
# Nigeria

# Operational Plan Report

# FY 2010

# Operating Unit Overview

## OU Executive Summary

**Program Description/Country Context:**

Nigeria is not only populous (148 million) but also ethnically and culturally diverse. Under the federal system of government, Nigeria has six geo-political zones, 774 local government areas (LGAs), 36 states and a Federal Capital Territory (FCT), and occupies an area more than twice the size of California. In both geographic size and population, many states are larger than some African countries. The combination of Nigeria's large population and estimated HIV prevalence of 3.1% (UNAIDS, 2008) results in the second highest burden worldwide, with an estimated 2.6 million people infected with HIV. Adding to this burden are 1.2 million children orphaned by HIV/AIDS. In addition, Nigeria has one of the highest tuberculosis (TB) burdens in the world (311/100,000 population, WHO 2009) and the largest TB burden in Africa. Many TB cases go undetected despite increasing TB detection rates and TB program coverage. This results in a significant health issue within the HIV/AIDS response due to the high rates of TB/HIV co-infection.

Nigeria has a generalized/mixed HIV epidemic; however, prevalence varies widely across states and rural and urban areas. Concentrated HIV/AIDS epidemics occur in particular geographic regions and within certain segments of the population. The United States Government (USG) Nigeria program supported an antenatal prevalence survey in 2008 (ANC) and a population level prevalence survey in late 2007 (NHARS 2007) to clearly define the variability in prevalence. The variability in prevalence by states was demonstrated in the ANC survey, with prevalence ranging from a low of 1.0% in Ekiti state to 10.6% in Benue state. Nigeria's epidemic is largely fueled by heterosexual and mother-to-child transmission, but there are clearly identifiable risk groups that are similar to those in many other African countries. There are significantly higher rates among most-at-risk populations (MARPs), as demonstrated by the 2007 Integrated Bio-Behavioral Surveillance Survey (IBBSS), including commercial sex workers, injecting drug users, and men having sex with men. For example, HIV prevalence among female sex workers is 37.4% (IBBS 2007). Risky behaviors continue and are targets for key prevention interventions. For example, preliminary data from the 2007 National AIDS and Reproductive Health Survey (NARHS) demonstrate that only 54% of men reported using a condom during sex with a sex worker in the past 12 months. The USG will utilize this and data from other major surveys recently completed or currently underway in order to continue to tailor prevention efforts to derive the greatest impact on the epidemic.

Despite the rapid expansion of HIV services across the country, coverage of essential prevention and treatment interventions remains low, and the level of unmet demand is high. The response must be multisectoral and integrated, reduce duplication and build on synergies. Health systems, particularly at the primary level, are weak and require strengthening to expand access to critical services. The objectives to be achieved under the Nigeria Partnership Framework directly address these challenges. In line with the NSF 2010-2015, the six principal strategic areas addressed by the Partnership Framework are:

1. Behavior Change and Prevention of New HIV infections
2. Treatment of HIV/AIDS and Related Health Conditions
3. Care and Support for People Infected and Affected by HIV/AIDS and Orphans and Vulnerable Children (OVC)
4. Institutional Arrangements, Infrastructure Requirements, and Human and Financial Resource Issues
5. Policy, Advocacy, Legal Issues, and Human Rights.

6. Monitoring and Evaluation, Research, and Knowledge Management

We continue to work towards finalizing the USG-GON Partnership Framework and to push for the commitments of the GON to the HIV/AIDS response in Nigeria. The activities described in COP10 continue to be sustained primarily by the PEPFAR Nigeria program, with increased funding commitments also from the Global Fund.

**Prevention:**

Prevention activities in Nigeria include prevention of mother-to-child-transmission (PMTCT), prevention of sexual transmission (abstinence and be faithful (AB) programs, condoms/other prevention initiatives), and prevention of medical transmission (blood and injection safety) as well as HIV counseling and testing. With PMTCT Plus Up funds in FY 2010, the USG will continue its efforts to support expansion of coverage of PMTCT services to pregnant women. USG will continue to dialogue with other stakeholders, particularly UNICEF, and the GoN to implement this expansion strategically, reaching out to high prevalence communities and to rural areas where many women give birth without a skilled birth attendant. As PEPFAR Nigeria shifts its emphasis from an emergency response to a more sustainable health systems strengthening approach, PMTCT service provision will emphasize strengthening of diagnostic services for exposed infants, linkages to family planning services, referral networks to reduce loss to follow-up, and infant feeding counseling to support appropriate feeding choices. The USG continues to expand its coverage started in FY 2008 with the provision of PMTCT services using the “hub” and “spokes” model to increase PMTCT coverage. This expansion builds on PEPFAR PMTCT networks, leveraged resources from UNITAID and UNICEF, and the GoN National Scale-Up Plan. The USG is leveraging resources for PMTCT commodities which include laboratory test kits for HIV testing, reagents for Early Infant Diagnosis (EID) and antiretroviral drugs for prophylaxis. The USG will support the Government of Nigeria to review the National PMTCT guidelines based on new recommendations from WHO on antiretroviral therapy in HIV positive pregnant women and infant feeding in the context of HIV. Also the USG will continue training of health workers to provide PMTCT services in line with the National guidelines as well as internationally accepted best practices. There will be an increased emphasis on training and involvement of traditional birth attendants especially with the renewed effort to increase PMTCT service provision at the LGA level.

The USG will continue to support high-quality, targeted behavioral change programs to deliver balanced AB and C messages. USG implementing partners (IPs) will continue to provide a range of prevention services that target the specific needs of different risk groups, providing them with the appropriate HIV prevention messages and a set of prevention skills to help reduce sexual transmission of HIV. USG prevention efforts will utilize data from recent studies, including the 2008 ANC survey, 2007 IBBSS and NARHS 2007, as well as formative research at implementing partner level to generate an evidence base for targeting of MARPs. Mass media messages, such as the popular and successful national “ZIP UP” campaign will continue, coupled with other prevention activities to strengthen the overall messaging occurring in a geographic area and improve the effectiveness of the mass media messaging. USG will continue to provide institutional capacity building to local civil society organizations (CSOs), non-governmental organizations (NGOs), community-based organizations (CBOs) and faith-based organizations (FBOs) to deliver accurate, high-quality AB and C messages.

Prevention activities will be integrated into all care and treatment activities, including HIV counseling and testing (HCT) services. Couples counseling will be expanded and will continue to provide targeted prevention messages for discordant couples. Efforts to reduce new infections among high-risk and high-transmission communities will continue, with messages specifically targeted for each risk group and drivers of the epidemic. USG will provide syndromic management services for sexually transmitted infections to persons engaged in high-risk behaviors to help prevent HIV infection.

The blood transfusion services in Nigeria still remain a source of transmission of HIV and other pathogens

despite the gains made by the National Blood Transfusion Service (NBTS) since 2007. In FY 2010, the USG continues its commitment towards ensuring that linkages between NBTS and IP-supported clinical sites are improved, thereby resulting in an increase in hospital utilization of NBTS-screened blood and a reduction in emergency transfusions at supported sites. Clinical service outlets will benefit from safe injection activities, and USG partners will promote universal precautions in all clinical settings.

**Care:**

Care activities in Nigeria include adult and pediatric care and support, TB/HIV, and support for orphans and vulnerable children (OVC). With the shift in emphasis from a rapid scale-up emergency response to a sustainability response, the USG in line with the NSF2 and the Partnership Framework (PF) is focused on ensuring maintenance of all supported clients receiving care, OVC, and treatment services. Strategies will include minimal expansion with greater focus on improved quality, sustainability, pooled procurements, cost efficiencies and health systems strengthening.

With PEPFAR support, the GoN has made progress in establishing a basic package of services for HIV-positive people and their relatives. In FY 2010, care services, including opportunistic infection management, laboratory follow up, management of sexually transmitted infections, and referral to a care network will be provided to all HIV-positive patients identified in USG programs. People affected by HIV/AIDS will receive support services, home-based care kits, and access to psychosocial support. The USG will promote access to home-based care and strengthen networks of health care personnel and community health workers. USG will continue to support the harmonization of training materials and their use, increased focus on adherence counseling and pooled commodity procurements. Children of HIV-infected adults in care will be linked to OVC specialized services.

In the Tuberculosis Directly Observed Treatment Short-Course (TB DOTS) settings, USG will continue provider-initiated routine HIV testing, thereby greatly increasing access to services for adults and children co-infected with HIV and TB. The focus will also be to reduce TB transmission, improve diagnosis and management of TB and MDR-TB cases especially among HIV positive patients. Data from the ongoing USG-supported national MDR-TB and HIV survey will become available and will be incorporated into evidence-based service provision in the TB/HIV program.

Children continue to remain a priority in FY 2010, with a significant increased focus on: PMTCT outcomes; provision of EID; prioritization of scale-up of treatment services to children; provision of pediatric tuberculosis services; prevention initiatives focused on school-aged children; nutrition and education programs; and direct needs based services for OVC and their care providers. The USG will continue to support the Federal Ministry of Women Affairs and Social Development OVC Division to improve its capacity for better coordination of activities, initiatives & advocacy to address the overwhelming needs of Nigeria's OVC and their caretakers. The improved access to a variety of educational choices (based on need) will continue to be available to OVC, building on a broad USAID basic education program being implemented in selected states in Nigeria. High protein vitamin enriched nutritional supplements will be distributed to children clinically identified with the highest need. USG will also increase efforts in system strengthening and capacity development of Local and State structures and organizations responding to the needs of OVC via a new efficient and flexible grant making mechanism under the newly developed Umbrella Grant Mechanism RFA.

**Treatment:**

Treatment activities in Nigeria include the provision of antiretroviral drugs (ARVs) and services to eligible patients, as well as laboratory support for the diagnosis and monitoring of HIV-positive patients identified through USG activities and in line with goals and strategies of the NSF and the PF. Funds will be used to purchase FDA-approved or tentatively approved antiretroviral drugs, in their generic formulation whenever possible, in an effort to maximize the number of Nigerians receiving treatment. Harmonization, quality of

service, reduced target costs and cost leveraging continue to be mainstays of the Nigeria treatment program, with standardized services and health care worker training provided across all implementing partners. Pediatric treatment services also remain a priority in FY 2010. The USG will continue its efforts to leverage GoN, Global Fund, and other development partners for ARVs as these commodities account for a significant percentage of the USG budget.

In FY 2010, the USG will pool all ARV procurements through SCMS. This method, based on PEPFAR/Government of Nigeria forecasting, will decrease duplication efforts by individual partners and increase efficiency. The USG supports logistics management activities, a key component of ARV delivery, through the ongoing development of a Logistics Management Information System and an Inventory Control System. Staff in all sites will be trained in all aspects necessary to maintain a safe and secure supply of high-quality pharmaceutical products in a cost-effective and accountable way. Other strategies including task-shifting, decentralization and regionalization will result in service improvement and efficiency. Follow-up activities to the costing studies already done will include resource tracking, HRH monitoring framework and participation in policy development and implementation.

Integral to the provision of treatment services, laboratories will focus on maintaining services through the implementation of expanded and harmonized lab quality assurance/quality control (QA/QC) systems. In addition, the USG will continue to emphasize networking of care with a tiered approach to laboratory equipment platforms for HIV clinical monitoring and service delivery. USG-supported labs will continue to scale-up support for the implementation of a national network for early infant diagnosis (EID). Efforts to increase efficiency will be achieved through two training proposals. The first, instruction for biotechnical engineers in equipment maintenance is a new initiative designed to reduce down-time of equipment in order to maintain high throughput of samples. The second, training and guidance in shipping and transportation of specimens, supports QA in the tiered lab network. Also critical in FY 2010 will be the development of a National Laboratory Strategic Plan. Improved cost efficiencies that could result from this overall approach advance USG efforts in reducing overall treatment costs and making routine monitoring available to all antiretroviral treatment patients.

**Health Systems Strengthening**

In FY2010, there will be a greater emphasis on health systems strengthening activities, using the defined WHO six HSS building blocks of: health service delivery, human resources for health (HRH); medical products, vaccines and technologies; information; leadership and governance, and financing.

While continuing the range of activities that serve to strengthen these six areas, particular emphasis will be placed on the sustainability of these and previous PEPFAR investments. The strategy for accomplishing this will focus on governance and leadership with the goal of supporting national ownership and leadership. Existing state level and national level government initiatives that seek to reinforce the foundation upon which PEPFAR services are based will be strategically identified and analyzed for targeted support. Resolving issues of service delivery, health financing, human resources and the provisions of supplies, medications, equipment and infrastructure in the context of sustaining the PEPFAR investment requires national ownership and leadership and emphasis on governance by national institutions and organizations. Efforts to harmonize health information systems will be complemented by encouraging and supporting the use of information collected to support advocacy initiatives of institutions involved in governance. Defined efforts aimed at supporting strategies for accurate health workforce data generation for a planned health workforce production, distribution/deployment and retention at the national and state levels of government will be given priority attention. All planned HSS interventions will be strictly monitored during implementation, and evaluation of the outcomes including operational research initiatives will be done periodically to ascertain the impacts of the intervention. Gaps will be identified periodically and corresponding activities will be re-evaluated/identified.

