
<tr><th colspan="4">Member 9...</th></tr>
</table>

3.6.3.2

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

3.6.3.2

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

3.6.3.2

National/Sub-National/Regional (C)CM member details			
Member 11			
Agency/organization	Civil Society Network on HIV and AIDS in Nigeria (CiSNHAN)	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Non-governmental organisation.	Sector represented	Civil Society Organisations (HIV/AIDS).
Name of representative	Lady Nkechi **Onah**	CCM member since	5 March 2002
Title in agency	National Moderator.	Fax	
E-mail address	ciscghan@yahoo.com, waro_2000@yahoo.com	Telephone	234-9-2344518, 234-42-259275, 234-42-457812 234-803-338-6951
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, Finance and Secretariat subcommittees.	Mailing address	CiSNHAN 38A Umuezebi St. P.O. Box 15672 New Haven Enugu
Member 12...			

3.6.3.2

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

3.6.3.2

<table>
<tr><th colspan="4">National/Sub-National/Regional (C)CM member details</th></tr>
<tr><th colspan="4">Member 13</th></tr>
<tr><td>Agency/organization</td><td>Nigerian Union of Journalists.</td><td>Website</td><td></td></tr>
<tr><td rowspan="5">Type
(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)</td><td rowspan="5">Private Sector</td><td rowspan="5">Sector represented</td><td>Private Sector - Media</td></tr>
<tr><td></td></tr>
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<tr><td></td></tr>
<tr><td>Name of representative</td><td>Mr. E. <u>Couson</u></td><td>CCM member since</td><td>5 March 2002</td></tr>
<tr><td>Title in agency</td><td>Manager, Northern Operations</td><td>Fax</td><td></td></tr>
<tr><td>E-mail address</td><td>emmaabi@yahoo.com</td><td>Telephone</td><td>+234-803-588-2742, +234-9-3143016, +234-66-221103, +234-66-225046.</td></tr>
<tr><td rowspan="4">Main role in the Coordinating Mechanism and the proposal development
(proposal preparation, technical input, component coordinator, financial input, review, other)</td><td rowspan="4">Representative - Media</td><td rowspan="4">Mailing address</td><td></td></tr>
<tr><td>Nigerian Union of Journalists Head Quarters.</td></tr>
<tr><td>Area 11, Garki</td></tr>
<tr><td>Abuja</td></tr>
<tr><td colspan="4"></td></tr>
<tr><th colspan="4">Member 14...</th></tr>
</table>

3.6.3.2

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

3.6.3.2

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

3.6.3.2

<table>
<tr><th colspan="4">National/Sub-National/Regional (C)CM member details</th></tr>
<tr><th colspan="4">Member 16</th></tr>
<tr><td>Agency/organization</td><td>Pharmaceutical Manufacturers Group (PMAN).</td><td>Website</td><td></td></tr>
<tr><td rowspan="5">Type
(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)</td><td rowspan="5">Private Sector</td><td rowspan="5">Sector represented</td><td>Private Sector</td></tr>
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<tr><td></td></tr>
<tr><td>Name of representative</td><td>Emma <u>Ebere</u></td><td>CCM member since</td><td>5 March 2002</td></tr>
<tr><td>Title in agency</td><td>President, PMAN-MAN.</td><td>Fax</td><td></td></tr>
<tr><td>E-mail address</td><td>emmaebere@hotmail.com</td><td>Telephone</td><td>234-803-432-3415
234-1-288-3056
234-1-588-2172.</td></tr>
<tr><td rowspan="4">Main role in the Coordinating Mechanism and the proposal development
(proposal preparation, technical input, component coordinator, financial input, review, other)</td><td rowspan="4">Member, Drug Procurement subcommittee.</td><td rowspan="4">Mailing address</td><td>Pharmaceutical Manufacturers Group (PMAN)</td></tr>
<tr><td>c/o Gemini Pharmaceutical Ltd</td></tr>
<tr><td>Isolo-Apapa Expressway</td></tr>
<tr><td>Lagos</td></tr>
<tr><td colspan="4"></td></tr>
<tr><th colspan="4">Member 17…</th></tr>
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3.6.3.2

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

3.6.3.2

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

3.6.3.2

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

3.6.3.2

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

3.6.3.2

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

3.6.3.2

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

3.6.3.2

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

3.6.3.2

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

3.6.3.2

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

3.6.3.2

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

3.6.3.2

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

3.6.3.2

National/Sub-National/Regional (C)CM member details			
Member 28			
Agency/organization	WHO	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Multi-/Bilateral Development Partner	Sector represented	Development Partner
Name of representative	Dr. Belhocine	CCM member since	5 March 2002
Title in agency	Country Representative	Fax	
E-mail address	aweayo@yahoo.co.uk	Telephone	+234-8023144120
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Representative of the UN-System (TB)	Mailing address	World Health Organisation, UN Plaza Abuja

National/Sub-National/Regional (C)CM member details			
Member 29			
Agency/organization	MACOA (CSO)	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	NGO	Sector represented	Civil Society Organisations (Malaria)
Name of representative	**Prof. H. Abdulkareem**	CCM member since	5 March 2002
Title in agency	President	Fax	
E-mail address	Profhussain@yahoo.com Lasucomikj.co.uk	Telephone	+234-1 – 8950823 +234-80 4-412 6067
Main role in the Coordinating	Member	Mailing address	27, Ayodeji Otegbola Street,

Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*			Gbagada Phase II, P.O. Box 6595 Ikeja, Lagos.

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

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

PROPOSAL TITLE:

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

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

Agency/organization	**Name of representative**	**Title**	**Date**	**Signature**

3.6.5 CCM Endorsement Details for Applications from Regional Organizations:

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

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

Table 3.6.5 – Regional Organization Endorsement

Names of CCM	**Country**	**Attachment number**

4 Components Section

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

4.1 Identify the Component Addressed in this Section

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

4.1.1 Indicate the Estimated Start Time and Duration of the Component

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

Table 4.1.1 – Proposal Start Time and Duration

	From	To
Month and year:	1st January 2006	31st December 2010

4.2 Contact Persons for Questions Regarding this Component

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

Table 4.2 – Component contact persons

	Primary contact	Secondary contact
Name	Dr. Mansur Kabir	Dr. Kefas Samson
Title	National Coordinator, NTBLCP	NPO Tuberculosis
Organization	FMOH	WHO Nigeria
Mailing address	Plot 1205, Accra Street, Wuse Abuja	Rm 609, BOI House, Bauchi Nigeria
Telephone	+234-803-703-8113, +234-9-670-1135	+234-803-701-2417
Fax	+234-9-523-8190	+234-77-541-872
E-mail address	jfrmkabir@hotmail.com	samsonkefas@yahoo.co.uk samsonkefas@hotmail.com

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

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

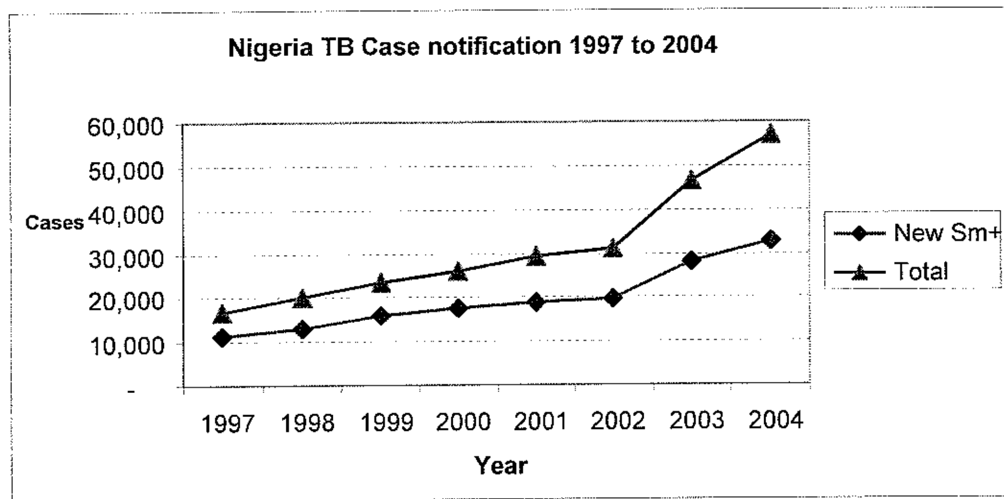
4.3 National Program Context and Gap Analysis for this Component

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

4.3.1 Epidemiological and Disease-Specific Background

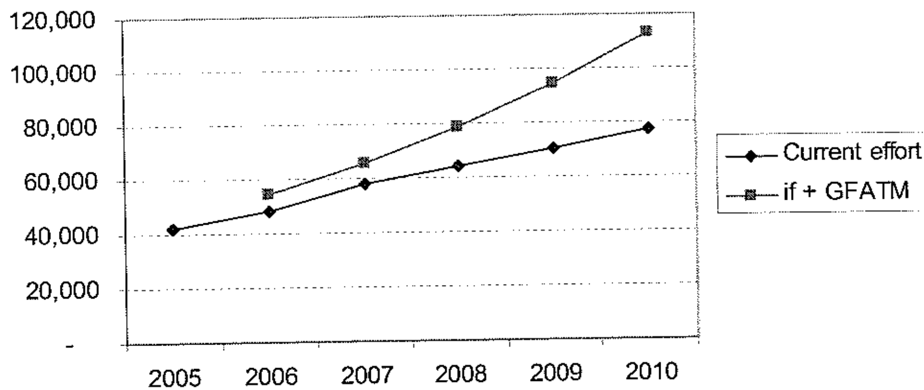
Describe, and provide the latest data on, the stage and type of epidemic and its dynamics (including breakdown by age, gender, population group and geographical location, wherever possible), the most affected population groups, and data on drug resistance, where relevant. (Information on drug resistance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

Ranking 4th among the 22 TB High Burden Countries (HBC) in the world and highest in Africa, an estimated 380,000 (293/100,000 population) new tuberculosis cases occur in Nigeria annually of which 60% (126/100,000) are smear positive (WHO Global TB report 2005). According to NTBLCP 2004 statistics, the TB case detection rate has been increasing from 15% in 2002 reaching 26% in 2004 (59,493 TB cases out of which 33,755 (60%) were smear positive. This has a direct relationship to the rate of expansion of DOTS within the same period.



The age group 15-34 years is worst hit by the epidemic (55% of all smear positive cases detected), while females constitute 41%.

The increasing association between HIV and TB observed over the past 10 years poses a significant challenge. The HIV sero-prevalence rate among TB patients increased over the years from 2.2% in 1991 to 19.1% in 2001 (NASCP 2001 – Annex 3), which indicates that the TB situation will continue to be HIV-driven. On the other hand, an estimated 30% of PLWHA have TB. The HIV factor is expected to result in further increase in case detection in the coming years. Further expansion of DOTS diagnostic and treatment service points is also expected to result in an increase in the number of TB cases to be detected and treated with DOTS. The chart below demonstrates a graphic description of the expansion plan with current support and compared to the expected if GFATM funding becomes available to fill the gap.



Note: In this proposal, the estimated TB incidence as contained in the WHO Global TB report 2005 as well as the case detection experience of past years was used to arrive at realistic estimates for 2006 to 2010.