In FY 2010, the USG will continue to strengthen the capacity of the GoN to provide comprehensive antiretroviral treatment and to build the systems and structures that will support the countrywide HIV response. Under the PEPFAR reauthorization, the goal of these efforts is to shift responsibility and costs and create a sustainable, Nigerian-led HIV/AIDS response. A key component of this effort includes improving the policy environment underpinning the provision of prevention, care and treatment services. Monitoring and evaluation practices will also be strengthened to effectively measure progress in these program areas.

Activities to strengthen the GoN's provision of comprehensive antiretroviral treatment will include a continued focus on improving antiretroviral commodity forecasting and procurement in the national system, surveillance, patient management and monitoring systems, public health evaluations and population-based surveys. In addition to supporting the development and dissemination of guidelines and policies necessary to direct the provision of prevention, care, and treatment, specific legislation influencing HIV/AIDS activities will be supported in the National Assembly. Other national agencies, such as the National Agency for Food, Drug Administration and Control, National Primary Health Care Development Agency, the Medical Laboratory Science Council of Nigeria, the National Central Public Health Laboratory, and the Nigerian Institute for Medical Research will be supported in their HIV-related activities. The Global Fund Country Coordinating Mechanism (CCM) Secretariat will also be supported with financial and technical resources. PEPFAR and the Global Fund program activities will be closely coordinated and harmonized at the technical and managerial levels as discussed below.

**Other Costs:** The USG will also advance the goal of providing timely strategic data for evidence-based policy and program decision making. At the forefront of this effort is also the establishment of a unified national monitoring and evaluation framework with harmonized measurement and reporting activities. Qualitative and quantitative data will be collected to monitor all partners' performance to support program management. Information necessary to report on PEPFAR indicators will be collected, compiled, analyzed, and used for programmatic decision making.

Management and staffing funds will support the in-country personnel needed for USAID, HHS/CDC, Department of State, and DOD. Funds will ensure effective program management, monitoring and accountability, adherence to USG policy while working under the leadership of the Nigerian national response, and will cover office and administrative costs.

**Other Donors, Global Fund Activities, Coordination Mechanisms:**

Through PEPFAR, the United States is the largest bilateral donor to Nigeria's health sector, having provided a total of nearly $442 million in support during FY 2009, the majority of which is for HIV/AIDS prevention, care, and treatment. The USG in-country agencies include USAID, HHS/CDC, the Department of State, and the Department of Defense. In addition to USG agencies, development partners include the Global Fund, the World Bank, the Clinton Foundation, UNITAID, UNAIDS, DFID, JICA, CIDA, the European Union, WHO, UNICEF, the African Development Bank, the International Labor Organization (ILO), Italian Cooperation, UNDP, UNDCP, UNFPA, and UNIFEM. The primary GoN HIV/AIDS coordinating body is the National Agency for the Control of AIDS (NACA). In addition to regular planning with NACA and the Federal Ministry of Health, the USG team holds one of two bilateral seats on the Country Coordinating Mechanism for the GF. The USG is also the current Chair of the Development Partners Group for HIV/AIDS, which is the primary donor coordination body for multilateral and bilateral organizations providing HIV support. USG is coordinating the partnership framework development with GON and other development partners, in line with the GoN's NSF2.

The USG will continue to leverage and harmonize funding from the Global Fund, Clinton Foundation, DFID, World Bank, GAVI Alliance, and other bilateral and multilateral donors.

**Program Contact:** PEPFAR Coordinator, Adrienne Parrish Fuentes

**Time Frame:** FY 2010 – FY 2011

## Population and HIV Statistics

| Population and HIV Statistics | | | | Additional Sources | | |
|---|---|---|---|---|---|---|
| | Value | Year | Source | Value | Year | Source |
| Adults 15+ living with HIV | | | | | | |
| Adults 15-49 HIV Prevalence Rate | | | | | | |
| Children 0-14 living with HIV | | | | | | |
| Deaths due to HIV/AIDS | | | | | | |
| Estimated new HIV infections among adults | | | | | | |
| Estimated new HIV infections among adults and children | | | | | | |
| Estimated number of pregnant women in the last 12 months | | | | | | |
| Estimated number of pregnant women living with HIV needing ART for PMTCT | | | | | | |
| Number of people living with HIV/AIDS | | | | | | |
| Orphans 0-17 due to HIV/AIDS | | | | | | |
| The estimated number of adults and children with advanced HIV infection (in need of | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| ART) | | | | | | |
| Women 15+ living with HIV | | | | | | |

## Partnership Framework (PF)/Strategy - Goals and Objectives

(No data provided.)

## Engagement with Global Fund, Multilateral Organizations, and Host Government Agencies

Redacted

## Public-Private Partnership(s)

| Partnership | Related Mechanism | Private-Sector Partner(s) | PEPFAR USD Planned Funds | Private-Sector USD Planned Funds | PPP Description |
|---|---|---|---|---|---|
| Central Medical Store Upgrades PPP | | TBD | | | REDACTED |
| New Pharmaceutical Warehouse PPP | | TBD | | | REDACTED |
| Workplace HIV Prevention | | TBD | | | REDACTED |
| Zonal Reference Laboratories | | Abbott Laboratories | | | This PP is to support the establishment of Regional Reference Laboratories in the 6 geopolitical zones of the country, to provide specialized |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | clinical and public health laboratory services to the labs within the zonal networks. The zonal reference labs will be linked to an apex lab – a National Reference lab to be established through a different mechanism. When fully established, the zonal labs will provide specialized lab services for HIV/AIDS, TB, Malaria and other diseases of public health interest, including relevant neglected tropical diseases, based on the identified needs of the regions, conduct regional surveys and assessment, in collaboration with the National reference lab, support National surveys and disease surveillances, and serve as regional hub for clinical and |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | public health lab information management, and lab process standardization. |

## Surveillance and Survey Activities

| Name | Type of Activity | Target Population | Stage |
|---|---|---|---|
| HIV Incidence Study | Recent HIV Infections | Pregnant Women | Implementation |
| Monitoring of HIV drug resistance among patients on first line ART | HIV Drug Resistance | Other | Planning |

# Budget Summary Reports

## Summary of Planned Funding by Agency and Funding Source

| Agency | Funding Source | | | | Total |
|---|---|---|---|---|---|
| | Central GHCS (State) | GAP | GHCS (State) | GHCS (USAID) | |
| DOD | | | 11,913,473 | | **11,913,473** |
| HHS/CDC | | 3,056,000 | 136,067,775 | | **139,123,775** |
| HHS/HRSA | 14,330,999 | | 36,796,294 | | **51,127,293** |
| State | | | 813,000 | | **813,000** |
| State/AF | | | 25,000 | | **25,000** |
| USAID | 555,000 | | 252,851,340 | | **253,406,340** |
| **Total** | **14,885,999** | **3,056,000** | **438,466,882** | **0** | **456,408,881** |

## Summary of Planned Funding by Budget Code and Agency

| Budget Code | Agency | | | | | | | Total |
|---|---|---|---|---|---|---|---|---|
| | State | DOD | HHS/CDC | HHS/HRSA | State/AF | USAID | AllOther | |
| HBHC | | 750,000 | 15,380,318 | 8,309,141 | | 16,950,335 | | **41,389,794** |
| HKID | | | 6,209,491 | 1,433,758 | 25,000 | 36,410,752 | | **44,079,001** |
| HLAB | | 2,447,200 | 17,910,487 | 6,663,023 | | 13,170,646 | | **40,191,356** |
| HMBL | | | 4,770,516 | 80,913 | | 2,347,512 | | **7,198,941** |
| HMIN | | | 229,286 | 155,806 | | 2,830,000 | | **3,215,092** |
| HTXD | | 511,580 | 6,795,293 | 3,215,213 | | 70,088,487 | | **80,610,573** |
| HTXS | | 2,450,000 | 33,364,098 | 19,521,554 | | 25,279,867 | | **80,615,519** |
| HVAB | | | 1,192,022 | 304,099 | | 13,108,466 | | **14,604,587** |
| HVCT | | 65,000 | 569,051 | 190,500 | | 656,899 | | **1,481,450** |
| HVMS | 813,000 | 4,891,255 | 18,200,424 | | | 12,287,902 | | **36,192,581** |
| HVOP | | | 3,949,868 | 1,220,874 | | 15,578,737 | | **20,749,479** |
| HVSI | | 100,000 | 4,070,818 | 1,612,853 | | 9,079,945 | | **14,863,616** |
| HVTB | | 100,000 | 3,560,954 | 1,620,621 | | 4,513,626 | | **9,795,201** |
| MTCT | | 283,436 | 12,951,764 | 4,632,094 | | 11,434,235 | | **29,301,529** |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| OHSS | | 140,002 | 2,768,136 | | | 15,484,844 | | **18,392,982** |
| PDCS | | 75,000 | 2,416,104 | 1,145,022 | | 1,254,563 | | **4,890,689** |
| PDTX | | 100,000 | 4,785,144 | 1,021,823 | | 2,929,525 | | **8,836,492** |
| | **813,000** | **11,913,473** | **139,123,774** | **51,127,294** | **25,000** | **253,406,341** | **0** | **456,408,882** |

## Budgetary Requirements Worksheet

(No data provided.)

# National Level Indicators

## National Level Indicators and Targets

REDACTED

# Policy Tracking Table

(No data provided.)

# Technical Areas

## Technical Area Summary

**Technical Area:** Adult Care and Treatment

| Budget Code | Budget Code Planned Amount | On Hold Amount |
|---|---|---|
| HBHC | 41,389,794 | |
| HTXS | 80,615,519 | |
| **Total Technical Area Planned Funding:** | **122,005,313** | **0** |

**Summary:**
COP10 ADULT CARE AND TREATMENT TAN

Context and Background

The PEPFAR Adult Care and Treatment program, in line with the draft National Strategic Framework II (NSF II) and the Partnership Framework, complements the effort and commitments of the government of Nigeria and her partners, especially the Global Fund, the UN system, DFID and other stakeholders. The PEPFAR Adult Care and Treatment program plans for minimal expansion with greater focus on improved program quality, sustainability, cost savings, pooled procurements, and health systems strengthening. Government of Nigeria (GoN) is committed in the NSF II to a significant continuation of counseling and testing and to enroll all positive clients into care as well as ART eligible HIV positive adults into treatment. As the USG's contribution to these overall national goals, PEPFAR Nigeria plans maintenance of current levels of care and treatment with minimal expansion and a greater focus on improved program quality, sustainability, cost savings, pooled procurements and health systems strengthening.

In COP10, the Nigeria USG Adult Care and Treatment program will use the following strategies to achieve the goals enumerated above: 1) continuing decentralization of Care and Treatment to Primary Health Care (PHC) levels using the 'Hub and Spoke' model developed in collaboration with GoN; 2) developing strategies for regionalization of partners for greater efficiency and lower administrative overheads. 3) improving quality of Care and Treatment services using HIV/QUAL and other QI/QA systems, including clinical outcomes evaluation; 4) enhancing networking and referral mechanisms including patient tracking; 5) supporting task shifting policy development & implementation; 6) strengthening linkages between Adult & Pediatric Care, Treatment, PMTCT, OVC programs, nutritional services and PLHIV support groups; 7) expanding the strategic integration of HIV/AIDS Care & Treatment services into the routine and already existing health systems such that it is beneficial to all patients including non HIV infected clients patronizing the health facilities; 8) programming for pre-ART clients towards improving retention in care; 9) enhancing the integration of facility and community based prevention services for PLHIV across HIV services; 10) pooling procurements; and 11) strengthening health systems.

The USG Nigeria Adult Care and Treatment program includes all facility-based and community/home-based care (CHBC) activities for HIV-infected adults and people affected by HIV, extending and optimizing quality of life for HIV-infected individuals from the time of diagnosis throughout the continuum of illness, through provision of clinical, psychological, social, economic, spiritual, and prevention services.

Continuity of care is the goal of care and treatment programs and priority areas include prevention with positives (PwP), nutrition, cotrimoxazole (CTX) prophylaxis, pain management, ARVs, palliative care, early referral and retention in care and treatment, monitoring, reporting, program evaluations, quality assurance, task shifting (training and deployment of additional categories of care providers to provide basic care and treatment), central procurement mechanisms, and strategic alignment of partners' activities.

Clinical care includes nursing care, prevention and treatment of opportunistic infections, assessment and management of pain and other symptoms, nutritional assessment and support, antiretroviral therapy, CHBC, providing access to commodities (such as pharmaceuticals and insecticide treated nets), safe water interventions and related laboratory services. The minimum care package of services provided to each PLHIV includes at least one clinical care service with basic care kit and two supportive services delivered at the facility and CHBC levels in accordance with the National ART and Palliative Care Guidelines. ART eligible clients are placed on a first line regimen (2NRTIs + 1NNRTI, specifically 3TC, AZT, and NVP/EFV with alternative of TDF, 3TC or FTC) as outlined in the National ART Guidelines. The use of d4T will be gradually scaled down in compliance with the National ART Guidelines.

Through CHBC, USG will continue to emphasize ART adherence in the home setting through education and addressing adherence barriers, utilizing volunteers, peers and buddy systems and pill boxes as reminders for effective drug adherence. Terminal care, TB screening, water, hygiene and sanitation education will be given to clients and family members.

Psychological support includes group and individual counseling, culturally-appropriate end-of-life care, bereavement services and effective adherence education and counseling. Spiritual care addresses the major life events that cause people to question their purpose and meaning in life. The interventions are culturally sensitive and include life review and assessment and involve clergy/spiritual leaders. Social care assists individuals and family members in maintaining linkages to and use of various social services, including community-based support groups, stigma reduction activities, training and support of caregivers, transportation support, economic empowerment, food support or legal assistance.

Prevention services including Prevention with Positives (PwP) will continue to be carried out by providers at all service delivery points. PwP services using the standardized 5-step strategy will continue to be rolled out. Interventions include: HIV Counseling and Testing (HCT) services for family members and sex partners; health education promoting hygiene practices; and prevention messages focused on disclosure, partner testing, correct and consistent condom use, mutual fidelity, reduction in alcohol use, and STI management. Existing CHBC teams will include sufficient skill sets to provide the range of facility, community and home care services. GoN, supported by USG, is developing a Community PwP manual and this will be utilized to provide PwP services at community and home settings.

Service provision data are collected by the use of National PMM forms and ART cards. Most partners have in place electronic systems for information collection and analysis. These databases improve efficiency in service provision including tracking early or missed appointments.

Despite a lack of national task shifting policy, facilities are training nurses to triage patients and prioritize access to physician care. Attention is also being paid to ensuring a more manageable physician to patient ratio at facilities with secondary and tertiary facilities graduating stable patients to lower level facilities.

Accomplishments since last COP

The GoN with the support of PEPFAR and other stakeholders are finalizing the NSF II and National Strategic Plan, the Partnership Framework and Implementation Plan and a pilot decentralization plan. The

National HIV treatment guidelines are under review and a revised version will be available for use in COP10. Standards of practice for various aspects of care and treatment are already in use. Harmonized training manuals for treatment are finalized and ready for use, while the Care and Support manuals are at an advanced stage of development and will be ready for use in COP10. Services are now available in all 36 states and the Federal Capital Territory and there is movement of services to local levels with the consequent increase in access to care and treatment services such as CTX prophylaxis, TB screening at care and treatment sites, malaria prevention, safe water, hygiene and sanitation. PEPFAR has strengthened facility, community, and home based care (CHBC) services. The existing CHBC programs and resources are realigned to training providers on client-oriented, family-centered care and support and PwP services with increasing male involvement.

An initial costing study was done using HAPSAT which estimated resource needs under alternative policy scenarios. There was strong government involvement and buy-in, co-authoring with NACA. This study has been used in NACA's application for World Bank MAP2 and in the National Strategic Framework development process. Additionally the USG team is using it in Partnership Framework discussions and COP planning.

Goals and Strategies for the coming year

USG will continue to support the national HIV counseling and testing efforts including provider initiated testing of patients in hospital inpatient wards and other clinical settings, and testing of pregnant women, TB patients and STI patients towards early identification of HIV infected individuals to reduce morbidity and mortality from HIV and related opportunistic infections as well as target prevention efforts to these groups. ART eligible clients will be enrolled into ART programs and others will be enrolled in HIV care wellness programs for periodic follow-up and to identify change in ART eligibility status. Linkage of adult care and treatment programs to OVC programs such that children of enrolled PLHIVs are able to access OVC services in the communities, and strengthening of the support group programs to reach out to more non-ART eligible individuals through restructuring of support group activities will further ensure retention of pre-ART clients in care. The PEPFAR Nigeria program already has in place "pre-ART" registers for monitoring these Non ART Eligible patients. In COP10, USG Nigeria will further expand and strengthen the already existing referral mechanisms and systems through networks and mechanisms for referring clinically stable patients to the Primary Health Care centers attached as spokes to the secondary and tertiary care facilities (Hub & Spoke model for services).

Dietary and nutritional assessment and counseling will be provided for PLHIVs and their families at all care and treatment settings including health facilities, communities and homes. Multi-micronutrient supplementation will be provided for all at risk PLHIV. Therapeutic feeding will be provided for malnourished clients and referral for food assistance and IGA will also be provided.

Challenges to PwP implementation have included poor lay counselor motivation and retention, condom stockouts, data capturing tools and effective referral systems. In COP10, multidisciplinary task teams will be formed at National and sub-national levels and National policy/ guidelines on PwP and harmonized DCT tools will be developed. PwP training is already incorporated into the ART as well as Care and Support training manuals. Training of health care workers and lay counselors to provide PwP services, including setting prevention goals at every contact with clients, will continue. Referral linkages between clinic and community programs will be strengthened.

This program seeks to increase gender equity in programming through counseling and educational messages targeted at vulnerable women and girls. Furthermore, through gender sensitive programming and improved quality services the program will contribute to reduction in stigma and discrimination and address male norms and behaviors by encouraging men to contribute to care and support in the families.

USG and IPs have continued to focus on improvement in ART quality of care through establishment of site-based Clinical Quality Improvement committees. Clinical Associates, mentors and internationally trained "preceptors" are deployed by partners to address deficiencies in clinical practice identified during ongoing quality of care assessment using modified HIVQUAL assessment tools. Improvement in quality has also been achieved in the use of best practices to address challenges in patient management, treatment adherence and patient retention in care. Checklists were developed to identify suspected treatment failure cases and PEPFAR-supported laboratories collaborated and networked in viral load testing.

The Care and Treatment training plans for COP10 are aimed at quality assurance and improvement. These include the training, retraining, and mentoring of Care and Treatment providers using the National Care & Treatment Training Curricula. The USG will coordinate IPs to train master trainers in good clinical care. All Care and Treatment trainings will emphasize pain assessment and management using the National Guideline which includes the WHO stepladder approach. Additional training plans include further expansion of the HIVQUAL program for QA/QI. Further collaboration and integration with the GoN will continue in these areas and others, such as medical records systems, personnel, monitoring and evaluation.

USG will utilize Partnership for Supply Chain Management Systems (SCMS) for care commodities, OIs and ARV drug procurements. USG will work closely with GoN and the Global Fund to harmonize and institute a nationwide supply chain and logistics management system that will not only cater for ART drugs but will increase efficiency and effectiveness of distribution of other commodities and supplies like the OI drugs and Basic Care kits. USG will also continue to partner with the Clinton Foundation and the Global Fund to utilize opportunities to reduce cost. REDACTED. USG will also participate in and support the harmonization process led by GoN in line with one national program at all levels, build capacity of health care providers as well as facilitate Public Private Partnerships to increase access to Care and Treatment services. To further strengthen health systems in Nigeria, clinical facilities and implementing partners are encouraged to arrange a mechanism for sharing part of the cost of the laboratory and other services to enable non-HIV positive clients to access these services formerly available only to the HIV-infected population.

Costing of Care and Treatment Programs

USG will support GoN to further conduct integrated costing and sustainability studies and model Nigeria's HIV program across several technical areas to build upon the previous approach of vertical studies. This will be aimed at identifying resource gaps, reacting to policy changes, helping with target setting, and advocating resource mobilization/rationalization. Substantial innovation in health system improvement and health financing utilizing PF and the NSF2 strategies will be needed to mobilize domestic resources and increase operational efficiency.

**Technical Area:** ARV Drugs

| Budget Code | Budget Code Planned Amount | On Hold Amount |
|---|---|---|
| HTXD | 80,610,573 | |
| **Total Technical Area Planned Funding:** | **80,610,573** | **0** |

**Summary:**
COP10 ARV Drugs TAN
Context and Background

The long term goal of PEPFAR Nigeria supporting a sustainable supply chain management system for ART continues to be the guiding principle in this technical area. USG investments in this area have already led to an uninterrupted supply of ARVs to deserving patients across the country. In Nigeria all the ARVs required for the implementation of the PEPFAR program are procured with USG funds; however, a few health facilities are supported by both PEPFAR and the Global Fund. In such centers, most ARVs are procured with Global Fund resources while PEPFAR provides what is not available through the Global Fund procurement system. The USG procurement system supports the host country procurement system by adhering to the recommendations in the national ART treatment guidelines vis-a-vis product selection. This ensures the uniformity of ARVs available for use at health facilities irrespective of funding source.

The USG through SCMS, one of its implementing partners, supported the national ARV planning and procurement process by providing technical expertise and guidance. This has resulted in effective and efficient monitoring of the supply pipeline and procurement based on actual needs.

The USG team also supported the first national ARV forecasting exercise that was conducted in April 2009. National ARV requirements from 2010 - 2014 were estimated from inputs from the various stakeholders, including GoN, PEPFAR implementing partners, Global Fund, Clinton Foundation and others. The outcome of this exercise is being used by GoN and donors to determine the funding requirements for future ART services.

Accomplishments Since last COP

Significant accomplishments have been recorded during COP09. There has been an increase in the percentage of generic ARVs procured versus innovator (or branded) to 85% generic, up from70% the previous year. At commencement of COP09 some partners planned to enroll most first line patients on tenofovir based regimens in line with the national treatment guidelines. A limiting factor to this plan was the non-availability of the generic formulation during the planning phase of COP09, and its usage was limited due to the cost implications. However, with the recent approval of a generic cheaper tenofovir based regimen by FDA, this plan will be more feasible.

The prompt approval of a supplementary importation waiver by NAFDAC (National Agency for Food, Drug, Administration and Control) for newly approved generic ARVs following an application by the PEPFAR team is a contributing factor to the successes recorded during the COP year. Increased usage of the generic ARVs has resulted to cost savings to USG. During COP09, concerted efforts were made to minimize the use of Stavudine based regimen in line with WHO and national treatment guidelines, and this has been made possible by the decreasing cost of generic tenofovir based regimens.

In COP09, PEPFAR Nigeria, together with the SCMS team, successfully pooled procurement of two first line ARVs for all PEPFAR implementing partners. The pooled procurement strategy enabled PEPFAR Nigeria to save costs through economies of scale and to better account for commodity spending at the country level. Following the success of the pilot, PEPFAR Nigeria will pool procure all first line adult ARVs during COP10. PEPFAR Nigeria will continue to collaborate with Clinton Foundation for pediatric ARVs and second line adult ARVs.

The use of pediatric fixed dosage combinations received a boost from the collaboration between PEPFAR Nigeria and Clinton Foundation. The use of these water-dispersible tablets instead of syrups has improved adherence to therapy, reduced cost of medications, and reduced storage space requirements when compared to syrups.

In COP09 the USG continued harmonization of many logistics activities across PEPFAR IPs. This has resulted in the collation and reporting of logistics data by the partners on a quarterly basis to the USG

logistics TWG and SCMS. Results from these reports are useful in confirming the inventory levels of ARVs in-country and those in the pipeline and well as providing a valid basis for decision making on logistics related activities.

In COP09, the USG supported varying levels of infrastructural upgrades to the Federal Medical Store in Oshodi Lagos, as well as state-owned Central Medical Stores, and over 400 storage facilities in service delivery points. This effort has reduced the challenge of inadequate storage space and storage of medicines at sub-optimal conditions; overall, the warehousing conditions for health commodities at several government facilities were improved as a result of USG support since the last COP.

In COP09, the supply chain capacity of the country was boosted through local and international training activities supported by the USG. The logistics team of GoN and USG partners were provided with technical assistance through SCMS on the various components of the logistics cycle. This has improved the effectiveness and efficiency of supply chain systems for ARVs and other commodities in the health system of the country. Currently, over 50% of USG implementing partners run their ARV forecasts and monitor their supply pipeline using standard forecasting tools and software (Quantimed & Pipeline, respectively). This is an improvement over the use of IP specific excel worksheets used in previous years for this purpose.

Goals and Strategies for the coming year

In the coming year, the USG team will procure and support the use of zidovudine and tenofovir based regimens for first line therapy. Second line regimens will continue to include lopinavir/ritonavir boosted regimens, in compliance to the national and WHO treatment guidelines. While PEPFAR Nigeria will pool the procurement of all first line adult ARV regimens during COP10 through SCMS, it will leverage donations from Clinton Foundation/UNITAID for all adult second-line lopinavir/ritonavir and all pediatric first and second line regimens. It will also leverage PMTCT ARVs and Cotrim from UNICEF/UNITAID. The USG team will also be pooling the procurement of other ARVs that might not be accessible from CHAI as donation.