Tuberculosis cases are treated under two broad categories in Nigeria based on WHO/IUATLD recommendations (Revised NTBLCP Workers Manual 2004 – Annex 4): All new pulmonary TB cases regardless of smear result, and extra-pulmonary TB are treated with **Category 1 regimen:** 2RHZE / 6EH. This is in view of the availability of the 4FDC (RHZE), which minimizes drug logistic problems for health staff in the field. On the other hand, all cases eligible for re-treatment which includes relapses, treatment after failure and cases returning after treatment default are treated with **Category 2 regimen:** 2SRHZE / 1RHZE /$5R_3H_3E_3$ and 2SRHZE/6RHZE. So far, the country has maintained a good treatment success rate of 80% in 2002 with a significant number of states having results above 85%. Although MDR surveillance is not well established in the country, the priority is on prevention of MDR-TB by first demonstrating country-wide high case finding and cure through existing public and private health services with good access.

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

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

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

Health care services in Nigeria are provided at 3 levels namely Primary, Secondary and Tertiary. To meet the constitutional provision of health on the concurrent list, each of these levels of care is allocated among the three constitutional levels of government as follows: Local government level is responsible for primary level of care, State government for secondary level of care and provision of technical guidance to the LGAs, and the Federal Government is responsible for the tertiary level of care in addition to policy formulation and technical guidance to the State level.

The general policy framework for health care is the National Health Policy, which has an overall goal to achieve a level of health that will enable all Nigerians to achieve socially and economically productive lives with Primary Health Care (PHC) as its cornerstone.

Currently, there is an ongoing Health Sector Reform (HSR) process which is expected to

result in *fundamental change* in policy, regulation, financing, provision of health services, re-organization, management and institutional arrangements aimed at improving the performance of the health system. A health bill which seeks to address the issues of resource mobilization for health care among the three tiers of government as well as providing greater opportunities for effective private sector participation and partnership is currently receiving attention of the National Assembly.
Health care services are discharged through about 30,000 public, and about 20,000 private health care facilities. All tertiary and most secondary facilities have laboratories and have the capacity to provide basic laboratory services including AFB microscopy for identification of PTB. The private sector, non-governmental organizations, and local communities also provide considerable services at all the levels of health care. The private sector accounts for about 50% of health care delivery in the country.

With respect to the fight against Tuberculosis, TB control is one of the key components of the basic health care package. The National Primary Health Care Development Agency (NPHCDA) recognizes training of PHC staff for detection of suspects, examination of sputum smears by an accessible network of laboratories, referral of suspects to secondary level when required, treatment of all patients as close to their domicile as possible, using the PHC network and the community, and tracing and examination of contacts as essential elements of sustainable control.

The institutional capacity has been developed in the country since 1991 with establishment of the National Tuberculosis and Leprosy Control Programme (NTBLCP) under the Department of Public Health in the Federal Ministry of Health (FMOH). NTBLCP is responsible for coordination of the TB control efforts at the Federal level and providing support to states. The NTBLCP is currently headed by a Consultant Public Health Physician, supported by 3 Medical Officers and 20 support staff. At the state level, each of the 36 states and FCT have State TBL Control Programme (STBLCP) headed by a Medical Officer who is supported by 3-4 Senior TBL supervisors. The programme has a National Tuberculosis and Leprosy Training Centre (NTBLCP), which trains mainly TB and Leprosy Supervisors.

The capacity of the health care delivery system to provide comprehensive TB services exists within both the public and private sectors but the implementation capacity needs to be strengthened through training and re-training (Fabio Oct. 2003). Tertiary, secondary and some PHC Comprehensive Health Centres provide laboratory services though with varying degree of functionality, while most DOTS treatment units are located within PHC facilities. So far 496 laboratories and 1,929 health care facilities collaborate with the NTBLCP in this regard. Faith Based Organizations (FBOs) are already actively providing TB treatment services with great potential for further DOTS implementation. In order for these health facilities to offer the desired level of TB care, there is need for provision of extra microscopes in some laboratories and training of the staff in the whole concept of DOTS.

The various partners contributing to the fight against TB in Nigeria are as follows:

Stakeholder	Area of work
WHO	Technical Assistance; Support in strategic planning, implementation, monitoring and evaluation.
Damien Foundation Belgium (DFB)	Supporting TB and Leprosy Control in 2 states of S/W Nigeria (Oyo and Osun): provision of anti-TB drugs, lab reagents/consumables, training of health staff and supervision.
German Leprosy and TB Relief Association (GLRA)	Supporting TB and Leprosy Control in 14 States in S/E, S/W and S/S Nigeria (Abia, A/Ibom, Anambra, Bayelsa, CrossRiver, Delta, Ebonyi, Edo, Ekiti, Enugu, Imo, Ondo, Ogun and Rivers: provision of anti-TB drugs up to 2006, lab reagents/consumables, training of health staff and supervision. TB/HIV project in Lagos, PPM in Anambra.
Netherlands Leprosy Relief (NLR)	Supporting TB Control in 4 States in N/C and N/E Nigeria (Bauchi, Gombe, Kaduna and Plateau) include provision of anti-TB drugs, lab reagents/consumables, training of health staff and supervision up to 2006.; Supporting 9 other states in same area

	in Leprosy control (Adamawa, Benue, Borno, Jigawa, Kano, Katsina, Nasarawa, Taraba and Yobe).
The Leprosy Mission Nigeria	Supporting Leprosy Control in 7 States of N/C and N/W Nigeria (FCT, Kebbi, Kogi, Kwara, Niger, Sokoto and zamfara). Partly supporting TB in the states with respect to training of State and LGA TBL Supervisors and technical support in field supervision.
Canadian International Devt Agency (CIDA)	Financial /Technical support to DOTS expansion in 17 States (Adamawa, Benue, Borno, FCT, Jigawa, Kebbi, Kano, Katsina, Kogi, Kwara, Lagos, Nasarawa, Niger, Sokoto, Taraba, Yobe and Zamfara)
USAID	Financial /Technical support to DOTS expansion in 17 States (Adamawa, Benue, Borno, FCT, Jigawa, Kebbi, Kano, Katsina, Kogi, Kwara, Lagos, Nasarawa, Niger, Sokoto, Taraba, Yobe and Zamfara)
Private Health Care Providers	Provide service for profit mainly clinical care. Current piloting going on to determine public private sector mix in TB control
Network of People Living With HIV/AIDS in Nigeria (NEPWHAN)	Providing peer support to HIV/AIDS persons through a network of support groups.
Christian Health Association of Nigeria (CHAN).	Offer TB control services in Mission health care institutions.
ENHANSE	Financial /Technical support in planning and resource allocation for Advocacy, Communication and Social Mobilization (ACS)
Inter-News	Mobilizing Media institutions and training of reporters on health care issues. Facilitation of coverage of health care events including TB.
Inter-Gender	Community mobilization, Gender and Social research, Advocacy, communication and social mobilization training.
Partnership for Transforming Health Systems (PATHS)	Supporting implementation of TB control in Enugu, Jigawa, Ekiti and Kano states in terms of laboratory strengthening, ACS and policy development.

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

The current strategy to control tuberculosis in Nigeria is based on the WHO recommended Directly Observed Treatment Short course (DOTS) policy, which was adopted since 1993. The goals and objectives are consistent with the Global Plan to Stop TB. Therefore the WHA targets for TB control, which include detection of 70% of existing smear positive TB cases and successfully treating 85% remain the core objectives of TB control in Nigeria. So far the efforts of the programme are on accelerated expansion of the DOTS strategy to provide equitably distributed services throughout the country.

In this proposal, 5 objectives have been developed specifically for scaling up of DOTS service provision that will result in achievement of the Global TB targets. The first 2 objectives aim to address the technical and managerial capacity of the NTBLCP to provide the needed leadership and coordination with respect to policy, advocacy, technical support and implementation as well as stimulating the demand side, while access is being created through vigorous DOTS expansion. This is in recognition of the fact that a strong Central Unit backed by sustained government commitment is critical to the success of TB control. It is also recognized that although the NTP has been able to achieve its objective in making services available to about 50% of the Nigerian population there is varied and often minimal political will at all levels to TB control. Advocacy efforts

have been limited and ad hoc, while the CU had difficulty in accessing funds allocated to TB control from Federal level. Though funds may be allocated, it is often difficult for the programme to access them as and at when due. State Governments support to TB control is inconsistent and varies from state to state depending on the political will of the Governor. Assessment of the national health account shows that 13% of health cost is borne by federal government, another 13% by partners and rest by households. It is not clear how much is borne by the State and LGA apart from staff remuneration (Health Sector Reform Document, FMOH 2005 – Attachment 5)

Patients and the general public are poorly informed about TB and its treatment, how and where to access care due to lack of a consistent and sustained communication programme for TB control. Current ACS activities to support TB control are weak, ad hoc and driven by desire to celebrate World TB days. There is no national ACS strategy to guide actions and advise development partners. Moreover the National Health Education Department is institutionally weak to carry out relevant operational research as well as drive a national communication initiative

The 3rd and 4th objectives which aim at improving case detection and providing quality care under standard management conditions leading to cure of smear positive TB cases and ultimately interrupting transmission of the disease as envisaged in the WHA targets. These objectives will be achieved through increasing access to TB diagnostic and treatment services. This entails expanding TB diagnostic services to 900 laboratories and 3,600 general health facilities from both public and private sector by 2010 (i.e increasing the number of laboratories from the current 568 to 1,468; and treatment centres from 2,077 to 5,677 by 2010).

The 5th objective aims at mitigating the impact of TB among PLWAs. This is in recognition of the fact that TB/HIV collaboration is vital to ensure reduction of mortality among both TB and HIV patients. This entail ensuring DOTS provision in HIV/AIDS centres as well as HIV/AIDS services in DOTS centres. About 100 out of 218 ARV scale up sites are targeted for DOTS interventions during the proposal period.

Current TB control efforts are supported by Canadian CIDA, USAID, WHO and the International Federation of Anti-Leprosy Associations (ILEP) namely Damien Foundation Belgium (DFB), German Leprosy and TB Relief Association (GLRA), Netherlands Leprosy Relief (NLR) and The Leprosy Mission Nigeria (TLMN).

WHO remains the major technical partner and does that through National professional Officers (NPOs) for Tuberculosis (1 at Central and 6 at Zonal level). CIDA and USAID support expansion of DOTS mainly in 16 states and FCT including support to the central level. Combined leprosy and tuberculosis supervision at state and LGA levels is actively supported by ILEP organizations through provision of transport, training, supervision, monitoring and drugs management. The absorption capacity of the TBL control programme (through additional funding) has been demonstrated over the last 2 years.

The scale up plan is as follows:

	2005	2006	2007	2008	2009	2010	Total	CIDA/ USAID x 5 yrs	ILEP	Unmet need
Cumulative LGAs participating	**568**	**624**	**674**	**724**	**774**	**774**				
Microscopy Centres to be established		200	200	170	170	160	**900**	**400**	**200**	**300**
Cumulative Microscopy Centres	**568**	**768**	**968**	**1,138**	**1,308**	**1,468**	**1,468**			
DOTS Centres to be established		800	800	680	680	640	**3,600**	**1,000**	**400**	**2,200**
Cumulative DOTS Centres	**2,077**	**2,877**	**3,677**	**4,357**	**5,037**	**5,677**	**5,677**			
Lab Technicians to be trained		200	200	170	170	160	**900**	**500**		**400**
Cumulative trained Lab techs	**568**	**768**	**968**	**1,138**	**1,308**	**1,468**	**1,468**			

Health staff to be trained		1,600	1,600	1,360	1,360	1,280	7,200	2,000		5,200
Cumulative trained Health staff	4,154	5,754	7,354	8,714	10,074	11,354	11,354			
LGA TBLS to be trained		50	50	50	50		200		200	
Cumulative trained LGA TBLS	574	624	674	724	774	774	774			

As indicated in the plan, USAID/CIDA through the TBCTA, have committed to expand DOTS to 400 microscopy centres and 1,000 treatment centres, while ILEP will expand to 200 microscopy centres and train 200 LGA TBL supervisors.