Product selection: The USG team will continue to adhere to the national treatment guidelines, ensuring that only recommended ARVs are procured and distributed. The USG team will also coordinate with other partners to participate in the review and update of the national treatment guidelines. This will enable the team to keep abreast of any potential changes that will impact on logistics and procurement plans.

Forecasting/Quantification: USG ARV procurements will continue to be guided by forecasted estimates of future needs. COP10 ARV requirements were determined through a PEPFAR-wide forecasting among IPs and coordinated by the USG Logistics TWG and SCMS. The forecast and supply pipeline will be monitored periodically to ensure an uninterrupted supply of ARVs and maintenance of optimum stock levels.

Procurement: In COP10 ARV procurement will be funded with $96M (including cost of ARVs, freight, handling charges and in-country logistics). Some of the ARVs will also be leveraged from Clinton Foundation as donation. Overall the ARV drug budget for COP10 will be supporting about 350,000 patients on ART. The USG team will procure all the first line ARVs and some second line ARVs. Most of the second line ARVs and pediatric formulations will be leveraged from the Clinton Foundation. PMTCT drugs will be leveraged through the country UNICEF/UNITAID donation. In COP10 PEPFAR Nigeria will continue to support costing studies of ART programs.

Freight/Forwarding and Importation: Importation of all the ARVs for the USG team will be coordinated by SCMS. The team of experts at the SCMS local office and headquarters will ensure seamless freight and importation of these ARVs to the country using standard and cost-efficient routes. The US Embassy on

behalf of PEPFAR Nigeria manages port clearance, administrative requirements and duty waiver requests. The commodities will be cleared to the SCMS central warehouse within 48 hours of arrival under normal circumstances with support from the shipping/operations office of the embassy.

In-Country Warehousing and distribution: All ARV procurements in COP10 will be received at the SCMS warehouse in Abuja. Partners will pick up their consignments centrally from this facility in Abuja for their various programs. The SCMS warehouse, located in the MDS warehousing complex, is pharmaceutically compliant and managed by experts according to international standards. The warehouse also has cold chain capacity. Partners will continue to warehouse ARVs in their respective warehouses, most of which are located within government-owned facilities. The host government capacity to store ARVs securely and effectively is boosted through this collaboration with USG partners, and very few partners rely on the use of private sector facilities for warehousing. Distribution of ARVs to service delivery points will continue to be in line with existing systems established by individual IPs, most of whom rely on the use of project delivery vans and third party logistics providers (courier companies and corporate logistics companies).

During COP10 the USG will collaborate with other donors to support the GON's plan to design a national system for warehousing and distribution. Furthermore, the host government has received a GF R8 HSS grant for health system strengthening activities to improve infrastructure of the federal medical stores and other regional facilities. The USG will work closely with GON to ensure that the intervention is effective and beneficial to the national health system.

Logistics Management Information System: In COP09 USG implementing partners began quarterly reporting of logistics data via the Logistics Management Information System (LMIS) to the USG/SCMS. This report includes data on types of regimens used and inventory levels at warehouses and treatment sites. These reports are collated and analyzed for use in decision-making.. Other related activities also include a quarterly LMIS review meeting for all the partners with the USG/SCMS team, during which inventory levels are assessed to ensure availability of optimum inventory levels among all IPs. The risk of ARV expiries will also be evaluated for corrective actions, and the outcome will inform the procurement planning process. These activities provide a holistic overview of the status of commodity logistics across the PEPFAR program in the country, and the system will continue to be improved for better results in COP10.

Capacity building: In COP10, activities aimed at building local supply chain capacity will be sustained through trainings, mentorship and technical assistance. The capacity building program will focus on forecasting, procurement, warehousing, inventory management, pharmaceutical management, distribution, and LMIS. The PEPFAR country team will also support the GoN in collaboration with NAFDAC to monitor and ensure that ARVs used at the various health facilities continue to be safe for patients' use, through a well laid out pharmacovigilance reporting mechanism. Partners will be supported to provide training on pharmacovigilance to health facilities staff.

Donor collaboration: In COP10 PEPFAR Nigeria will further strengthen its relationship with the GoN and other donors, ensuring that available resources are deployed in a coordinated manner without duplication of efforts. PEPFAR Nigeria will leverage second line adult ARVs as well as first and second line pediatric ARVs from CHAI. In COP10 PEPFAR Nigeria will work closely with UNICEF/UNITAID to leverage ARVs and Cotrim formulations for the PMTCT program in Nigeria. A special focus will be given towards ensuring that USG and Global Fund resources in Nigeria are synergized and leveraged to the maximum extent possible.

Waste disposal: In COP10, the PEPFAR team will support the government to develop the policy and guidelines for safe disposal of expired ARVs and other medicines. It will also promote proper handling and management of expiries among USG IPs. Concerted efforts will be made to reduce expiries to the barest minimum.

**Technical Area:** Biomedical Prevention

| Budget Code | Budget Code Planned Amount | On Hold Amount |
|---|---|---|
| HMBL | 7,198,941 | |
| HMIN | 3,215,092 | |
| **Total Technical Area Planned Funding:** | **10,414,033** | **0** |

**Summary:**
TECHNICAL AREA NARRATIVE -BIOMEDICAL TRANSMISSION

Context and Background

Nigeria's efforts at prevention of medical transmission of HIV have undergone tremendous growth since the inception of support from PEPFAR. The Government of Nigeria (GoN) has also paid more attention to and stressed the importance of Blood and Injection Safety.

Blood Safety

The 2003 sero-prevalence sentinel survey found a 5.1% HIV prevalence among women who had ever received a blood transfusion compared to 4.8% prevalence among those who had never had a blood transfusion, yet reliable information regarding suspected transmission of HIV through infected blood is currently unavailable. A baseline survey of blood transfusion practices in the country which was conducted by the GoN in March 2007 confirmed a severely limited infrastructure for blood banking.

The USG continues to support capacity building towards developing safe blood transfusion systems at the national level as it has been noted that blood transfusion services are currently underutilized by the country. In COP09 USG-Nigeria supported initiatives aimed at improving blood collection techniques and utilization at the facility level, to develop linkages between facilities and the national system, and to strengthen the National Blood Transfusion System (NBTS). Although the USG efforts in blood safety have resulted in the establishment of NBTS centers with the capacity for appropriate blood screening, this capacity is not being fully utilized. In the past year only about 2% of the estimated national need for blood units was met safely by NBTS.

Injection Safety

A 2004 GoN injection safety assessment, which was supported by the USG, showed that an average of 4.9 injections was given per person per year. The assessment also showed that safety boxes were not used in three-fifths of the facilities surveyed; two handed recapping was observed in 76% of observed injections; 45% of providers had at least one needle stick injury in the last one year and 94% of these providers were not offered HIV post exposure prophylaxis. These are common findings across all geopolitical zones of Nigeria. The USG concurrently supported an expanded injection safety program to respond to these challenges through the activities of a lead technical partner and 6 other implementing partners. Since the inception of injection safety activities in Nigeria by the USG, over 40,000 healthcare workers have been trained across 791 project sites in 14 states.

Accomplishments since last COP

Blood Safety

In COP09 USG Nigeria emphasized improved donor identification and blood collection practices at the facility level in line with NBTS guidelines. Transition from family replacement and paid donors to voluntary, non-remunerated donors (VNRD) in USG-supported sites was implemented by partners as they worked to harmonize standards of practice within the NBTS guidelines. Pre- and post-donation counseling, with appropriate deferment of high risk donors, was conducted at the facility level. Linkages with NBTS increased donor drives that were coordinated jointly with facilities and surrounding communities. NBTS centers and associated mobile outreach clinics are now increasingly better staffed and with support from USG have been able to leverage additional GoN funds.

In COP09 the lead technical implementing partner (Safe Blood for Africa Foundation, SBFAF) provided technical support to the NBTS and other IPs for capacity building in program development and implementation of blood safety activities at national and site-specific levels. SBFAF developed a national training plan consistent with NBTS policy. Participating staff from USG-supported hospitals, USG IPs, and NBTS were trained on phlebotomy, donor recruitment and counseling, lab screening and blood banking, use of blood and hemovigilance, medical waste management, QA/QC for HIV serologic testing, and transport and other logistics for blood safety. In line with the GoN national training guidelines, several of these trainings were developed as training of trainers (TOT). SBFAF provided the lead support in the development of a standardized training manual and production of IEC materials and job aids. Master trainers stepped down training to staff in their respective health facilities.

Injection Safety

In COP07 a national policy on injection safety and healthcare waste management was developed with USG support. The USG also supported the development and adaptation of the "Do No Harm" training curriculum by the GoN. Infection prevention committees were inaugurated at facility level to provide on-site supportive supervision and ensure post exposure prophylaxis. USG, through MMIS, provided technical support to the GoN and other key stakeholders (Nursing and Midwifery Council, schools of health technology, Medical and Dental Council of Nigeria) in curriculum review and the inclusion of updated safe injection practices into pre-service and refresher trainings to ensure sustainability. Advocacy efforts were intensified for the use of retractable syringes and non re-use of syringes through an identified injection safety champion. Advocacy efforts have also resulted in the Federal Ministry of Environment (FMOE) budgeting for healthcare waste management.

In COP09, there was a strategic delineation of responsibilities among implementing partners. This was done to ensure efficiency and quality of injection safety activities. AIDSTAR Injection Safety was tasked to work at both national and facility levels to provide expertise in the area of training by conducting regular TOT courses and supportive supervision to other IPs, to take the lead on production and distribution of IEC materials and job aids, and to distribute commodities such as safety boxes and retractable needles/syringes.

At the national level, USG Nigeria has supported work with NAFDAC to implement the gradual shift from procuring the standard disposable syringe towards auto disable syringes is critical. At the local level, USG Nigeria has supported community mobilization to promote oral medication over unnecessary injections, working in collaboration with community-based organizations and the mass media. Collaboration with the GoN on collection and tracking of consumption data has also been emphasized.

IPs working at the facility level are required to provide a minimum package of injection safety activities at this level. This minimum injection safety package includes: training of all health workers and waste handlers; utilization of safety boxes in all units of the health facility; promotion of awareness on injection safety and healthcare waste management policy; establishment of infection control committees at tertiary

and secondary facilities; and the provision of color-coded bin liners at waste generation points for segregation of waste. The implementation of these activities in every department in supported facilities has been directed at reaching the goal of "facility saturation," i.e., healthcare injection safety practices and waste management implemented facility-wide. In addition, appropriate healthcare and waste management was regularly emphasized with supportive supervision.

Goals and strategies for the coming year

PEPFAR Nigeria's overarching prevention goal is to provide effective and sustainable evidence-based prevention programs and services that will contribute significantly to the reduction in the overall incidence of HIV in Nigeria. We intend to achieve this through programs and services that promote safer sexual behavior through communication-related interventions; appropriate use of male and female condoms and lubricants; prevention of biomedical transmission of HIV; HIV counseling and testing; prevention of mother-to-child transmission; early diagnosis and effective treatment of sexually transmitted infections; and positive health, dignity and prevention interventions by and for PLHIV.

Blood Safety

The September 2009 TA observed increased commitment by GoN to blood safety initiatives, increased healthcare worker safety, and increased demand for NBTS products, with a highly functional medical transmission TWG. Still major challenges exist with the new hospital linkages program as blood from hospitals is being screened with rapid tests, coupled with poor blood banking practices and insufficient hemovigilance. As a means of overcoming these challenges, the strategies to be employed in COP10 are: to clarify roles and responsibilities in the hospital linkages program, to strengthen QA/QC, to strengthen mentoring/supportive supervision, to increase donations of VNRD, and to strengthen supply chain management.

In COP10, USG-supported sites will continue to be sustained to develop blood banking capacity and linkages to nearby NBTS zonal centers. The on-going NBTS hospital linkage is a significant change within the Nigerian system. The NBTS will develop a logistics system to support these facilities for their transfusion needs. NBTS will work to identify other non-PEPFAR facilities in the catchment areas of the zonal centers to develop similar partnerships. This activity will utilize the already existing counseling and lab staff, and will leverage the relationships between the facilities and community where they work to scale up voluntary blood donation. Blood obtained from blood drives and those from family donors at the facilities shall be collected according to NBTS guidelines and subjected to ELISA screening. The NBTS will develop a courier system to regularly collect unscreened blood from participating sites and to deliver screened blood to sites based on supply and demand. This linkage will be supported by hotlines at the NBTS centers where the participating facilities will make requests for screened blood as the need arises.

To facilitate scale-up and increased coverage, the USG will support the NBTS to accept and screen blood collected at participating hospitals from family replacement donor and to convert these donors to VNRD. Feedback on the rates of the four TTIs found through ELISA screening will be regularly provided by NBTS to enhance migration to VNRD.

USG will continue to focus on partnerships that include groups such as Exxon Mobil and telecommunication companies to leverage resources for blood safety. Proper waste management will be promoted through collaboration with injection safety activities, the use of biohazard bags and sharp containers, and the repair/utilization of incinerators at PEPFAR-supported sites. The SCMS procurement role will be developed to support the NBTS in the purchase of supplies needed in the realization of a functional national system. To augment this system, NBTS will conduct limited procurements to complement supplies that come through SCMS and serve as a stop gap against stock outs.

Injection Safety

Injection safety activities ongoing from COP09 will continue to focus on four major technical areas: human and institutional capacity building; behavioral change communication for healthcare personnel to promote safe injection practices, and for communities to promote oral medication where possible; supply chain management for availability of equipment and supplies; and appropriate healthcare waste management. In addition, COP10 activities will be expanded to include: improved reporting of accidental occupational injuries, promotion of PEP protocol, and improving phlebotomy practices. The major goal this year will be to improve the quality of service delivery in a most cost effective manner and in line with the National Prevention Plan. Technical assistance will be provided to other USG partner-supported sites through TOT and cascaded down to health workers, storekeepers and waste handlers. Refresher trainings and supportive supervision will ensure quality services are maintained. In addition, implementation of the Healthcare Waste Management (HCWM) policy, plan and guidelines will be ensured at all levels of government.

USG-supported advocacy kits will continue to be used by partners to advocate for budgeting/funding support for injection safety activities and health workers safety targeting legislators, policy makers, community leaders and the media. This effort will be continued in COP10 with a bid on institutionalizing injection safety practices. Safe injection practices and oral medication to reduce unnecessary demand for injections will be promoted at the community level through Community Based Organization (CBOs) in collaboration with the mass media and other relevant agencies.

The USG team plans to continue collaborating with the GoN and will ensure commodity security by planning for and supporting procurement of IS, BS and phlebotomy supplies, including safety boxes at the sites. The team we will also continue to sustain the Logistics Management Information System (LMIS) for USG-supported sites and GoN partners to ensure that there are no stock-outs. Other key partners will be steered towards identifying and implementing practical, affordable and effective means of handling and disposing of healthcare waste. Support will be given for the building/procurement of incinerators for appropriate disposal options in accordance with WHO standards. Support will also be provided for the repairs/maintenance of old incinerators and technical assistance provided on alternative options.

The USG Nigeria team will continue to work with the Federal Ministry of Health (FMOH), and other major stakeholders (such as the Nursing and Midwifery Council of Nigeria and Medical and Dental Council of Nigeria) to incorporate IS and HCWM in pre-service curricula. We will continue to work with healthcare training institutions (such as Medical, Dental, Pharmacy, Nursing and Midwifery schools, and schools of health technology) that are yet to include and update safe injections practices in their various curricula.

The National Policy on injection safety and healthcare waste management will continue to be disseminated widely in COP10. The USG will support other IPs to institutionalize supportive supervision at individual sites. State MOH and other USG IPs will participate at state level meetings to give feedback for service delivery quality improvement.

A desk review to document the prevalence of male circumcision was planned for COP09. This activity is still ongoing in COP10.

**Technical Area:** Counseling and Testing

| Budget Code | Budget Code Planned Amount | On Hold Amount |
|---|---|---|
| HVCT | 1,481,450 | |
| **Total Technical Area Planned** | **1,481,450** | **0** |

| | | |
|---|---|---|
| **Funding:** | | |

**Summary:**

Nigeria has a generalized/mixed HIV/AIDS epidemic with adult HIV prevalence (age 15-49) of 3.1% (UNAIDS). Commercial sex workers (CSW), long distance truck drivers, and men who have sex with men (MSM) constitute the country's main Most at Risk Populations (MARPs), and have a localized HIV/AIDS prevalence as high as 30% in some states (IBBSS 2007). To address this within the context of HIV counseling and testing programs, the Government of Nigeria (GoN), in collaboration with Development Partners including PEPFAR Nigeria, provides HIV/AIDS testing and counseling (TC) through various levels of service to scale out and scale up HIV counseling and testing services. This aims to ensure increased access at all levels of care, especially at community and rural area levels where access to health facilities is limited.

The country currently implements provider initiated testing and counseling (PITC) within health facilities, using the opt-out and multiple points of service model, as a strategy to enable all hospital attendees to have access to TC services, and are linked to treatment, care, support and prevention services. Within the community, stand alone HCT sites provide traditional voluntary counseling and testing (VCT) services. These "stand alone" sites are also utilized by USG implementing partners to provide targeted testing for MARPs through strategic location of the centers and engaging the MARPs for HCT awareness and service demand creation. Some of these stand alone sites are designated "Youth Friendly HCT Sites" and specifically target youth in the communities. In addition, USG partners implement Mobile TC and Community outreach programs to increase access at the community level and rural areas. Home based TC is also utilized to reach index cases and their family members with care and support services. Through the support of the USG, the country initiated couples counseling and testing in 2007 and many USG partners have incorporated couples counseling into their TC programs.

The GoN, in collaboration with development partners, has developed a new National Strategic Framework (NSF 2) for the next 5 years (2010-2015). This strategy depicts a national HCT goal of achieving "Universal Access" by 2015. PEPFAR Nigeria has further developed a Partnership Framework (PF) in collaboration with the GoN, which aligns with the focus and strategies of the NSF. To this effect, as well as towards meeting the PEPFAR-2 strategic objectives, the USG HCT program plans to support the GoN through much needed capacity building and system strengthening activities.

Accomplishments

In COP09 the USG partners enabled 1.5million Nigerians to know their HIV status in HCT and TB settings (APR09). This accounts for 51 % of the overall National HCT achievement of 3,011,538 (GoN estimate) for the country in FY09. The USG currently supports 1,137 (APR09) HCT sites spread across the 36 states of the Federation and Abuja. The number of USG implementing partners providing HCT services has increased to 22 within this reporting period; this has resulted in increased access to populations that hitherto were unreached and/or underserved.

In COP09, a USG Partner, Population Council, initiated HCT services targeted at the MSM population. This was in response to the last IBBSS survey (2007) which indicates HIV/AIDS prevalence of more than 20% in this group. Plans are underway to increase services to this population and to provide an enabling environment for them to receive these essential services without discrimination through appropriate government policies. Another new USG partner, AED/Smart-Work, has a program that will focus on provision of HCT services in the workplace, through collaboration with organized trade unions and business groups in the organized private sector.

The HCT/LAB TWGs collaboration has enabled the training of site lab supervisors and lay site counselors on HIV testing quality control and quality assurance (QA/QC) in order to achieve reliable, reproducible and acceptable HCT results. This has enabled all PEPFAR-supported HCT sites to implement the serial testing strategy. This continues to make the testing process simpler, especially for lay counselors and testers, who as a result of progress being made in the area of task shifting, are involved in the provision of HIV testing, and makes "same hour" counseling and testing a norm. There is however no formal government policy on task shifting as yet, and a few sites still have challenges using lay counselors as

testers.
Service Referral
To ensure that HCT clients do not miss the opportunity of getting linked to other HIV/AIDS prevention, care, support and treatment services as necessary, strengthening referral linkages within and across USG and non-USG supported programs was one of the priorities in COP09. All USG partners currently have referral networks and client referrals are monitored using a nationally adopted referral tracking sheet. However, referrals in rural areas remain a challenge, due to the limited availability of HIV/AIDS services in those areas.
The national program has fully integrated TB and STI screening using the WHO standard questionnaire into the HCT program. HCT clients identified as TB and/or STI suspects are referred to TB or STI clinics as appropriate. The Prevention with Positives (PwP) program has also been integrated into the HCT services. The PwP services are provided directly or through referral linkages by USG partners.
The USG HCT program continues to collaborate closely with and leverage resources from the British Department for International Development (DFID) which provides all the condoms used in the program through a USG partner, Society for Family Health (SFH). Similarly, leveraging of funds and collaboration exists between the USG HCT program and the Global Fund program. These mechanisms have enabled the expansion of HCT services to all the 36 states of the nation. In addition, strengthened collaboration between the PEPFAR program and GoN enabled USG partners to receive test kits procured by the GoN, making it possible for USG IPs to accomplish beyond their set targets. As a result of the close GoN/PEPFAR collaboration, in December 2008, as part of the World AIDS Day (WAD) celebration, USG IPs provided community outreach and mobile HCT services in 22 states of the Federation and the FCT using test kits procured by the GoN. This WAD outreaches enabled 27, 964 individuals to know their HIV status within a week.
To create awareness and increase demand for HCT services, the country's national program continues to rely significantly on electronic and print media. In addition to this, HCT sites are branded with the national "heart-to-heart" logo to mark sites where quality HCT services are provided. Hand bills and billboards are also utilized extensively by USG IPs for HCT demand and awareness creation. A recent survey of HIV/AIDS awareness in the community indicated a 90% level of awareness in the population surveyed but only 30% of these new their HIV status.
The USG continues to partner with the GoN to streamline and standardize all HCT data collection and M&E tools. These tools are updated from time to time to reflect changes in program focus. The national HCT tools are currently being reviewed to align it with the UNGAS indicators.
Goals and Strategies for the coming year:
PEPFAR Nigeria's overarching prevention goal is to provide effective and sustainable evidence-based prevention programs and services that will contribute significantly to the reduction in the overall incidence of HIV in Nigeria. This will be achieved through programs and services that promote safer sexual behavior including communication-related prevention interventions; promoting appropriate use of male and female condoms and lubricants; promoting prevention of biomedical transmission of HIV; HIV counseling and testing; prevention of mother-to-child transmission (PMTCT); early diagnosis and effective treatment of sexually transmitted infections; and positive health, dignity and prevention interventions by and for PLHIV.
The guiding principle in the current strategies for the next five years is to enable the GoN to achieve "universal access to quality HCT services", and to ensure that services are sustained beyond the PEPFAR funding period. It plans to focus on providing capacity building support to the GoN and introducing program sustainability strategies. The key strategies will include: integration of programs within the national health system and leveraging funds and wraparound activities, while the responsibilities of direct service delivery will be left to the GoN. To this end, the USG HCT program in COP2010 will support activities with a focus on the following:
Phase-over direct service implementation to GoN: the USG IPs will commence the phase-over of direct service implementation to GoN, whilst maintaining technical support and capacity building initiatives. This phase-over will commence with facility integrated HCT sites and stand alone sites.
Implement Targeted HCT activities: USG IPs will focus direct HCT services to the implementation of targeted HCT, especially for MARPs, prison inmates, alcohol/drug rehabilitation centers, pediatrics HCT

and home-based HCT for index cases of care and support program, using appropriate strategies, including community outreaches and mobile HCT. The PEPFAR/Nigeria HCT program will encourage linkages to appropriate prevention, treatment, care and support programs.
Technical Assistance for targeting of MARPs: USG Nigeria, through linkages to OGAC TC TWG, will provide TA on the implementation of targeted testing programs. Success in this will contribute significantly to the overarching goal of reducing HIV incidence in Nigeria by targeting the major drivers of the HIV epidemic in the country.
Engage with the GoN for increased HCT program funding and leveraging of resources from other donors: As the sustainability of any program depends on sustainable program funding, the USG HCT program will strengthen its engagement with the government to advocate for increased funding for HCT programs at all levels, especially at the state and local government levels. The HCT TWG will also work closely with the Global Fund and other donors for continued leveraging of funds. This shift to sustainability of the National HCT program through increasing investments by the GoN, initiated in COP09, has seen some success over the past year with regular procurements of HIV test kits by the GoN.
Improved Quality of HCT Training: USG IPs have initiated and are currently implementing joint HCT training to ensure that the quality of trainings currently provided by USG IPs is maintained and improved through cost sharing. This strategy will be further encouraged and sustained in COP10

**Technical Area:** Health Systems Strengthening

| Budget Code | Budget Code Planned Amount | On Hold Amount |
|---|---|---|
| OHSS | 18,392,982 | |
| **Total Technical Area Planned Funding:** | **18,392,982** | **0** |

**Summary:**
HSS Technical Area Narrative COP10

Background and HSS assessments:

According to the HSS state of the program area (SOPA), effective life-saving health interventions to prevent HIV transmission, care and treatment have been available for at least a decade. Yet, many in desperate need in developing countries lack access to essential services. The gap between what is expected and what those in need actually receive stems largely from challenges that developing countries face in carrying out the six core health system functions identified by the World Health Organization, namely: health service delivery; human resources for health (HRH); medical products; vaccines and technologies; information; leadership and governance; and financing. The major challenge faced across the Health System Strengthening (HSS) program area is how to effectively bridge the gap between knowledge and action, and how to improve access to interventions in those PEPFAR-supported countries where these gaps constitute threats to the impact of health interventions.