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

The economic burden of tuberculosis is substantial. Every year, the nation looses tremendously from loss of man hours due to TB, cost implications on health services. The direct impact of this economic burden is an impediment on human development and consequent underdevelopment. Furthermore malaria control in Nigeria is directly linked to the following initiatives:

1. ***The Stop TB Initiative.***

Aims at detecting 70% of estimated infectious TB cases and curing 85% of them. This is expected to reduction in transmission, halting and reversing TB prevalence and incidence by 2015 as contained in the MDG 6 goal 8, target 24.

All the initiatives mentioned above are aimed at national economic empowerment and development through disease burden reduction, poverty reduction and improvement in human development.

2. ***Millennium Development Goals* (MDGs)**

Malaria control would be pivotal to the attainment of the MDGs especially the area of maternal and child health and poverty reduction.

3. ***Contribution to Health Sector Reform*:**

The ongoing Health sector Reform in Nigeria is based on the principle that qualitative and efficient health care delivery can only be achieved in the context of a virile health structure/system. One of the benefits of tuberculosis control that is already evident is serving as a vehicle for strengthening the primary health care system in the country.

4. ***Contribution to National Poverty Eradication Program* (NAPEP)**. The NAPEP is an initiative to alleviate poverty by providing facilities for small scale entrepreneurship and job creation. This objective is enhanced by current tuberculosis control activities by detecting and curing smear positive TB cases, morbidity and mortality among the most productive segment of the population is reduced. This will lead to increased productivity and poverty reduction.

5. ***National Economic Empowerment Development Strategy* (NEEDS).** Tuberculosis control will contribute to reversal of economic losses due to tuberculosis and improve wealth generation. Furthermore current impetus of TB control is directly linked to various capacity building activities that is empowering a lot of health staff, community members and people living with TB and HIV, thus serving as a stimulus for economic development in Nigeria.

4.3.3 Financial and Programmatic Gap Analysis

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

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

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

The NTBLCP DOTS expansion initiative is supported by the following partners:

a) ILEP member organizations contributing a total of about $1.5m annually to provide TB drugs, laboratory strengthening, vehicles and supervision costs. The number of states covered by individual ILEP member is as follows:
   - German Leprosy and TB Relief Association - 14 states
   - Damien foundation Belgium - 2 states
   - Netherlands Leprosy Relief – 4 states

7. USAID/CIDA: commit a total of about $2.1m annually to support laboratory strengthening, expansion of DOTS treatment network in 17 states.
8. The Global drug facility grant contributed about $800,000 annually (anti-TB drugs).
9. The Federal Government of Nigeria will contribute a total of about $3m annually in staff salaries and upgrading laboratory facilities, procurement of microscopes and reagents.

The total programme requirement for the five year period amounts to $105,439,230 including PR/SR costs of which the government of Nigeria and partners are expected to meet $37,173,708 leaving and Unmet need of $68,265,522. The sum of $25,570,061 is required in the first 2 years (Detailed budget in Annex 6).

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

The overall costing approach for meeting the overall programme goal as reflected in this proposal is consistent with the NTBLCP DOTS expansion strategic plan 2001-2005. Extrapolation was also made from the strategy meeting of NTBLCP and partners held for the development of the 2006-2010 strategic plan, which basically revised the objectives and strategies of the 2001-2005 plan in line with current realities. The experience acquired in DOT expansion was an additional resource that was utilized in the costing of this proposal. Details of the budget including essential cost elements are reflected in the attached budget.

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

The gap calculation is based on the commitments made by the Government of Nigeria and the development partners supporting the National TB response. The key elements of the budget include:

- The government of Nigeria will contribute to fund procurement of microscopes for AFB microscopy and rehabilitation of laboratory facilities from year 1, gradually increasing until it is fully taken over by 2010. Therefore gap for GFATM funding in this respect exist only in the aspect of reagents for MDR surveillance to be procured for the National Reference laboratory.
- From second year onwards, a substantial increase in laboratory activities (AFB microscopy) is expected, which the existing funds from partners will not be able to cover. The Nigerian Government will in addition to continuous rehabilitation of laboratory facilities contribute to procurement of basic AFB microscopy reagents and consumables.
- Nigerian is currently benefiting from GDF grant for anti-TB drugs. The grant covers the period up to 2007. The KfW funds with which anti-TB drugs are supplied to 14 states of the country will end by the end of 2005 though already procured drugs for those areas will last until 2006. Therefore while there is no

funding gap exists for drugs in year and 2, it exists from 2008 onwards for drug supply to the whole country. This gap is expected to be filled by the GFATM for anti-TB drug procurement through GDF.

- Training and retraining of health staff is expected to escalate from year 1 onwards. The committed resources from partners is considered as the key source of financing these trainings, for which a substantial gap is already apparent. GFATM is expected to fill these gaps in training particularly general health care staff and laboratory technicians needed to implement the DOTS strategy.
- The strengthening of the institutional capacity to conduct MDR surveillance involves developing capacity of one national Reference laboratory and six zonal ones within the first 2 years. The equipment requirement constitute gaps that GFATM funds are expected to fill.
- Involvement of the private sector in provision of DOTS is an initiative that has been conceived as a veritable strategy to ensure appropriate and timely detection of infectious TB cases. The FIDELIS Funds from the CIDA, through UNION, is available to commence a pilot project in the first year, but a gap exists in expansion of the initiative. GLRA and CHAN has some experience in this area and is willing to assist the NTBLCP in implementation in the South and Northen Nigeria respectively. These organizations require additional funding to carryout this task for which GFATM is required to fill the gap.
- The country does not have any support currently to implement Community DOTS, which entails empowering community members to support patients on treatment. This gap is expected to be filled by GFATM.
- Enhancement of the human resource capacity at the Central Unit level is necessary to ensure adequate implementation especially with respect to laboratory services, ACS, Administration and finance and logistics. The funding gap is this aspect is expected to be filled by GFATM;
- A gap is apparent in the implementation of the advocacy, communication and social mobilization initiatives. The current funding is from development partners and is very limited. In order to make substantial impact, the gap needs to be filled by GFATM funding.

The details of the cost implications of the above description of gaps are explicitly reflected in the detailed budget attached to this proposal.

Table 4.3.3 - Financial Contributions to National Response

	Financial contributions in US$						
	2004	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
Domestic (A)	2,142,805	2,142,805	3,519,760	3,898,719	4,189,939	4,268,679	3,753,679
External (B)							
CIDA	900,000	900,000	759,541	759,541	759,541	759,541	759,541
USAID	1,067,500	1,067,500	927,264	927,264	887,264	887,264	887,264
GDF	780,000	-	1,059,300	1,256,148	-	-	-
ILEP	943,708	1,500,000	1,543,359	1,606,900	1,254,400	1,254,400	1,254,400
Total resources available (A+B)	5,834,013	5,610,305	7,864,224	8,448,572	7,091,144	7,169,884	6,654,884
Total need (C)	11,656,793	16,661,374	21,479,637	20,228,220	20,322,116	20,887,506	21,541,576
Unmet need (C)-(A+B)	5,822,780	11,051,069	13,670,413	11,779,648	13,230,972	13,717,622	14,886,692

4.3.4	Confirm that Global Fund resources received will be additional to existing and planned resources, and will not substitute for such sources, and explain plans to ensure that this is the case.

The TB control program in Nigeria has, over the last few years, yielded surprisingly good results (80% treatment success rate, 26% case detection rate) notwithstanding the difficult situation in which it had to operate over the period. TB control activities have been implemented in the states supported by NGOs under the coordination of NTBLCP and with technical assistance provided by WHO. For the past 10 years, the fundamental elements of the program (provision of high quality drugs, basic training on DOTS, regular monitoring and supervision, surveillance) have been implemented to the best of the partners' capacities. However, with the available resources, the Nigerian TB program has not yet reached its optimal expansion capacity. The provision of services to a greater number of people and the achievement of the set targets can be reached only through the expansion of the diagnostic capacity of the existing health facilities and establishing new ones, which require additional resources in terms of manpower, infrastructures, equipment and supplies. The proposal therefore aims at filling the gap for DOTS expansion along with the plan agreed upon by all the partners involved in the program and in line with the strategic plan.

The National Tuberculosis programme in collaboration with its development partners is currently developing the 2006-2010 TB control strategic plan for the country. In this plan, activities have been outlined for the next five years based on expected government contribution as well as the pledge of the development partners. Until now, some state governments committed funds to TB control through ILEP NGOs based on agreed Memoranda of Understanding (MOUs). A system for tracking of all funds for TB control at all levels will be developed as an integral part of the M&E system in this proposal.

The expected commitment of development partners in the NTBLCP draft strategic plan 2006-2010 include continuation of GDF support for anti-TB drugs until 2007, continuation of support for transportation and supervision from the ILEP organizations, though at a lower level due to board decisions of Netherlands Leprosy Relief and The Leprosy Mission and expiry of KfW funds for German Leprosy and TB Relief activities (see respective sub-proposals); continuation of CIDA and USAID grant for laboratory strengthening, technical assistance and expansion of DOTS treatment network.

Therefore the Global Fund resources when received will be additional to existing support received from the NTBLCP partners and specifically fund activities that constitute the gap in the overall strategic plan.

4.4 Component Strategy

4.4.1 Description and justification of the program strategy

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

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

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

4 Components Section

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

Goal No.	Goals over five years
1.	**To reduce significantly the burden, socio-economic impact, and transmission of TB in Nigeria.**
2.	
3.	

Goal No.	Impact indicator	Baseline			Year 1 target	Year 2 target	Year 3 target	Year 4 target	Year 5 target	Source and comments
		Value	Year	Source						
1.	Increased detection of the estimated TB cases under DOTS	26%	2004	NTBLCP	32%	40%	50%	60%	70%	NTBLCP data is a reliable source for information on registered cases
1.	Increase proportion of detected TB cases that are successfully treated	80%	2002	NTBLCP	80%	81%	82%	83%	85%	NTBLCP data is a reliable source for information on registered cases
1.	Reduced number of TB-related deaths	?/100,000	2005	Survey	# and % from baseline	-	-	-	# and % from survey	Baseline to be established in year 1 through national survey.
1.	Reduced proportion of TB-related deaths among diagnosed patients	7%	2002	NTBLCP	6%	5%	5%	4%	4%	The mortality figure in year 1 to 2 may be higher than the baseline due to improved recording and reporting and HIV.
1.	Reduced incidence of active TB among PLWHA	30%	2003	UNDP HDR	28%	25%	25%	22%	20%	Depending on established baseline data
1	Increased % of adult population that practise healthy behaviour that contribute to reduced transmission and incidence of TB	N/A	2005		% from baseline				70%	Baseline to be established through a survey.

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

4 Components Section

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

Program objectives over five years		
Objective No.	**Objective description**	**Link to goal by number**
1.	To strengthen the technical and managerial capacity of the National TB and Leprosy Control Programme at all tiers to ensure achievement of at least 80% implementation rate of programme activities by 2010.	#1
2.	To promote behaviour change in the community about TB such that 70% of adult population know about TB, its prevention and free treatment, TB services and at risk groups are motivated to seek prompt care by 2010	#1
3.	To increase TB case detection rate from 26% to 70% by 2010	# 1
4 .	To treat at least 85% of all TB cases detected successfully by 2010	# 1
5.	To reduce by at least 25% the incidence of TB among PLWHA by 2010	#1

Objective No.	Service delivery area	Directly tied	Indicator description	Baseline		Year 1 target	Year 2 target	Year 3 target	Year 4 target	Year 5 target	Frequency of data collection
				Value	Year						
1	Advocacy initiatives	Yes	Number of advocacy materials developed and distributed	0	2005	120,000	80,000	80,000	80,000	80,000	Annual
		Yes	Number of key Federal, State and Local Government officials reached with advocacy.	0	2005	200	400	600	800	1,000	Annual
		Yes	Proportion of NTBLCP budget released	2%	2005	5%	15%	30%	40%	50%	Quarterly, annual
		Yes	Number of States releasing funds for TB control	10	2005	15	20	25	30	36	Quarterly, annual
1	Human resources	Yes	Number of staff vacancies filled	10	2005	8	10	10	10	10	Annual
		Yes	Number of health staff trained in programme management and advocacy.	0	2005	10	28	48	48	48	Annual
		Yes	Number of states meeting optimum Programme management performance requirements	5	2005	10	20	30	37	37	Annual

4 Components Section

1	Strengthen TB partnership and coordination	Yes	Number of members of different organizations oriented in TB.	0	2005	5	10	20	30	50	Annual
		Yes	Number of partners, community groups actively involved in TB partnership.	15	2005	25	30	40	50	70	Annual
		Yes	Number of community groups actively involved in TB prevention and treatment support activities.	0	2005	200	500	1,000	1,500	2,000	Quarterly, annual
2	Behavioral change and communication to Communities	Yes	Number of people trained in BCC	0	2005	200	400	600	724	774	Quarterly, annual
		Yes	Number of targeted communities that have established BCC services	0	2005	200	500	1,000	1,500	2,000	Quarterly, annual
		Yes	Number and % of people reached with BCC activities.	0	2005	20m	30m	40m	50m	65m	Quarterly, annual
2	Behavioral Change Communication (BCC) using the mass media	Yes	Number of people trained in BCC mass media.	0	2005	180	360	540	720	900	Quarterly, annual
		Yes	Proportion of population knowledgeable on TB	?	2005	10	25	40	55	70	Annual, end-term
3	Expansion of microscopy network	Yes	Number of Laboratory Staff trained	568	2005	768	968	1,138	1,308	1,468	Quarterly, annual
		Yes	Number laboratories included in the National TB Network	505	2005	768	968	1,138	1,308	1,468	Quarterly, annual
		Yes	One TB Microscopy centre per # population	221,000	2005	168,656	137,557	120,284	107,581	98,539	Quarterly, annual
3	Quality Assurance for labs	Yes	No. of State Laboratory Scientists trained in QA	21	2005	37	37	37	37	37	Quarterly, annual
		Yes	Nr. of labs included in QA network	250	2005	500	800	1,000	1,300	1,468	Quarterly, annual
		Yes	Nr. of labs which have acceptable performance	200	2005	400	700	900	1,200	1,400	Quarterly, annual
	Detection of TB cases	Yes	Number of general health care staff trained in identifying TB	4,154	2005	5,754	7,354	8,714	10,074	11,354	Quarterly, annual

			suspects.								
		Yes	Number of health care facilities involved in TB screening according to national guidelines	2,645	2005	3,051	4,351	5,081	6,345	7,145	Annual
		Yes	Number of new all forms of TB cases detected	59,493	2004	82,025	98,429	118,115	141,738	170,086	Quarterly, annual
		Yes	Number of new smear positive TB cases detected.	33,765	2004	54,683	65,620	78,744	94,492	113,391	Quarterly, annual
		Yes	Proportion of estimated smear positive TB cases detected.	26%	2004	30%	40%	50%	60%	70%	Annual
3	Public-Private Mix for DOTS (PPM)	Yes	Number of Laboratory staff of Private not-for-profit Health care Institutions trained in DOTS	50	2005	150	200	250	300	350	Quarterly, annual
		Yes	Number of Laboratory staff of Private for-profit Health care Institutions trained in DOTS	20	2005	50	80	110	130	150	Quarterly, annual
		Yes	Number of General Health Care staff not-for-profit Health care Institutions trained in DOTS	100	2005	300	500	700	900	1,000	Quarterly, annual
		Yes	Number of General Health care staff of Private for-profit Health care Institutions trained in DOTS	40	2005	100	150	220	260	300	Quarterly, annual
		Yes	Number of Private not-for-profit Health Care providers involved in delivering DOTS	50	2005	450	700	950	1,200	1,350	Quarterly, annual
		Yes	Number of Private for-profit Health Care providers involved in delivering DOTS	20	2005	150	230	330	390	450	Quarterly, annual
3	TB case finding in Congregate settings (Prisons and Barracks)	Yes	Number of Laboratory technicians of Prison/Barracks Health Services trained in DOTS.	10	2005	90	150	210	270	360	Quarterly, annual
		Yes	Number of General Health Care staff of Prison/Barracks Health Services trained in DOTS.	30	2005	90	150	210	270	360	Quarterly, annual

		Yes	Number of Prisons/Barracks health services delivering DOTS.	10	2005	30	50	70	90	120	Quarterly, annual
			Number of TB Patients detected among Prisoners and Barracks residents treated with DOTS.	N/A	2005	To be established					Quarterly, annual
3	Intensified TB case finding in PLWHA	Yes	Number of Staff of VCT/ARV sites trained in DOTS	0	2005	Value established	100	150	200	240	Quarterly, annual
		Yes	Number of ARV and VCT sites screening HIV clients for TB.	0	2005	25	50	75	100	120	Quarterly, annual
		Yes	Number of registered new cases of TB identified through screening in PLWHA receiving HIV testing and counseling and or HIV treatment and care services	0	2005	Value established					Quarterly, annual
3		Yes	Prevalence survey conducted	0	2005	1				1	Quarterly, annual
4	Treatment of TB cases with DOTS	Yes	Number of General Health Care workers trained in DOTS service delivery.	4,154	2005	5,754	7,354	8,714	10,074	11,354	Quarterly, annual
		Yes	Number of General Health facilities delivering DOTS treatment.	2,077	2005	2,877	3,677	4,357	5,037	5,697	Quarterly, annual
		Yes	Number and percentage of new smear positive pulmonary TB cases registered in a specified period that were cured plus the number that completed treatment (treatment success rate)	80%	2002	81%	82%	83%	84%	85%	Quarterly, annual
		Yes	Number and percentage of new smear positive TB cases registered under DOTS who	85%	2003	87%	89%	90%	90%	90%	Quarterly, annual

			smear convert at the end of initial phase								
4	Control of Drug Resistance	Yes	Number and percentage of new smear positive pulmonary TB cases registered in a specified period that are smear positive five months or more after initiating treatment (failure rate)	1.7%	2002	1.5%	1.2%	1.%	1%	1%	Quarterly, annual
4	Surveillance of Multi-Drug Resistant Tuberculosis (MDR-TB)	Yes	Number of Laboratory Scientists of Reference laboratories trained in MDR surveillance and Drug Susceptibility Testing (DST)	0	2005	10	16	20	24	24	Quarterly, annual
		Yes	National Reference Laboratories functional in MDR surveillance and DST.	0	2005	1	1	1	1	1	Quarterly, annual
		Yes	Zonal Reference Laboratories functional in MDR surveillance and DST.	0	2005	3	6	6	6	6	Quarterly, annual
		Yes	Number and percentage of suspected cases of MDR-TB tested for drug susceptibility	N/A	2005	Baseline survey					Quarterly, annual
4	Supporting Patients through Direct Observation of treatment	Yes	Number of Patient Support Group (PSG) Members oriented on TB and DOTS.	N/A	2005	400	800	1,200	1,600	2,000	Quarterly, annual
		Yes	Number of PSGs set up for supporting patients on DOTS.	N/A	2005	400	800	1,200	1,600	2,000	Quarterly, annual
		Yes	Proportion of new smear positive pulmonary TB patients supported by PSGs	0	2005	5%	10%	15%	20%	25%	Quarterly, annual
4	Supervision of DOTS activities	Yes	Number of LGA TBL Supervisors trained	574	2005	624	674	724	774	774	Annual
		Yes	Number of LGAs with trained TBL Supervisor	574	2005	624	674	724	774	774	Annual
		Yes	Proportion of planned supervisory visits executed.	50%	2005	60%	70%	80%	90%	90%	Annual

	Monitoring and Evaluation	Yes	M&E plan developed	N/A	2005	Yes					Annual
			Number of Health care staff trained and re-trained in M&E and data management	0	2005	10	47	94	94	94	Annual
		Yes	Number of LGAs submitting complete and timely reports	574	2005	624	674	724	774	774	Quarterly, annual
4	Community TB Care	Yes	Number of Health Care staff trained as Community TB Care Supervisors	0	2005	40	80	120	160	200	Quarterly, annual
		Yes	Number of Community Volunteers (Treatment supporters) trained in DOTS	0	2005	3,000	6,000	9,000	12,000	15,000	Quarterly, annual
		Yes	Number of Communities with established CBTC.	0	2005	1,200	2,400	3,600	4,800	6,000	Quarterly, annual
		Yes	Number of TB patients cared for under the CBTC	0	2005	6,000	12,000	18,000	24,000	30,000	Quarterly, annual
5	Prevention of active TB in PLWAs.	Yes	Number of staff of VCT/ARV sites trained in delivering DOTS and INH prophylaxis for HIV positive individuals.	0	2005	50	100	150	200	250	Quarterly, annual
		Yes	Number of VCT and ARV centres delivering IPT to HIV positive individuals	0	2005	25	50	75	100	125	Quarterly, annual
		Yes	Number of people HIV positive persons without active TB who are placed on IPT	0	2005	To be established					Quarterly, annual
	TB/HIV Care and support (Provision of Antiretroviral Treatment for TB patients during TB treatment, OI management and HIV/AIDS prevention in TB patients)	Yes	Number of Health care staff of DOTS Centres trained in TB/HIV care and support.	0	2005	90	180	270	360	450	Quarterly, annual
		Yes	Number of DOTS centres providing TB/HIV care and	0	2005	90	180	270	360	450	Quarterly, annual

			support.								
		Yes	Number of TB/HIV patients receiving care and support.	N/A	2005	To be established					Quarterly, annual
5	Operational research	Yes	Number of health staff trained in Conducting Health Systems Research (HSR)	25	2005	50	75	100	125	150	Annual
		Yes	Number of State research teams conducting HSR projects	5	2005	10	15	20	25	37	Annual

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

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

The overall goal of the National TB and Leprosy Control programme (NTBLCP) is ensure a reduction in the burden and human impact of TB and its transmission to such an extent that it no longer constitutes a public health problem (reduced burden of TB).