In Nigeria, baseline assessment studies by HS20/20 revealed that relative to disease burden and population size, health financing levels are low (per capita and share of government (GoN) budgets) and systematic underfunding of capital budgets exist at both federal and state levels. Despite a significant donor presence, health financing has remained comparatively low, with a per capita expenditure of less than US $4. In terms of service delivery coverage, most key preventive and curative services are low: e.g. fewer than 25% of pregnant women receive PMTCT counseling, and only 6% of women and 14% of men (age 15-49) have had HIV testing and received results. The rural northern areas still lag in VCT and low-income individuals are less likely to receive HIV-related services.

Hospital availability stands at an average of 9.2 per 10,000 people. Notably, this is higher than the Sub-Saharan average of 5.6 per 10,000 people. However, in certain regions this is substantially lower; the North-West zone has a figure of 4.3 beds per 10,000 people. Governance across the health sector is also weak, and yet there are only a few community organizations that are informed enough to engage health sector policymakers.

Most states have limited Health Information System (HIS) budgets and there is a discrepancy with regard to human capacity across states. Most states do not have an adequate number of trained HIS cadres, and competency levels vary widely across the states. In the area of pharmaceutical management, HS20/20 findings reveal that GoN has made progress in developing national pharmaceutical policies and regulations, but not much has evolved in the implementation and enforcement of these policies and regulations.

Current significant Health Systems strengthening efforts:
HSS efforts within the country are increasing significantly in the commodity logistics area. These efforts are largely funded by the USG in collaboration with other stakeholders including Global Fund and DFID. The activities include upgrading of warehouse facilities within existing government structures - which could also be used to store other health program commodities including TB, Malaria and MCH supplies. The USG, through SCMS and other partners, continues to support capacity building programs focusing on commodity logistics for health program managers and health facility staff through local and international trainings, on-site mentorship programs and technical assistance in different areas of logistics.

The USG is also supporting the GoN to monitor its pipeline for the various HIV/AIDS commodities, to ensure that an optimum quantity of commodities are available for program implementation at all times, and building the capacity of the various GoN staff in this area to ensure sustainability. The USG is also fostering a donor coordination effort that includes leveraging commodities from other donors like CHAI and GoN; this has resulted in the favorable use of scarce resources for program implementation.

In the area of Human Resources for Health (HRH), activities are guided by the available national HRH Policy and Strategic Plan. In-service trainings have been harmonized across the various HIV/AIDS program areas by building a base of master trainers and using standardized training materials. In working towards the realization of the PEPFAR global target of 140,000 new health care workers, consultations are ongoing and aim to identify ways in which to collaborate towards increasing the country's pre-service target via the finalization of the National Strategic Framework and the Partnership Framework. Consultations have also been ongoing between the USG and GoN in the development of a Human Resource Informatics System (HRIS) with support for professional and regulatory bodies aimed at creating a continuum of education; this has been recognized as key to improving the quality of service delivery.

HSS accomplishments in the first five years of PEPFAR:

In the first five years of PEPFAR the Nigeria team has made significant progress in the HSS area, even though HSS activities were not funded directly in the previous COPs, but were considered as cross cutting interventions and accommodated under various program areas. Since the inception of PEPFAR, major achievements have been realized, particularly with regard to policy and human and infrastructural capacity building and include: improvement to government storage capacity and logistics management, a draft policy on waste management, and a growing interest in issues relating to human resources for health.

The USG supported the GoN to conduct the first national ARVs forecast in April 2009; the outcome is useful for planning and financing of the HIV/AIDs program With direct support from the USG, varying

levels of infrastructural upgrade have been carried out in the federal medical stores in Oshodi Lagos, about 10 state-owned central medical stores, and over 400 storage facilities at service delivery points (SDPs). This has reduced the challenge of inadequate storage space as experienced during the initiation phase of the PEPFAR program, during which most of these storage facilities, although in existence, were in a dilapidated state and insecure for storage of medical commodities. This intervention has reduced the lead time for re-supply from the central storage points to the SDPs.

The USG has also supported the GoN to train health facility staff on the use of the LMIS tools and SOPs; these tools are used by the health facilities to send periodic reports on logistics data to be used for monitoring of the logistics system and decision making. To ensure the quality of medical products like RTKs and ARVs used in the country, the USG is supporting the GoN to conduct QA tests on all RTK procurements, and only RTKs that passed the QA test are distributed. The USG is also supporting the NAFDAC (Nigerian Drug regulatory authority) to strengthen its pharmacovigilance activities. This will ensure that medicines used at the SDPs are safe for patient use. These HSS interventions, from the logistics perspective, have resulted in an uninterrupted supply of commodities, and have also brought attention to strategies that need to be in place to ensure sustainability of these efforts and improved health systems.

Barriers to accomplishing 3-12-12:
Uneven distribution of skilled health workers, characterized by urban concentration and rural deficits, in addition to problems of skill mix, continue to present challenges in the provision of quality services. Evidence shows that the gaps in coverage are due to poor planning for service distribution, in addition to political partiality. Furthermore, poor planning for appropriate utilization of health professionals encourages persistent brain drain thus exacerbating deficits. Institutional deficiencies typified by poor equipment, lack of infrastructure and lack of proper logistics systems to support established institutions to provide quality service, with the patient as the hub of service, also contributed to challenges of service delivery.

Chosen areas of focused and reasons:
The chosen areas of focus are based on the recommendations from gaps identified in past assessments. Emphasis will be on established needs for HRH (based on burden of disease, population size, and incentives). Strengthening of public participation in health policy development and implementation will be an additional priority area. Design and implementation of resource tracking efforts, including national and state health accounts, will be another area of focus and will seek to enhance public financial accountability. Other focus areas will be increased funding and personnel to the HIS (State and Federal levels) to produce timely health information and engagement of stakeholders to enforce policies and guidelines on pharmaceutical management.

All the planned HSS interventions will be strictly monitored during implementation, and evaluation of the outcomes will be done periodically to ascertain the impacts of the interventions. Gaps will be identified periodically and corresponding activities will be re-evaluated/identified.

**Technical Area:** Laboratory Infrastructure

| Budget Code | Budget Code Planned Amount | On Hold Amount |
|---|---|---|
| HLAB | 40,191,356 | |
| **Total Technical Area Planned Funding:** | **40,191,356** | **0** |

**Summary:**

CONTEXT AND BACKGROUND:

The PEPFAR-Nigeria laboratory program continues to focus on building capacity and promoting quality laboratory service delivery to support increased access to HIV diagnosis and monitoring of care and treatment, including early infant diagnosis (EID). The lab package for diagnosis includes HIV serology (rapid tests and EIA), and for care and treatment monitoring the test range includes: CD4 count, viral load, hematology, clinical chemistry, and diagnosis of opportunistic microbial infections, of which enhanced TB diagnostics is of particular interest.
PEPFAR supported the Phase 1 laboratory-based evaluation of non-cold chain rapid test kits (RTKs) that recommended a serial algorithm strategy which was adopted by the Federal Ministry of Health (FMOH) for all HIV testing programs in Nigeria. For monitoring and treatment purposes, the national guidelines require CD4 and recommend viral load testing. Early infant diagnosis (EID) continues to be utilized to identify infected infants.
In FY09, the laboratory program was expanded by 7% from 8 implementing partners (IPs), and an additional 8 new IPs were supported to extend the national coverage - increasing the total PEPFAR supported labs to 317 compared to 273 in FY08. To date, USG-supported IPs are operating a tiered service comprising of tertiary facilities within Federal government referral hospitals offering comprehensive lab services, secondary state run facilities offering a similar package of services but limited by molecular diagnosis (PCR), and primary sites run within local government structures offering only basic lab support.

The PEPFAR laboratory program also provided direct technical and logistical support to the FMOH through a collaborative partnership with the WHO and Global Fund in support of national surveillance programs. The Medical Laboratory Policy laid emphasis on quality for all laboratory structures, including PEPFAR-supported sites. The PEPFAR Laboratory Technical Working Group (LTWG), to which the FMOH's HIV/AIDS Division (HAD) is a lead member, collaborated with the other stakeholders and convened a brain storming session during the quarterly PEPFAR laboratory IP meeting. This session served to explore modalities that could translate the policy and develop the National Laboratory Strategic Plan under the leadership of the Medical Laboratory Science Council of Nigeria (MLSCN) and Central Public Health Laboratory (CPHL).

ACCOMPLISHMENTS SINCE LAST COP:
The main focus in FY09 was to improve quality of provided services. The USG LTWG instituted regular bimonthly meetings on focused themes that addressed quality system management. A laboratory audit/monitoring tool was developed from adaptation of the FY08 site visit tool, the WHO accreditation guide and the national accreditation tool. The adopted tool was piloted in 25% of PEPFAR-supported sites across all levels of care, and the analysis used to tailor the tool and improve IP non-compliant operations with corrective support.
The PEPFAR Quality Assurance Team that was initiated in FY08 to validate RTKs procured for use in PEPFAR programs was expanded in FY09 to include the HAD and the National laboratory regulatory body, MLSCN. The protocol was reviewed and a certification process was developed as a reporting format to which the FMOH are signatory. This was achieved through capacity building of the FMOH team, working in close collaboration with the USG, and taking leadership as the main procurement unit of the country.
To promote quality service, PEPFAR-supported labs subscribed to various commercial EQA schemes with cost and access challenges. In an effort to address this and support a sustainable EQA program, an IP activity was refocused in FY09 to support a PEPFAR-wide EQA program. This was achieved in collaboration with the FMOH through the MLSCN who provided personnel to support the operations of the center.
To effectively articulate quality system delivery across IPs the LTWG monthly meetings were rescheduled to a full day quarterly meeting in FY09. Each IP was represented by their lab director and QA officer. These members presented the activity status, highlighting progress and challenges. This forum also gave

the IPs an opportunity to provide an update on implementation processes, best practices, and to arrive at a consensus on equipment platform performances and maintenance support services. An important achievement was the adoption of the site audit tool which will serve to guide the IP QA officer on ensuring the quality of structures and systems in place towards national and international accreditation. Twenty labs are working towards the WHO Pilot Accreditation Scheme.
In FY09 support to EID continued to be expanded under the phased activation approach to ensure quality results. Twenty PCR facilities were supported to implement both EID and viral load testing when indicated. The USG's lead laboratorian for EID HIV diagnosis provided technical guidance for the national EID program and to support the two Quality Assurance Laboratories (one in the north and one in the south), which were set up to assess the quality of results produced by the PCR testing laboratories. A pilot assessment of PCR laboratories to support the national EID program has been conducted and gaps are being corrected in readiness for nationwide scale-up. A vertical audit tool has been developed to monitor performance and to improve the service of PCR labs.
USG continued its support to the FMOH and national surveillance activities. The CDC lab and SI teams in collaboration with FMOH and WHO supported the National ANC HIV sero-prevalence sentinel survey in FY08/09. The report was collated in FY09 and is now awaiting dissemination. The USG lab and SI teams participated in the development of the IBBS protocol that was forwarded for the Nigerian national IRB to be followed by CDC IRB.
The HIV Drug Resistance Monitoring (HIV DRM) team completed a pilot study in drug naïve patients and an analysis of baseline samples for drug resistance mutations; results of the baseline analysis were accepted as poster presentation at the XVIII International HIV Drug resistance Workshop in Florida. An abstract on the challenges of implementing the HIVDRM pilot study was accepted as an oral presentation at the IAPAC 2009 Conference in New Orleans.
The USG PEPFAR program has been instrumental in supporting the National HIV testing algorithm. In FY09, PEPFAR supported the development of the protocol for the RTK Phase 2 field evaluation and committed technical assistance in sample collection accessories, training, site monitoring and result collation, and report writing. The protocol has been forward for IRB approval.

The PEPFAR program has contributed to capacity building within the Nigerian laboratory workforce. To address the acute shortage of laboratory skilled personnel, support was provided towards training 1000 staff from non-PEPFAR supported sites, in addition to the over 2000 staff trained within the program supported sites. Staff from the MLSCN was included in the QA teams and were provided with basic training as well as specific (international level) training on Biosafety and System Strengthening Accreditation. ASCP and CLSI, technical assistance lab IPs supported pre-service training improving in the pool of skilled personnel. Training opportunities for the Central Public Health Lab also increased, providing them with opportunity to play a key role in QSM forums with IPs. In addition, the lab team, in collaboration with the Nigeria Field Epidemiology and Laboratory Training Program and WHO, conducted 2 short courses for epidemiologists and laboratory scientists. The USG lab team also supported the HIV testing and counseling program to improve QA systems for non-laboratorian testers and to work on the validation and certification process for proficiency.
There was increased HIV and TB testing services in all supported sites during this past reporting period. Support for enhanced TB diagnosis with fluorescence or LED microscopy, augmented with smear microscopy training, improved TB diagnosis. The MDR-TB program was intensified and strong collaborative efforts with the National TB program resulted in the implementation of the first National MDR-TB survey. Two BSL3 labs designed to support TB culture were installed and one of them has already been commissioned. The USG through ASM, a technical assistance IP, is providing the labs with ongoing technical support, moving toward TB facility accreditation.