The main objectives are to increase access to DOTS facilities and to improve quality of care for TB patients, achieving the targets of 70% Case Detection Rate and of 85% Treatment Success Rate by 2010 and maintain the achievements thereafter. The expected outcome is the DOTS services available to the whole population of Nigeria (130 million) in an equitable manner, detecting about 70,000 new TB cases (50% of the estimated total incidence) annually by 2008 and curing an average of 60,000 of them.

To reach these set targets, the proposal aims to enhance the technical and managerial capacity of the NTBLCP and other implementing partners in strengthening the existing services and establishing new peripheral DOTS centers in areas at present not covered. To improve the quality of treatment, the program will continue to ensure a regular supply of drugs and laboratory supplies to all DOTS centers, provide training to health staff, strengthen supervision, monitoring and evaluation activities. TB partnership will be strengthened to work in close collaboration with the NTBLCP so to advocate for governments' commitment and ownership of the program, hence the elaborate ACS activities under the first 2 objectives of the proposal.

Objective one which is specifically formulated to strengthen the capacity of the NTBLCP and advocate for government's commitment has service delivery areas that address the inadequacy of human resources at the National level by filling 8 key vacancies identified, advocacy initiatives targeting the National Assembly and Federal Executive council who make decisions on fund allocation. Advocacy campaigns will be through visits, media sensitization, conference and enlistment of civil society organizations. The target is to achieve at least 50% release of programme budget by the year 2010 to ensure sustainability.

Objective 2 is meant to create sufficient awareness of the general population on common signs and symptoms of TB with the view to creating demand for the services as they are made available through the DOTS expansion. It is expected that at the end of the proposal period, about 70% of the population will know about TB and practice healthy behavior that will contribute to reduction of its transmission. The service delivery areas include community directed behavioral change communication, mass media campaigns and social mobilization through civil society groups. Since the current level of knowledge, attitude, behavior and practice (KABP) related to TB is not known, a KABP study will be commissioned in the first project year to establish the baseline and at the end (2010) to assess impact.

Objective 3 relates to one of the main targets of TB control to detect at least 70% of the estimated TB cases by 2010. To achieve this objective, the capacity of the health service to deliver AFB microscopy services will have to be strengthened through expansion of the laboratory network to provide quality-assured AFB microscopy. In the previous 2 years of DOTS expansion, about 200 laboratories were added to the DOTS network representing about 50% increase. This resulted in a corresponding increase in case detection rate from 15% to 26%. This proposal aims to include 900 additional laboratories in both public and private sectors across the country to increase accessibility to TB diagnosis with an expected result of meeting the 70% case detection by 2010. The service delivery areas include expansion of laboratory network, Quality assurance, Public-Private Mix, and intensified case finding among PLWAs. The main

activities include training of laboratory and health facility staff, procurement of microscopes and reagents. The specific activity related targets include training of 2,000 laboratory technicians, Involvement of Private Health care providers in DOTS service delivery (PPM) targeting 6 states per year (total of 350 private not-for-profit health care providers (FBO facilities) and 150 private for profit in delivering DOTS by 2010). TB case finding in congregate settings like prisons and military barracks will be embarked upon targeting all major prisons and barracks by 2010. In order to intensify TB case finding in PLWA, staff of 100 ARV and ARV sites will trained in TB.

Objective 4 relates to another core for TB control, which aims to improve the current level of treatment success from 80% to 85% by 2010. The service delivery areas include treatment of identified TB cases under DOTS while preventing anti-TB drug resistance, supporting patients through direct observation of therapy, sustained quality and supportive supervision, monitoring and evaluation and community TB care. The main activities under these service delivery areas include procurement of quality-assured anti-TB drugs, training of health facility staff on DOTS, setting up the national and zonal reference laboratories to commence MDR surveillance, and involving community members to support patients through the duration of treatment. The main activity related targets include expansion of DOTS treatment service delivery points to selected 3,000 health facilities and training of 2 health staff from the 3,000 selected health facilities (6,000 staff by 2010). The National Quality Assurance system will be developed through establishment of the National Reference Centre and 6 Zonal reference laboratories by 2010. In order to effectively support patients on treatment, community participation in DOTS services will be engaged with aim of supporting 2,000 patient groups by 2010.

The fifth objective aims to reduce the burden of TB among PLWHA through the following service delivery areas: ACS (Advocacy, communications), Prevention of active TB through provision of IPT, prompt treatment of active TB in PLWHAs with DOTS and provision of care and support through prompt referral to HIV units for ARVs and CPT where indicated. By the end of the project period, it is expected that about 50% of PLWHA requiring IPT are given.

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

The key problems and gaps identified in the gap analysis include:

- Insufficient government commitment to TB control especially at the federal level
- Low case detection rate which currently stands at 26%
- A fairly modest treatment success of 80% which can be improved upon
- High proportion of TB patients that are co-infected with HIV (19.1%) as at 2001 and estimated about 30% currently.
- Inadequate managerial capacity at the Central Unit level of the NTBLCP.

The overall goal is to reduce the impact of TB, and is directly linked to all the above mentioned problems and gaps as solving them is crucial to sustainable control. The strong advocacy, communication and social mobilization initiatives captured in objectives 1 is meant to get policy makers informed and sensitized to fighting TB, which should translate in better funding for the programme at all levels thereby safeguarding programme sustainability. Objective 2 is directly related to the third objective to ensure early case finding by getting the public informed about TB and deliberate efforts to substantially reduce stigma which is a major hindrance to people seeking help for fear of discrimination.

The 3rd and 4th objectives are aimed at addressing the problems of inadequate access to the services at the institutional level. With increase in access to diagnosis and treatment,

a greater proportion of the estimated existing infectious TB cases can be detected and cured thereby reducing the transmission of the disease in communities.
The 5th objective is directed towards addressing the attendant consequences of the increasing TB/HIV association in the country. It aims to significantly reduce the impact of TB among PLWAs as well as avail TB patients with HIV/AIDS preventive and care and support interventions.

[For health systems strengthening components only:]

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

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

See Health System strengthening component.

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

The principal beneficiaries of the proposal are the TB patients that will be treated under DOTS. Throughout the period of the program (2006 – 2010), more than 600,000 TB cases (300,000 smear positives) will be detected and treated by the expanded DOTS services, thus saving about 75,000 lives (Case fatality rate of 50% in 5 years for smear positives).
The secondary beneficiaries are the patients' families, their communities and indeed the general population, who will be at lower risk of acquiring TB infection. It is estimated that with the support of the Global Fund 70% of the population (90 million) will eventually benefit from the preventive and curative measures adopted to reduce the burden of TB in Nigeria. Another relevant group of beneficiaries is represented by the health workers and local authorities who will be trained in TB during the project period.

Given the fact that the disease impacts most on the age group 15-44 years, and 45% of all newly detected cases being female, representatives of PLWHA were deliberately included in the proposal development process. The PLWHA have an organized association in the country under the auspices of the Network of People living with HIV/AIDS in Nigeria (NEPWHAN), but such an organization for TB patients does not exist. Since about 30% of PLWHA have TB in Nigeria, and in the absence of any organized TB group, the NEPWHAN represented both TB and HIV interests in the proposal development process. In addition, interested civil societies organizations and NGOs working in TB/HIV were involved in the proposal development process. These include GLRA who is active in TB/HIV care and support activities in Lagos State, PPM in Anambra State; CHAN (Association of faith-based organizations) with multiple HIV/TB programmes throughout the country. These groups will be involved in periodic review of progress during partnership meetings and joint monitoring and evaluation of the proposal. The direct impact of activities of this proposal will be prolongation of quality life especially among dually infected individuals.

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

Table 4.4.1.5 Objectives

	Estimated percentage of people reached who are:		
	Women	Youth	Living in rural areas
Objective 1	40%	50%	80%
Objective 2	50% 24.1% of women nationally reached through radio, TV, newspaper (DHS 2003- no specific data on TB) Of women living in rural areas, only 5.5 % are exposed to mass media. National HIV/AIDS and reproductive health survey **(NARHS-2003 – Annex 7)** indicate that 86% of females (5128) prefer radio for communication followed by TV (78.8%) and print media (76.1%) Females (6919) in rural areas prefer radio 85.4 followed by (75.6%) and print (72.7%) (NARHS-2003) (No specific data on public awareness - KAP on TB)	60% Already 55% of all smear Positive cases are within age group 15-45 years	60% About 70% of Nigerian population live in rural areas.
Objective 3	50% Overall M:F ratio of all detected TB cases is about 1:1.	60%	70%
Objective 4	50%	60%	80% Most of areas to be targeted for expansion of DOTS will be rural.
Objective 5	50% Males and females are almost equally affected.	80% About 80% of PLWAs fall within the youthful group.	50% There is tendency now towards equal affection of rural versus urban population affected by HIV.

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

The general approach will be to phase activities in a systematic manner so as to allow a focused and efficient management of human, material resources and time leading to a result-oriented implementation. The available of partners with tremendous expertise in some specific fields e.g PPM DOTS, TB/HIV, BCC that will assist the NTBLCP mean that a number of activities can be implemented simultaneously. However good coordination is required. The implementation of activities will also be decentralized to zonal, state and LGA levels as appropriate.

Objective 1. To strengthen the technical and managerial capacity of the National TB and Leprosy Control Programme at all tiers to ensure achievement of at least 80% implementation rate of programme activities by 2010.

SDA 1: Strengthen programme management capacity at Central Unit in terms of human resources.
Main activities:

- Appointment / transfer / recruitment or deployment of high caliber staff in key programme areas e.g. four Public Health Medical officers, one Admin and Finance officer, one Logistician. This is to be done by the Federal Ministry of Health, Nigeria.

SDA 2: Technical assistance to the programme to ensure efficiency in implementation.
Main activities:

- recruitment of a laboratory expert who will provide technical guidance to the overall laboratory expansion and quality assurance and
- an ACS consultant to support advocacy, communication and social mobilization.

Identification and engagement of the right caliber of personnel will be organized through WHO.
SDA 3: Advocacy initiatives, which entails mobilizing support for TB control.
Main activities:

- Identify/appoint a local ACS focal point for the CU NTBLCP and states.
- orientation of state ACS focal points
- identification/appoint LGA ACS focal points in 100 LGAs,
- orientation of LGA ACS focal persons on TB and HIV,
- TOT Training of 10 CU and NTBLTC staff in Organization and advocacy followed by;
- Orientation of 2 State Control Programme staff in Organization and advocacy in each of 18 States.

Theses activities will be coordinated by the NTBLCP, with the help of the ACS consultant.
SDA 4: advocacy to key Government officials.
Main activities:

- advocacy to the National Assembly and the Federal Executive council,

This is crucial to putting TB high on the agenda and realization of the much needed allocation and timely release of NTBLCP budget. These activities will be carried out by an advocacy, communication and social mobilization (ACS) sub-committee of the Nigerian TB partnership (to be strengthened into a formidable lobby group.

SDA 5: TB Partnership strengthening. As this partnership is already in existence, the main activities are directed towards strengthening it.
Main activities:

- conducting bi-annual TB Partnership meetings
- TB partnership ACS sub-committee meetings
- half-yearly TB partnership newsletter production

The partnership strengthening activities will be coordinated by bu the NTBLCP.
SDA 6: Engagement of Civil Society Organizations (CSOs) for communication and social mobilization on TB and DOTS in communities.
Main activities:

- CSO training in advocacy skills
- Training of journalists in TB reportage.

The tasks will be subcontracted to some organizations with experience in the field e.g PATHS, GHAIN, ENHANSE, SFH, NEPWHAN, INTERNEWS, INTER-GENDER, GLRA, DFB etc who will work with NTBLCP to roll out is activities.