GOALS AND STRATEGIES FOR THE COMING YEAR:

The main focus of COP10 is to improve on Quality System Management (QSM) of laboratory delivery service in both PEPFAR-supported sites and also work with the FMOH agencies to include non-PERFAR

supported sites. In COP10 support will be focused not on expansion but rather on building the capacity of existing labs to output accurate, reliable and cost effective services, working toward a sustainable program that will be locally translated and maintained. Both internal quality assessments (IQA) and external quality assessments (EQA) are prerequisite for quality assurance (QA) schemes to be effected in a laboratory program. In combination, both assessments can be used to monitor precision and accuracy of the lab performance and contribute to user satisfaction, and ultimately accreditation of the establishment. All PEPFAR IPs will be expected to contribute to the PEPFAR-Nigeria EQA scheme. Technical assistance in QA processes will be provided through APHL.
IPs will be encouraged to expand training initiatives in order to produce more reliable and efficient staff that are appropriately qualified and have the necessary experience to accurately and safely conduct all the functions and duties required for operations. They will comply with standards set by regulatory authorities and be committed to staff recruitment, training, development and retention at all levels in order to provide comprehensive and effective services. To keep up with progress in scientific methods, COP10 will continue to support ongoing staff capacity development with current information on new and improved technologies. IPs will be expected to organize well-coordinated training courses. Training initiatives will also collaborate with the N-FELTP long course program conducted by the FMOH and USG.

Training of bioengineers is the key to maintaining equipment and ensuring a continuous work flow. Therefore, support has been provided for training of lab staff in basic equipment maintenance and repairs (such as fuse changing, bulb changing and tube changes). These basic training packages will be provided by equipment suppliers. The bioengineers shall provide back-up training for minor repairs outside the warranty period.
USG will review and coordinate standard operating procedures (SOP) to standardize the functions of labs. SOPs for monitoring and documenting laboratory instruments and performance will be reviewed and standardized, such as electrical checks, instrument performance history, calibration procedures, and control measures. Recommended schedules of maintenance will be instituted as an integral part of the manufacturer's instructions and control procedures shall be a part of the assay protocols. Responsibility for monitoring equipment performance and carrying out cleaning and maintenance shall be clearly defined in the SOP associated with maintaining the equipment.
The highly technical BSL3 labs will be supported to perform full operations with the vision of accreditation through mentorship from technical assistance IPs such as ASM. Additional labs will be upgraded for PCR activities after undergoing the newly adapted Site Activation Criteria generated by the National EID lab team. Continued improvement will be monitored with the adapted vertical audit tool.

The lab team will continue to participate in the HIV DRM protocol, focusing specifically on building in-country capacity to operationalize four DNA sequencers. Mentorship will ensure that facilities repeat sample testing during the scale up phase to validate their activities. The lab program will also collaborate with the FMOH on plans to conduct an HIV incidence survey from residual samples during the 2010 ANC surveillance.

In COP10 laboratory management systems and infrastructure will be enhanced. For data management, an adaptable Basic Laboratory Information System (BLIS) will be developed using a phased approach that will standardize the variables captured in both paper based and electronic systems. For stock management, IPs will be provided with technical support to standardize management of stock levels to avoid service interruption. Forecasts will be monitored by the LTWG. IPs will be expected to support a waste disposal process that will institute a system that liaises with a disposal team for timely and efficient disposal schedules.

To allow for safe delivery of all services and proper operations the program plans to ensure that laboratories will have adequate spatial facilities and infrastructure. This shall include well-designed rooms with enough space to house the equipment and perform laboratory work. It shall also allow easy access for operations, cleaning and maintenance. Defined rooms shall be available to support functions that

require separating infectious from non-infectious activities.
Supported labs shall develop a safety policy and have a designated safety officer to oversee the activity. The role of the officer will be to ensure that the lab meets all the requirements relating to health and safety (staff welfare, waste management) and work towards maintaining and extending accreditation/certification in keeping with evolving customer requirements.

Management review meetings are an integral component of the Quality Management System (QMS) of a laboratory system. This provides an avenue for the management team to view the overall functional capacity of the unit from the quality lens. It sets the stage for management to review control measures and set up precautions that depict the quality of the products that ultimately gain user satisfaction. This year management will assess and evaluate cost effectiveness of the various units and their operations. Specific reference shall be made to quality assurance with a focus on maintaining and sustaining quality, and gaining accreditation from the appropriate bodies. PEPFAR laboratory support will also be assessed through laboratory audits. With the use of the adopted laboratory audit tool, the LTWG has scheduled lab audits to be carried out quarterly to further improve lab services in Nigeria. Customer satisfaction is also a key component of any service delivered. In COP10 surveys will be carried out to assess the intermediary user's/recipient satisfactions of the service received, to find out if they are getting the prescribed quality service.

**Technical Area:** Management and Operations

| Budget Code | Budget Code Planned Amount | On Hold Amount |
|---|---|---|
| HVMS | 36,192,464 | |
| **Total Technical Area Planned Funding:** | **36,192,464** | **0** |

**Summary:**
(No data provided.)

**Technical Area:** OVC

| Budget Code | Budget Code Planned Amount | On Hold Amount |
|---|---|---|
| HKID | 44,079,001 | |
| **Total Technical Area Planned Funding:** | **44,079,001** | **0** |

**Summary:**
OVC TAN

It is estimated that Nigeria has 17.5 million orphans and vulnerable children (OVC), including 7.3 million orphans due to all causes and 2.23 million orphans as a result of death of their caregiver due to HIV/AIDS (NG-SAA, 2008). Data from the 2008 UNAIDS report estimates that the number of children (0-14) living with HIV/AIDS in Nigeria is 220,000. USG-supported secondary data analysis is planned for Nigeria's 2008 OVC Situational Analysis which will also include the integration of the recently released data from the 2008 Demographic Health Survey (DHS). Vulnerability as a result of poverty and other causes including low prioritization of the rights of children continues to impact on the magnitude of the situation in country.

The Federal Ministry of Women's Affairs and Social Development (FMWA&SD) with technical support from Management Sciences for Health (MSH) continues to improve its capacity for enhanced coordination of activities and initiatives supported by other donors including The United Nations Children's Fund (UNICEF), the Global Fund, the United Kingdom Department for International Development (DFID), The World Bank, The Clinton Foundation and public private partnerships such as MTN. With the embedding of a long term advisor on M&E at the OVC Division of the FMWA&SD, GoN's M&E capacity and overall managerial structure has been reinforced to better plan for and support the National OVC program. The Federal OVC Division senior staff has consistently shown that it is committed, capable, trustworthy, responsive, and ready to lead efforts to improve the quality of programming, coordination and monitoring. The current functional capacities of the Federal OVC Division and State OVC Units continue to be hampered by inadequate funding and resources. The GoN has developed several strong foundation documents, including the Situational Analysis, which have informed strategic decisions of the GoN, USG and other donors regarding geographic locations for scale up and capacity building.

With the assistance of the USG and our implementing partners, the FMWA&SD is currently developing a Harmonized National OVC Work Plan for all donors and partners to help ensure that there is no duplication of efforts or services within Nigeria. It is anticipated that the OVC operational plan currently under development will continue to represent a strong coordination of donors, provide for opportunities of co-funding for activities among donors and the GoN, and will draw on the specialized strengths and abilities of each organization to provide for the needs of the country's 17.5 million OVC.

Nigeria's OVC National Plan of Action (OVC NPA) for 2006-2010 will undergo review and revision during the upcoming COP year in an effort to ensure that the OVC NPA reflects Nigeria's new strategies and initiatives in addressing the needs of OVC and their families. This implementation of the OVC NPA has been delayed by limited GoN funding allocated to the OVC NPA as well as changes in Ministry leadership, limited GoN driven advocacy for OVC issues and the low technical capacity of FMWA&SD staff. The USG and our IPs will continue to be major contributors of content in the development and revision of the OVC NPA in an effort to harmonize USG PEPFAR OVC activities and strategies with the National Plan. The Nigerian Standards of Practice for OVC will also be reviewed and updated in an effort to build on the Quality Improvement (QI) process initiated during COP09. A Regional Quality Improvement Workshop encouraged partners to establish an initial baseline of child wellbeing using the CSI so that they may assess the impact of QI on service delivery and child outcomes. As partnerships between the GoN, UNICEF, and other donors continue to be productive and strengthened, PEPFAR support has been instrumental in the Nigerian government effort to clarify standards for OVC care and guidelines for the establishment of OVC programs.

Currently Global Fund is providing support to the FMWA&SD with its efforts in providing national training in Psychosocial Support for OVC. Global Fund has also provided funding to all 36 State Ministries of Women's Affairs and Social Development to provide educational support via selected Community Based Organizations OVC. UNICEF is supporting the advancement of advocacy efforts for the passage of the Children Right Acts at the State level in the remaining 13 of 36 states that have yet to pass it.

The functional capacity of Nigeria's 774 Local Government Social Welfare Officers to respond to the needs of OVC is predominantly nonexistent. There is a critical need for increased capacity building of government personnel and system strengthening of the non-functioning structures in place to address the needs of OVC. The American International Health Alliance (AIHA) which is working with the FMWA&SD School of Social Work and the University of Nigeria, Nsukka, to build the capacity and knowledge base of social workers and their educators will also include Local Social Welfare Officers in their regional in-service trainings. Other IPs such as the MSH-CUBS and PACT-Community Reach projects will also contributing to system strengthening efforts and capacity development of local and state structures responding to the needs of OVC. In the upcoming COP year new IPs under the newly developed

Umbrella Grant Mechanism (TBD) will also work with local and state OVC structures to strengthen their capacity.

The most recent data from APR09 showed that 203,211 OVC received services in Nigeria. The OVC program has experienced remarkable growth over the past year as a result of increased scale up of services for OVC. Through PEPFAR, the United States Government (USG) continues to be the largest contributor to programs for OVC in Nigeria.

In COP09 the cost of providing OVC services to one child decreased from approximately 500 USD in 2007 per child to a current cost of 175 USD per child. OVC partners have demonstrated innovative and effective strategies for identifying OVC and providing referrals to other programs, especially facility-based programs such as FHI/GHAIN and CU-ICAP. Partners have successfully integrated tools and resources made available through wraparound services provided by USG-funded projects such as MARKETS and Sesame Street. Many partners have increased their focus on supporting caregivers to better provide for the children within their household, through Savings and Loan Associations, and other economic strengthening initiatives.

USG-funded OVC partners are also implementing several innovative and cost effective service provision models (i.e. education and health block grants, fostering and adoption, savings and loan schemes, wraparound programs in nutrition, education, and economic empowerment). In addition FHI/GHAIN and Christian AID have developed sophisticated systems for tracking and using data for strategic planning and case management and assessments. Wraparound services have been critical in addressing the gap in current partner programming especially in the area of OVC psychosocial support (PSS) services for children under 5. Examples of wraparound services include psychosocial support being provided by the Sesame Street Project and the nutritional needs of OVC being provided by MARKETS which provides partners with Grand Vita, a highly vitamin enriched fortified meal.

In COP10 USG-funded partners will continue to use the Child Status Index (CSI) to assess the needs of the individual child and ensure that every child receives the appropriate services it requires and for monitoring and evaluating of OVC programming. The USG OVC TWG will continue to conduct supervisory and mentoring site visits, and advocate to State and Local Governments for continued support to OVC. At the USG quarterly IP meeting, partners will continue to share best practices and develop communities of practice (networks of association).

In COP10 all partners will continue to provide needs based and family centered services as well as link all OVC to services not provided by the primary IP, ensuring comprehensive quality services. Facility-based IPs will establish sub-agreements with CBOs that will provide at least three of the 6+1 services Facility based IPs will establish sub – agreements with CBOs to ensure seamless services to OVC and families are provided at the community level. OVC programming with continue to foster strong linkages and integrate with non PEPFAR USG supported wraparound initiatives in Education, Economic Growth, Agriculture, Trade and the Health sector.

During the upcoming COP year USAID will be establishing an umbrella grant mechanism (UGM) in an effort to improve and scale up programming for OVC in high prevalence states throughout Nigeria. The new UGM will provide an efficient and flexible grant making mechanism, awarding grants through a competitive process to ensure that both civil society and state and LGA officials have the skills and resources to effectively and efficiently manage programs for OVC. It is anticipated that the UGM will absorb current CBOs from partners whose cooperative agreements are ending during COP10. The UGM will also ensure that partners have the skills and resources to effectively and efficiently provide services that meet the needs of OVC with key focus areas of Household Economic Strengthening (HES) and household and community food security for OVC.