Objective 2: To promote behavioural change in the population such that about 70% of the adult population know about TB and its signs and symptoms, TB service centres and patients are motivated to seek prompt and effective treatment. This is expected to go along with the pace of DOTS expansion, to stimulate demand and access to DOTS services leading to increase in case detection rate from 26% to 70% by 2010.
SDA 1: Community-directed behaviour change communication (BCC) and this will be achieved through the use of CSOs and mass media campaigns on radio and television.
Main activities:

- review and adaptation of existing ACS materials.
- advocacy to stakeholders in the private sector as well as mobilization of community leaders to be facilitated by partners with experience e.g PATHS and ENHANSE.
- community mobilization include community dialogue (awareness in churches and mosques through the CSOs/NGOs, awareness talks in village market places and bus stations;
- inter-personal communication to marginalized groups in according to roll out into of the expansion also through NGOs and CSOs.
- Establishment of baseline for the level of community knowledge of TB through a baseline study of knowledge, attitude, behavior and practice with emphasis on gender will be conducted in the first year and to be repeated in year 5 to measure the impact of these interventions. This activity will be sub-contracted to a partner with relevant experience e.g Inter-Gender.

SDA 2: BCC targeting the general population.

Main activities:

- organization and broadcast of TV discussions and documentaries;
- radio discussions on TB;
- TB Conference/symposium to reach out to the academic community, the general population and political leaders.
- annual celebration of World TB Day at National level to be organized at national and state levels with support of partners including NGOs and CSOs.

SDA 3: Social mobilization mainly through the CSOs:

Main activities: include inter-personal communication to marginalized groups like prisoners, women in purdah, PLWAs etc.

Objective 3: To increase TB case detection rate from 26% to 70% by 2010.

SDA 1: Expansion of microscopy network (900 labs by the end of yr 5).

The implementation will be decentralized to state levels and to be phased as indicated in the table described in 4.3.2 (b) above.

Main activities:

- procurement of microscopes, laboratory reagents and consumables for the corresponding number of new laboratories to be carried out by FMOH.
- renovation of the selected laboratories, procure 0.5kva generators for 50 selected labs in rural areas and procurement of laboratory reagents and supplies to peripheral labs during same period.
- Training of 900 laboratory will also be done to function effectively in those laboratories.

The NTBLCP, particularly the National TBL training institute will coordinate the planning and supervise implementation of the lab staff trainings. Already a pool of trained facilitators and relevant guidelines are available to support the states in conducting these trainings.

SDA 2: Strengthening Quality Assurance.

Main activities:

- supervisory visits by National lab scientist, State lab scientist,
- conducting regular review meeting for quality assurance officers; and
- establishing collaboration with reputable international laboratories. This is with the view to ensure quality of care.

The implementation of these activities will be coordinated by the NTBLCP.

SDA 3: Involvement of private care providers in provision of DOTS services (Public-Private Mix for DOTS - PPM).

Main activities are first to make an

- inventory of private care providers through a consensus meeting with stakeholders from the private sector (Guild of Medical Directors);
- training of private medical practitioners on DOTS, train of the nursing and general staff of private hospitals and clinics on early detection and treatment of TB (15 facilities per state 2 health staff each),
- training of laboratory staff of private hospitals and clinics on early detection and treatment of TB (15 facilities per state 1 lab staff each).

In total 350 private not-for profit and 150 private for profit care providers will be fully involved in delivery of DOTS services by 2010. The implementation of PPM activities relating to the private for-profit will be coordinated by GLRA, while the private not-for-profit will be implemented by CHAN. The guild of Medical Directors will also be actively involved with the view to ensure their greater participation and complete ownership in future.

SDA 4: TB case finding in congregate settings (e.g prisons, military and police barracks).
Most of these institutions have established health services that can be integrated into the DOTS network.
Main activities:

- training of the Medical Officers and nursing staff of prisons and military barracks clinics on DOTS. The target is to train at least 2 Prisons per state /year.

These activities will be implemented by individual State TBL Control programmes with support from the central level.
SDA 5: Intensified TB Case Findings in PLWHA.
Main activities:

- consensus meeting with heads of the current 25 ARV sites to agree on the modalities,
- training of the staff of the ARVand VCT sites.

These trainings will be trained in batches decentralized to 5 zones. Subsequent trainings will follow the scale up plan. The training will jointly organized and conducted by the National TB and HIV/AIDS programmes with resource persons also to come from both.

Objective 4: To successfully treat at least 85% of all TB cases detected by 2010
SDA 1: Treatment of TB Cases with DOTS. This entails making quality-assured anti-TB drugs available through timely procurement, storage and distribution. This is NTBLCP responsibility.
Main activities:

- ensure procurement of required quantities of anti-TB drugs an maintaining 100% buffer stock at all times with good stock management.
- distribution of drugs on quarterly basis to states.
- Strengthening capacity of health facility staff to deliver DOTS treatment through training of Medical Officers of newly designated DOTS microscopy centres per state on TB management and ACS in all states (10/State) and training of 2 health staff each of selected general health facilities on TB and HIV/AIDS care..

The NTBLCP, particularly the National TBL training institute will coordinate the planning and supervise implementation of the lab staff trainings. Already a pool of trained facilitators and relevant guidelines are available to support the states in conducting these trainings.
SDA 2: Surveillance of Multi-drug resistant Tuberculosis (MDR-TB).
Main activities:

- equipping the National Institute for Medical Research (NIMR) laboratory to the standard of a National TB reference laboratory; and those of 3 laboratories of university Teaching Hospitals in 3 zones in the first year.

This activity will be coordinated by NIMR.
SDA 3: Supporting patients through direct observation of therapy. This will be done through involvement of patient support groups as well as participation of community members especially relations.
Main activities:

- orientation of community and patient support groups (PSGs) leaders on TB
- supporting PSG activities. About 2,000 PSGs to be supported by the end of 2010.

This activity will be coordinated by the Network of People Living with HIV/AIDS in Nigeria (NEPWHAN) who already have 120 PSGs currently and are interested to be involved in supporting TB patients on treatment adherence as well as counseling for HIV

test.

SDA 4: Supervision of expanded DOTS activities.
Main activities:
- supportive technical supervision of field staff by federal, state and LGA supervisors towards ensuring quality of care.
This will be implemented by the various levels of the NTBLCP.

SDA 5: Monitoring and Evaluation
Main activities:

- Development of a country M&E plan. WHO technical assistance will be sought for this.
- Joint International Monitoring mission to be conducted annually. Coordinated by the NTBLCP
- Mid-term and end-term evaluation, also to be coordinated by NTBLCP

SDA 6: Operational research
Main activities:

- Training of State TBL Control Programme staff in conducting Health System Research projects; this will be coordinated by NLR,
- Conducting field operational research projects to be coordinated by NLR and GLRA with collaboration of NTBLCP.

SDA 7: Community TB Care.
Main activities:

- Consensus meeting with stakeholders on CTBC at National level;
- Consensus meeting with stakeholders (NGOs, CBOs, CSOs) on CTBC at State level beginning with 18 states
- Conduct 2 workshops to develop guidelines and curriculum for training of volunteers for community DOTS (one to develop, and one to finalize)
- Printing of Community DOTS manuals;
- Conduct TOT for community DOTS trainers in two State per zone.
- Train 20 Community DOTS volunteers in 6 selected states (LGA based, 5 LGAs per state)
- Social mobilization for CTBC (LGA level)
- Community dialogue activities

These activities will be coordinated by CHAN on behalf of the NTBLCP.

5. To achieve 25% reduction in TB incidence among PLWHA by 2010
SDA 1: Prevention of active TB in PLWHA
Main activities:

- Hold meeting of TB/HIV working group twice a year;
- Pre-test TB/HIV collaborative activities implementation guidelines;
- Review guidelines after pre-testing
- Printing of guidelines for joint TB/HIV field activities,
- Hold meeting of the STBLCO and State focal person for HIV/AIDS from 6 selected States with the Central unit for TB and HIV/AIDS
- Procurement of INH for prophylactic treatment of HIV positives;
- Training and re-training of health staff of VCT and ARV centres on INH prophylaxis and other care and support for HIV positives
- Supporting meeting of PLWHA/TB support group: once per quarter in each state

These activities will be jointly planned and executed by NTBLCP and NASCP.

SDA 2: HIV Care and Support for HIV-positive TB patients
Main activities:

- Training of DOTS staff in VCT in selected DOTS centres
- Referral to ARV services;
- Treatment of opportunistic infections with CPT.

These activities will be jointly planned and executed by NTBLCP and NASCP in

collaboration with NEPWHAN.

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

The TB control program in Nigeria has reached a reasonable stage of development in terms of geographical coverage, case finding and treatment results (80% treatment success rate, 26% case detection rate) notwithstanding the difficult situation in which it had to operate over the last few years. TB control activities have been implemented by the ILEP NGOs (alongside leprosy control) under the coordination of NTBLCP and technical assistance provided by WHO. For the past 10 years, the fundamental elements of the program (provision of high quality drugs, basic training on DOTS, regular monitoring and supervision, surveillance) have been implemented to the best of the partners' capacities. However, with the available resources, the Nigerian TB program has not yet reached its optimal expansion capacity. The provision of services to a greater number of people and the achievement of the set targets can be reached only through the expansion of the diagnostic capacity of the existing health facilities and the establishing new ones, which require additional resources in terms of manpower, infrastructures, equipment and supplies. The proposal therefore aims at filling the gap for DOTS expansion along with the plan agreed upon by all the partners involved in the program and in line with the strategic plan.

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

The National Tuberculosis programme is making efforts to ensure steady funding from the government. A comprehensive advocacy plan directed at the government is part of this proposal and current indications are that more funding for health care is made available in 2005.

There are further prospects for savings accruing from the reform agenda of the Federal Government which is aimed at inculcating strict fiscal discipline in government. In order to solve the problem of inadequate resource allocation to the health sector and by implication disease control initiatives like TB control, the Federal Government sent a health bill to the National Assembly and is currently under consideration. The bill proposes a definite mechanism to harness resources from the three tiers of Government (Federal, State and LGAs) in a coordinated manner to comprehensively fund the health sector. It is foreseen that when this bill is passed, government will be in a position to redeem its responsibilities of funding a substantial part of the national TB response. In addition, the Health Insurance Scheme soon to be launched by the Government is expected to improve the funding situation for health.

The Government commitment to TB control has improved. Already Government has approved N75m ($560,000) for the NTP and N65m for the National Tuberculosis Training Centre Zaria for year 2005 (Annex 9). NTBLTC Zaria has actually received the first instalment of N7,302,225 ($55,000) –Annex 10. An increasing level of commitment is expected during this proposal period and has been reflected as such.

Nigeria is also actively soliciting for debt relief from its creditors, which is also expected to leverage resources for social services including health. It is therefore not unreasonable to expect that the Government of Nigeria takes greater responsibility in funding the National Tuberculosis Control programme beyond this proposal period.

4.4.3	Describe gender inequities regarding program management and access to the services to be delivered and how this proposal will contribute to minimizing these gender inequities *(2 paragraphs)*.
	Current statistics show that the male: female ratio of sputum smear positive patients is 1.5: 1. It is unclear to what extent this reflects the actual epidemiological situation or any gender related issues (e.g cultural barriers in accessing health services by women, literacy etc). Expansion of the network of diagnostic and treatment services to community level is aimed at improving access by reducing socio-economic and geographical barriers. The need to conduct a social research into the gender issues affecting case finding is part of this proposal with the view to establish some baseline information as well as monitor trend.

4.4.4	Describe how this proposal will contribute to reducing stigma and discrimination against people living with HIV/AIDS, tuberculosis and/or malaria, and other types of stigma and discrimination that facilitate the spread of these diseases *(1–2 paragraphs)*.
	Anecdotal evidence suggests high stigma associated with TB and especially with the link to HIV/AIDS. The proposal deliberately aims to reduce stigma associated with both diseases through strong advocacy, communication and social mobilization initiatives as well as the provision of HIV/TB collaborative services within the reach of communities. With additional donor support, combined TB/HIV activities within the government health service are to start in June 2005. Successful treatment will help to overcome fear and reduce stigma in families, communities and the society at large. Support will also be given to activities of NEPWHAN and other TB/HIV partners working on community-based stigma reduction activities. This also constitutes a research question to be addressed under this proposal.

4.4.5	Describe how principles of equity will be ensured in the selection of patients to access services, particularly if the proposal includes services that will only reach a proportion of the population in need (e.g., some antiretroviral therapy programs) *(1–2 paragraphs)*.
	One of the main objectives of National Tuberculosis programme in Nigeria is to provide quality-assured diagnostic and effective treatment services to all the population of the country in need of such services. In accordance with this principle, the expansion of services will be based on the estimated risk of TB in the area, the expected potential beneficiary population, and accessibility to health care services. This proposal also deliberately targets those that are considered most vulnerable e.g. those populations living in congregate settings, nomads, women under special cultural circumstances, People Living With HIV/AIDS and Internally Displaced Persons (IDPs) as a result of communal conflict situations.

4.5 Program and financial management

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

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

Christian Health Association of Nigeria

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

Table 4.5.1 – Implementation Responsibility

Responsibility for implementation			
Nominated Principal Recipient(s)	**Area of responsibility**	**Contact person**	**Address, telephone and fax numbers, e-mail address**
Christian Health Association of Nigeria (CHAN)	Financial Management Implementation of Community DOTS and Public Private Mix for DOTS programmes	Dr. A. Okey Osuji Director of Programmes	Christian Health Association of Nigeria (CHAN) Bukuru Road, Little Rayfield P. O. Box 6944 Jos, Plateau State Telephone:+234-73-280925/ 280974 (M) +234-802-302-5184 Email: aokeyosuji@yahoo.com chan@hisen.org chanpharm@hisen.org

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

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

By Consensus of CCM during formal meeting of 9th June 2005.

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

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

CHAN has a strong organizational structure, with a National Executive Council, headed by the President, as the central policy-making and coordinating body of the organizations. Operationally, the activities of CHAN are initiated from the Headquarters based in Jos, Plateau State. The Secretary-General who is responsible for the day-to-day running of the organization, reports to the National Executive Council. Below the Secretary-General, are a team of Directors, who have oversight responsibility for the various departments/units within the organization. The Departments/Units are Administration/Human Resources Management and Finance, constituting the support services and CHANPHARM and Programmes, constituting the technical wing. For purposes of ensuring effective service delivery, CHAN operates a de-centralized system of administration. Zonal Offices have been established in four locations in the South-east, South west , North east and North-west/central to manage the relationships with MIs as well as provide on-site support that MIs urgently require. To enhance the work of the organization, the MIs have been constituted into Zonal and State Committees

through which they input into the decision-making process and act as channels for communication. Presently, there are 358 registered members whose activities are carried out in 3,500 health facilities of various sizes and located in both urban and rural settings. The health facilities are by more than 15 various denominations in Nigeria.

4.5.4 Has the nominated Principal Recipient previously administered a Global Fund grant?	☐ Yes
	☒ No
4.5.5 If yes, provide the total cost of the project and describe the performance of the nominated Principal Recipient in administering previous Global Fund grants*(1–2 paragraphs)*.	

4.5.6 Describe other relevant previous experience(s) that the nominated Principal Recipient has had: *[Please describe in broad terms the relevant programs, as well as their objectives, key implementation challenges and results (2–3 paragraphs).]*

4.5.7 Describe the proposed management approach and explain the rationale behind the proposed arrangements.
[Outline management arrangements, roles and responsibilities between partners, the nominated Principal Recipient(s) and the CCM (2–3 paragraphs).]
The management of the project will be based on the GFATM guidelines with the project being coordinated by the FMOH. The CCM will have the general oversight on the implementation of the project and will work closely with the Principal Recipient to ensure adherence to the guidelines of the GFATM. Project management unit to manage the project will be established and the SR will work closely with the PR and report regularly on its activities to the PR and the CCM. The PR will on the other hand subject itself to the scrutiny of the LFA and it will make periodic report to the CCM. An organization chart and clear job description for each of the partners and staff will be prepared jointly and strictly adhered to. The project, with the assistance of the various partners will utilize modern management and disease tracking softwares in the process of implementation of the project. Quarterly meetings will be held by the partners to review the progress of the project.

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

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

	☐ more then 50

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

4.5.11 Describe the process by which sub-recipients were selected and the criteria that were applied in the selection process (e.g., open bid, restricted tender, etc.); *(2–3 paragraphs).*

Sub-recipients (TB partners) were selected on the basis of their areas of core competence related to program objectives and activities under the following criteria:

1. Human resources and technical capacity to implement
2. Previous experience in similar technical areas
3. Financial Management and reporting system

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

N/A

4.5.13 Describe the relevant technical, managerial and financial capabilities of the sub-recipients.

[Describe anticipated shortcomings or challenges faced by sub-recipients and how they will be addressed (e.g., capacity-building, staffing and training requirements, etc.).]

GLRA, NLR, DFB and TLMN: these organizations have a well organized administrative structure consisting each, of a Country Representative, 3 Medical advisors, an Accountant with support administrative staff. The organization has experience in procurement and supply management. The medical advisors have been providing technical support to the National TB programme for over 10 years. They also have wide area of coverage in the country working in all the 36 states.

The Society For Family Health is also an established organization with strong administrative structure and sound financial management system. The organization has administered quite a substantial amount of funds on a 'pass through' basis for USAID and DFID. They also have zonal spread across Nigeria.

Inter-Gender is an indigenous Gender and social research Centre with a well established management system. The organization is governed by a governing board and management headed by a CEO. The organization has funding from DFID for peace building and Gender related projects throughout Northern Nigeria.

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

N/A

4.5.15	Describe the process that will be used to select sub-recipients if the proposal is approved, including the criteria that will be applied in the selection process *(1–2 paragraphs)*.
	The German Leprosy and TB Relief Association, Netherlands Leprosy Relief, Nigerian Institute for Medical Research (NIMR), NTBLCP, SPETB, Society For Family (SFH), Inter-Gender, NEPWHAN and TLM Nigeria who are already working in partnership with the National TB programme expressed their willingness to serve as SRs to the round 5 TB proposal to CCM. The CCM will compile the letters of intent, examine the submissions of the SRs vis-à-vis their technical and managerial capabilities, after which the selection process based on a restricted tendering will apply.

4.6 Monitoring and Evaluation (M&E)

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

4.6.1	Describe how this proposal and its Monitoring and Evaluation plan complements or contributes towards existing efforts (including existing Global Fund programs) to strengthen the national Monitoring & Evaluation plan and/or relevant health information systems.
	Expansion of DOTS services will improve the quality and reliability of data from previously non-DOTS areas, which will provide more accurate information concerning the actual TB situation in Nigeria. With WHO support an electronic system for capturing the routine data at LGA, State and National level has recently been introduced and gradual implementation is expected, while maintaining the paper reports as long as needed to ensure complete collation, analysis and feedback. The proposal will also ensure adequate linkage between the programme and the overall Health Management Information System (HMIS) of the Federal Ministry of Health including Integrated Disease Surveillance and Response (IDSR) and the National Office of Statistics. The proposal provides for recruitment of an experienced Data Manager (Public Health Medical officer/Epidemiologist with Statistics background) to facilitate timely collation and analysis of national data as well as training. At the State and LGA level, capacity building will be achieved through the DOTS training by stressing on the recording and reporting component as well as on-the job training in the field during supervision. State and LGA M&E focal points will also be trained in DOTS monitoring and evaluation to enhance quality of data. The extensive list of indicators developed for this proposal demands not only a thorough review of the existing NTBLCP recording and reporting system, but also an M&E system to monitor the many different and new activities envisaged under ACS, training, quality assurance and the financial aspects thereof as well. This will be developed at the start of the proposal period.

4.7 Procurement and Supply Management

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

4.7.1	Briefly describe the organizational structure of the unit currently responsible for procurement and supply management of drugs and health products. Further indicate how it coordinates its activities with other entities such as National Drug Regulatory Authority (or quality assurance department), Ministry of Finance, Ministry of Health, distributors, etc.
	In 2002, the NTBLCP initiated a National Drug Procurement meeting with all development partners. This meeting is responsible for quantification of national drug needs and preparation of a procurement plan. Currently Nigeria is benefiting from a GDF grant covering the period 2003-2007 mainly for DOTS expansion areas as well having access to Direct Procurement. DFB and GLRA (KfW) are procuring anti-TB drugs and other supplies to cater for the states where DOTS has been implemented since 1993, and has recently procured through GDF. NLR was also procuring for 4 states through the GDF direct procurement mechanism. Even though the TB drugs from GDF were quality ensured, NAFDAC checked batches again. Distribution is through the stores of the ILEP NGOs.

4.7.2 Procurement Capacity
a) Will procurement and supply management of drugs and health products be carried out (or managed under a sub-contract) exclusively by the Principal Recipient or will sub-recipients also conduct procurement and supply management of these products? ☐ Principal Recipient only ☐ Sub-recipients only ☒ Both
b) For each organization involved in procurement, please provide the latest available annual data (in Euro/US$) of procurement of drugs and related medical supplies by that agency
GDF - TB drugs for 33,000 pts in 17 states + buffer stock (donation) NLR - TB drugs for 10,000 pts in 4 states + buffer? (State governments) DFB - TB drugs for 3,000 pts in 2 states + buffer stock (Belgian gvt) GLRA - TB drugs for 20,000 pts in 14 states + buffer stock (German gvt, KfW) Data on diagnostic supplies not immediately available

4.7.3 Coordination
a) For the organizations involved in section 4.7.2.b, indicate in percentage terms, relative to total value, the various sources of funding for procurement, such as national programs, multilateral and bilateral donors, etc.
See 4.7.2.b above; value not immediately available
b) Specify participation in any donation programs through which drugs or health products are currently being supplied (or have been applied for), including the Global Drug Facility for TB drugs and drug-donation programs of pharmaceutical companies, multilateral agencies and NGOs, relevant to this proposal *(1 paragraph).*
Nigeria currently benefits from support of Global Drug Facility (GDF). In 2002, GDF supported with anti-TB drugs for 33,000 patients, which assisted in facilitating the DOTS expansion. The Nigerian Government was primarily responsible for the clearing of the drugs. The World Health Organization assisted the country in maintaining adequate links with GDF and facilitated the clearing of the donated drugs. Other sources of donated drugs include ILEP Member Organizations (DFB and NLR procure GDF drugs, GLRA provides quality assured 4FDC blisterpacks) who support 20 states. SEE 4.7.1

4.7.4 Supply Management (Storage and Distribution)	
a) Has an organization already been nominated to provide the supply management function for this grant?	☐ Yes ➔ continue ☐ No ➔ go to 4.7.5
b) Indicate, which types of organizations will be involved in the supply management of drugs and health products. *[If more than one of these is ticked, describe the relationships between these entities (1 paragraph)]* ☐ National medical stores or equivalent ☐ Sub-contracted national organization(s) (specify which one[s]) ☐ Sub-contracted international organization(s) (specify which one[s]) ☐ Other (specify)	
c) Describe the organizations' current storage capacity for drugs and health products and indicate how the increased requirements will be managed.	
d) Describe the organizations' current distribution capacity for drugs and health products and indicate how the increased coverage will be managed. In addition, provide an indicative estimate of the percentage of the country and/or population covered in this proposal.	

[For tuberculosis and HIV/AIDS components only:]

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

[If yes, applicants should be aware that all procurement of medicines to treat multi-drug-resistant tuberculosis financed by the Global Fund must be conducted through the Green Light Committee (GLC) of the Stop TB Partnership. Proposals must therefore indicate whether a successful application to the

Committee has already been made. If not, a Green Light Committee application form must be completed and included with this proposal (see AnnexB).]

4.8 Technical Assistance and Capacity-Building

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

4.8.1 Describe capacity constraints that will be faced in implementing this proposal and the strategies that are planned to address these constraints. This description should outline the current gaps as well as the strategies that will be used to overcome these to further develop national capacity, capacity of principal recipients and sub-recipients, as well as any target group. Please ensure that these activities are included in the detailed budget.
The planned expansion of DOTS services to some 200 LGAs in Nigeria, which by implication entails developing the capacity of about 400 laboratories to perform AFB smear examinations according to National guidelines and enabling over 3,000 General Health Care facilities to deliver DOT. This constitutes a huge capacity challenge in terms of human resource development (HRD) and the whole programme managerial capacity. Although WHO has been able to provide technical support in form of National Professional Officers, human resource gaps still exist as follows: National level: Technical and supervisory capacity constraints in key programme areas e.g. An epidemiologist, Laboratory expert, 4 Senior Medical Officers to supervise DOTS implementation in states as well as TB/HIV, PPM, Community DOTS, and technical planning. Furthermore an ACS focal person is required to facilitate advocacy. The managerial aspects include a Senior administration and finance officer, a Procurement and supplies management specialist, preferably with a Pharmaceutical background. At the State level, the human resource gaps are: A few State Control programmes need a competent Medical Officer as head and inadequate numbers of State TBL supervisors. Due to land mass, there is inadequacy of transport facility in some states. Most gaps exist at the LGA level, which is also the operational level of the programme. The most important gap is in terms of: inadequacy of laboratory personnel within the public service employment to perform AFB. Logistically a gap also exists in the availability of motorcycles for supervision at LGA level. The strategies to overcome most of these constraints are as outlined in the NTBLCP draft Human Resource Development (HRD) Plan of 2005. This entails filling key NTP positions at the central level through recruitment of external expertise on term-limited basis to support implementation as well as build local capacity. In the short-term, the programme will maximize the use of the WHO technical support staff as well as the Medical Advisors of the development partners (mainly ILEP) to facilitate planning, implementation, monitoring and evaluation of the programme.At the state level, programme headship will be filled by competent Medical Officers, and ensuring at least 4 State TBL supervisors in each state. At the LGA level, training of competent Community Health Officers to take responsibility of the programme at that level. In addition, advocacy will be intensified at the State and LGA levels to recruit more laboratory technicians to ensure adequacy in all the laboratories. In order to strengthen the supervisory and monitoring capacity at the State and LGA level, programme staff at all levels will benefit from supervision course at the NTBLTC based on need.

5 Budget Section

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

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

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

5.1 Component Budget

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

Table 5.1 – Funds Requested from the Global Fund

	Funds requested from the Global Fund (in US$)					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Human resources	337,120	413,560	410,000	410,000	410,000	**1,980,680**
Infrastructure and equipment	871,000	303,050	85,700	100,700	615,700	**1,976,150**
Training	2,798,782	3,402,732	3,574,932	3,599,932	3,119,932	**16,496,310**
Commodities and products	120,000	-	-	-	-	**120,000**
Drugs	20,000	110,000	1,767,380	2,100,856	2,481,032	**6,479,268**
Planning and administration	1,624,091	1,546,336	1,236,732	1,329,906	1,423,976	**7,161,040**
Advocacy, Communication and Social Mobilization	4,134,270	3,536,370	3,809,020	3,829,020	3,829,020	**19,137,700**
Total funds requested from the Global Fund	**13,670,413**	**11,899,648**	**13,370,972**	**13,897,622**	**15,426,868**	**68,265,522**

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

a) It should be structured along the same lines as the component strategy—i.e., reflect the same goals, objectives, service delivery areas and activities.
b) It should be detailed for year 1 and indicative for year 2, stating all key assumptions, including those relating to units and unit costs, and should be consistent with the assumptions and explanations included in section 5.2.
c) It should provide more summarized information and assumptions for the balance of the proposal period (year 3 through to conclusion of proposal term).
d) It should be integrated with a detailed workplan for year 1 and an indicative workplan for year 2.
e) It should be fully consistent with the summary budgets provided elsewhere in the proposal, including those in this section 5.

5 Budget Section

5.1.1 Breakdown by Functional Areas

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

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

Table 5.1.1a – Costs for Monitoring and Evaluation

	Funds requested from the Global Fund for monitoring and evaluation (in US$)					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Monitoring and evaluation	3,290,150	2,122,600	2,217,208	2,217,208	3,217,208	**13,064,374**

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

Table 5.1.1b – Costs for Procurement and Supply Management

	Funds requested from the Global Fund for procurement and supply management (in US$)					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Procurement and supply management	360,000	350,000	140,000	180,000	200,000	**1,230,000**

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

Table 5.1.1.c – Costs for Technical Assistance

	Funds requested from the Global Fund for technical assistance (in Euro/US$)					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Technical assistance to CCM, PR and SR	115,000	115,000	130,000	130,000	130,000	**620,000**

5.1.2 Breakdown by Service Delivery Area

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

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

		Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Value per year (in US$)		13,670,413	11,899,648	13,370,972	13,897,622	15,426,868	**68,265,522**
Objectives	**Service delivery area**	**Estimated percentage of budget**					
To strengthen the technical and managerial capacity of the National TB and Leprosy Control Programme at all tiers to ensure achievement of at least 80% implementation rate of programme activities by 2010.	Human Resources Strengthening	7%	8%	7%	7%	7%	7%
	Technical Assistance	0.6%	1%	1%	1%	1%	1%
	Advocacy initiatives	6%	5%	5%	5%	4%	5%
	Advocacy to key Government Officials	0.7%	5%	1%	1%	1%	1%
	TB Partnership strengthening and coordination	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
	Engagement of Civil Society Organizations and TB advocate groups.	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
To promote behavior change in the community such that 70% of the adult population has a correct knowledge of TB by 2010	Behavioral Change Communication targeting Communities	8%	7%	6%	6%	5%	6%
	Behavioral Change Communication targeting general	10%	10%	9%	9%	8%	9%

	population						
	Social mobilization for behavior change	2%	3%	2%	2%	2%	2%
To increase TB case detection rate from 26% to 70% by 2010	Expansion of laboratory (AFB microscopy) network	1%	0.3%	0%	0%	3%	1%
	Quality Assurance system for smear microscopy	3%	4%	3%	3%	3%	3%
	Public-Private Mix for DOTS (PPM)	4%	5%	4%	4%	4%	4%
	TB case finding in congregate settings (e.g prisons)	1%	1%	1%	1%	1%	1%
	Intensified TB Case Findings in PLWHA	4%	4%	4%	4%	4%	4%
To increase treatment success all TB cases detected to at least 85% by 2010	Treatment of TB Cases with DOTS	6%	6%	15%	17%	18%	13%
	Surveillance of Multi-drug resistant Tuberculosis (MDR-TB)	7%	4%	0%	0%	0%	2%
	Patient treatment support	4%	7%	13%	13%	9%	9%
	Supervision of DOTS activities	9%	10%	9%	9%	9%	9%
	Monitoring and Evaluation	15%	7%	6%	6%	12%	9%
	Operational research	3%	3%	2%	2%	2%	2%
	Community TB Care	2%	2%	2%	2%	2%	2%
To achieve 25% reduction in TB incidence among PLWHA by 2010.	Prevention of TB Infection in PLWHA	3%	3%	4%	4%	3%	3%
	Care and Support for HIV-positive TB patients	3%	4%	3%	4%	3%	3%
Total:		100%	100%	100%	100%	100%	

5.1.3 Breakdown by Partner Allocations

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

Table 5.1.3 – Partner Allocations

	Fund allocation to implementing partners (in percentages)				
	Year 1	Year 2	Year 3	Year 4	Year 5
Academic/educational sector	5%	4%	0%	0%	0%
Government	53%	54%	44%	43%	49%
Nongovernmental/ community-based org.	23%	23%	19%	19%	17%
Organizations representing people living with HIV/AIDS, tuberculosis and/or malaria	5%	7%	13%	13%	9%
Private sector	3%	2%	3%	3%	2%
Religious/faith-based organizations	4%	4%	4%	4%	3%
Multi-/bilateral development partners	3%	1%	13%	14%	15%
PR/SRs admin costs	5%	5%	5%	5%	5%
Total	100%	100%	100%	100%	100%

5.2 Key Budget Assumptions for requests from The Global Fund

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

5.2.1 Drugs, commodities and products

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

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

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

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

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

The drug requirement was made based on estimated case detection for a particular year taking into consideration the rate of increase from the previous performance in case detection. Provision is made for adequate reserve stock in every yearly estimate to cover for expected/unexpected increases and lead time for importation. Based on the current costs of GDF drugs, an estimated $12 per full course of 8-month regimen and $18 for retreatment is used. The GDF donation will be deducted from the total estimation.

To estimate reagents requirements, the expected number of smear positive TB cases for the year is used. Based on the assumption of detection of one smear positive case among ten PTB suspects, this translates to 30 diagnostic and 6 follow up AFB slides per case. Therefore 36 slides by the number of smear positive gives the total expected number of smear examinations. Since the approximate cost of reagents and slides per examination is about N15 ($0.11), it then translates to $5 per detected smear positive case. To allow for 100% buffer, the number of smear positive cases will be doubled and the calculated stock be deducted from subsequent orders.

The number of microscopes requested is based on the number of laboratories to be established, at one microscope per laboratory.

5.2.2 Human resources costs

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

The ultimate aim of this proposal is to strengthen internal human resource capacity of Nigerians to sustain the National Tuberculosis Control efforts. External technical consultants with the right expertise and experience in TB control will be recruited on a contractual basis for the period of the grant. The terms of reference of such consultants will be to assist, in the short-term, with implementation of the proposal activities. Local Nigerian counterparts will be identified within the government workforce to work with the external consultants. Those showing interest and capability will be stimulated to undertake further studies and get international exposure. In the long-term, the external consultants are expected to help develop the capacity of the local consultants to take over and provide the needed technical support to the programme after the expiration of their contract period.

5.2.3 Other key expenditure items

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

The equipment needs indicated in the budget for the National and Zonal Reference laboratories were based on submissions from the Nigerian Institute of Medical Research (NIMR).