**Technical Area:** Pediatric Care and Treatment

| Budget Code | Budget Code Planned Amount | On Hold Amount |
|---|---|---|
| PDCS | 4,890,689 | |
| PDTX | 8,836,492 | |
| **Total Technical Area Planned Funding:** | **13,727,181** | **0** |

**Summary:**
COP10 PEDIATRIC CARE and TREATMENT TAN

The HIV epidemic in Nigeria is a generalized/mixed epidemic. Adult prevalence (age 15-49) is 3.1% among a population of 148 million people (UNAIDS). About 2.6 million Nigerians are infected (UNAIDS). Prevalence of HIV infection among pregnant women visiting an antenatal clinic is about 4.6% with mother-to-child transmission of 10% (ANC Survey 2008). An estimated 100,000 HIV-infected infants are born each year. HIV infection in Nigeria, therefore, remains a significant cause of childhood morbidity and mortality either in combination with other illnesses or alone. This is more so as progression occurs more rapidly in infected newborns than in adults.

The National Strategic Framework 2 (NSF 2) plans for the Government of Nigeria (GoN) to increase its commitment to pediatric HIV care and treatment. The NSF2 goal for pediatric care, support and treatment is to provide universal access to all eligible pediatric PLHIVs by 2015, enabling them to receive quality comprehensive care and treatment services for HIV/AIDS and opportunistic infections (OIs) as well as TBHIV co-infection. The PEPFAR program for pediatric HIV care and treatment and other donors' activities will contribute to the host country government's overall goals in COP10 through: Early Infant Diagnosis (EID) scale-up to identify children early and link them to care and treatment; active case detection through Provider Initiated Testing and Counseling (PITC) at multiple points of service including PMTCT; integration into MCH and scaling up PMTCT; training, retraining and mentoring of staff; improved supply chain management and procurement of drugs and supplies; and improved linkages between treatment and PMTCT, TB and OVC services.
Key elements of the PEPFAR Nigeria and partners' strong pediatric care and treatment program for HIV-exposed and infected children include early identification of HIV exposure and infection status, prevention and treatment of OIs and other HIV/AIDS-related complications including malaria and diarrhea (providing access to commodities such as pharmaceuticals, insecticide treated nets, safe water interventions and related laboratory services), pain and symptom relief, and nutritional assessment and support including food. Other services provided include prevention services, psychological, social, and spiritual interventions. Linkage, referral, and retention in care are emphasized. Pediatric treatment includes: provision of ART for all HIV-infected infants and eligible children with appropriate pediatric formulations; regular clinical and CD4 monitoring; monitoring of growth, nutritional status, and development; infant feeding counseling and support; CTX prophylaxis; treatment adherence support; OI prevention, diagnosis, and treatment; and linkage to child survival interventions.

PEPFAR Nigeria already co-exists and collaborates with GoN in service delivery. There is a close partnership and leveraging of resources between the USG and GFATM, UNICEF and CHAI, and these will continue in COP10 resulting in improved access to pediatric care and treatment services.

Accomplishments since last COP

In COP09, the USG and partners continued to support the scale up of Early Infant Diagnosis (EID) in

Nigeria using Dried Blood Spot (DBS) with the support of PEPFAR laboratories and a well developed national manual and plan. Results from the pilot phase have demonstrated the feasibility of EID in Nigeria using DBS. This will ensure that HIV exposed infants are linked early into pediatric care and treatment in keeping with the new WHO recommendations and the national guidelines. Partners' laboratory capacity to do PCR was strengthened to include DBS techniques to enable more sites to participate in EID. Poor infant feeding counseling, one of our key challenges, tends to reverse the gains of early diagnosis efforts; as such IFC training continued to precede all EID training to ensure competency in giving consistent and accurate IFC messages at facilities. Women and their families were counseled to exclusively breastfeed except when they can achieve AFASS.

Despite the challenges posed to identifying positive children by the poor PMTCT coverage in-country due to the predominance of home deliveries, partners continued active case finding by implementing PITC at multiple points of service including outpatient, inpatient, TB, adult ART clinics and patient support groups. Some partners implemented PITC at immunization clinics.

The USG and partners also supported the development of the national pediatric ART guidelines, SOPs, and job aids. Also, the USG provided training in HIV testing and counseling for infants, children and adolescents, CTX prophylaxis and ART in children; including fellowship trainings to health care providers to deliver comprehensive health care services to HIV/AIDS clients including children.

Goals and Strategies for the coming year

Improving access to pediatric care and treatment continues to be a priority for the Nigeria PEPFAR team in the coming year, especially with the reduction in pediatric coverage noted in APR09. Distinct areas of work provide the platform to accomplish this, through improved follow-up services for HIV-exposed infants and their mothers, enhanced diagnostic ability of HIV in infants and children, ensuring access to care and treatment for infants and children, retaining children and their families in care, monitoring response to treatment, adherence and identifying treatment failures.

Future directions in this area include ensuring that all PEPFAR-funded programs work with national programs to support the implementation of the national pediatric ART guidelines. Emphasis will be on activities to improve follow-up of HIV-exposed infants, including close follow-up from PMTCT sites, and community support for identification, referral, and linkage with facilities. Retention into care issues (such as financial and social barriers, access and transitioning care) will also be addressed.

Focus will be placed on treatment initiation in younger children, close follow-up of older children in care to identify those who qualify for treatment, tracking of loss to follow-up and support groups for caregivers and children. There will be a clear effort towards scaling up comprehensive, quality services to children and their families.

USG and partners will strengthen the integration of pediatric HIV care and treatment services with PMTCT, PDCS, OVC, ART and MNCH (co-location of services) programs to support a family-focused health approach with attention to challenges in implementation and strategies to overcome them. Large clinical facilities will not be able to provide all the care, support and treatment services for HIV-exposed and infected pediatric patients and will need to be linked with primary health centers near their homes.

An important barrier to the expansion and scale-up of pediatric HIV programs in Nigeria has been the critical shortage of health workers and low skill set of health care providers especially in rural areas with expertise in pediatric HIV management. As such, partners will be emphasizing health systems strengthening through training, retraining and mentoring of health care workers to ensure competence in the necessary skill sets. Efforts to train existing health care providers at all levels of the health care system are key to significantly increase the numbers of children receiving quality health care services. In

addition, the USG Nigeria team will continue joint supportive supervisory site visits with the relevant Government officials. The PEPFAR team will continue to support GoN in the development and implementation of a policy in task shifting, integration and decentralization.

Available National first line regimens presently are two NRTI and one NNRTI specifically having Zidovudine (ZDV) + Lamivudine (3TC) + Nevirapine (NVP) as recommended for use. Most sites have Fixed Drug Combinations (FDC) provided by UNITAID/CHAN. Pediatric care and support services include provision of a basic care package (insecticide treated nets, safe water interventions, soap and age appropriate IEC materials), growth monitoring, nutritional services (including assessment, counseling, and support/intervention), assessment of anthropometric status (weight for age, height for age, mid-upper arm circumference (MUAC), and body mass index (BMI)), provision of a daily multi-micronutrient supplement for children whose diets are unlikely to meet vitamin and mineral requirements, provision of therapeutic or supplementary feeding support for clinically malnourished patients (plumpy nut from Clinton Foundation); provision of infant feeding support linked to PMTCT programs and pediatric care programs, psychological, social, spiritual and prevention services. All exposed and infected children receive CTX prophylaxis according to National guidelines. The national updated "road to health" cards containing HIV-related information (ART PMM forms) are used at sites by most partners.

USG Nigeria will further strengthen support groups for children, adolescents, caregivers and families, support for disclosure and informing about HIV, adherence support and services, caregivers concerns and needs. TB screening will be provided to all exposed and infected children. The cost of TB diagnosis in children will continue to be addressed including issues around the national availability of drugs. Facilities providing pediatric care and treatment will be encouraged to have pediatric working groups, patient care team meetings and continuing medical education as appropriate.

Adolescent friendly services and clinics will continue to be operational in COP10, with age-appropriate referral to Prevention with Positives (PwP) programs as needed. USG and Partners will also support immunizations (EPI and well-child care programs), micronutrient supplementation and control of intestinal parasites (such as de-worming).
Despite the challenge of infant and child follow up, default tracking teams will continue to address retention in care.

The USG Pediatrics Care & Treatment program will continue to increase gender equity in programming through disaggregation of pediatric indicators by sex. Furthermore, through gender sensitive programming and improved quality services, the program will contribute to reduction in stigma and discrimination and address male norms and behaviors by encouraging men to contribute to children's care and treatment in the families.

In COP10, USG will pool procure ARVs, CTX, commodities, medical supplies and equipments used in ARV services by utilizing Supply Chain Management System (SCMS), for forecasting, pooled procurement, coordination between supply chain managers and program-service managers. Distribution and monitoring systems for pediatric ARVs, CTX, OI drugs and pain medications will be developed and supported. USG will continue leveraging procurement and supply chain strengthening across USG partners and other stakeholders (e.g. Clinton Foundation), while planning for alternate sustenance of pediatric ARVs when UNITAID/Clinton Foundation stocks cease in 2012.
The expansion of pediatric HIV services will require the parallel development of capacity for program monitoring and evaluation. Monitoring and Evaluation of the program will be supported by the USG. USG, GoN and IP SI teams will work to ensure that national registers, forms and tools for data capture are available and all staff are trained to recognize and use these tools appropriately. PEPFAR Nigeria teams and partners will assist the national program to develop, collect, report and monitor pediatric HIV indicators by age categories. USG will collaborate with GoN to support a unified and integrated national system for pediatric HIV monitoring in order to standardize data collection and monitoring procedures,

provide information to evaluate program performance. PEPFAR programs will support and actively participate in the regular review of country data along with FMOH and the National Pediatrics Technical Working Group, provide technical assistance to FMOH and implementing partners for Pediatric HIV monitoring, support training, and conduct joint supportive supervision to sites. Technical assistance will continue to be provided to FMOH for data management, quality assurance, analysis and feedback through the Strategic Information unit. Supervisory support to the state and local government SI teams will also be encouraged to ensure sustainability after training on the National data tools.

In COP10, quality of Pediatric Care, Support and Treatment services will be emphasized. The USG Nigeria goal will include performance measurement and analysis of data from the system in which care is delivered to monitor quality of care, define possible causes of system problems and make changes necessary to ensure patients receive appropriate interventions, using HIVQUAL and other QA/QI mechanisms.

Care and Treatment program evaluation will be conducted annually. Best practices will be evaluated and disseminated across PEPFAR/GoN partners. Areas of emphasis for program evaluation will include: models of service delivery, outcome studies, barriers to retention in care, integration of pediatric care and treatment into MNCH, adherence programs, best practices to support optimal infant feeding approaches, identifying and reducing missed opportunities for CTX prophylaxis, and pediatric HIV "mapping" activities. These mapping activities will be recommended in order to assess coverage and document referrals and linkages to and from programs.

Sustainability of pediatric care and treatment services will be based on durable therapeutic programs and health systems strengthening. It will also include strengthening of training institutions to provide long term training support and capacity development for health care workers involved in pediatric care. This will ensure the continuous long-term delivery of quality pediatric HIV care and treatment services by the GoN.

**Technical Area:** PMTCT

| Budget Code | Budget Code Planned Amount | On Hold Amount |
|---|---|---|
| MTCT | 29,301,529 | |
| **Total Technical Area Planned Funding:** | **29,301,529** | **0** |

**Summary:**
Context and Background
Prevention of Mother to Child Transmission (PMTCT) services in Nigeria commenced in 2002 with six service outlets, all based in tertiary health facilities. Since then, the number of PMTCT service outlets has increased significantly with PEPFAR supporting 651 sites as of September 2009. PEPFAR supports PMTCT service delivery at the primary, secondary and tertiary levels of health care.

Several policy documents with relevance to PMTCT exist in Nigeria. These include the National Policy on HIV and AIDS, which is currently under revision; the national PMTCT guidelines, which are expected to be reviewed following the release of revised guidelines from WHO; PMTCT Standard Operating Procedure (SOPs); job aids; training curriculum and manuals. Nigeria's presidential pronouncement directing free maternity services and care for all HIV positive pregnant women has increased access to PMTCT services in tertiary and some secondary facilities, although the implementation of this directive varies across states due to the Federal system of government. Nigeria has an Integrated Maternal, Newborn and Child Health (IMNCH) Strategy that includes components of maternal care, PMTCT and pediatric care and treatment.

In all thirty-six states and the FCT, PMTCT services are being supported by various developmental partners namely UNICEF, Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), USG/PEPFAR, World Bank and MTN Foundation. Support for PMTCT activities includes capacity building, equipment purchase and installation, infrastructural development, supply of HIV/AIDS commodities and drugs, mentoring and supportive supervision to facility staff.

Despite these efforts, to date PMTCT services reach only about 700,000 pregnant women with testing and counseling (TC) services annually, translating to about 11% coverage nationally.

National Scale-up
The Government of Nigeria (GoN) has acknowledged the need to drastically scale up PMTCT coverage. Although the National Strategic Framework for 2010 – 2015 (NSF 2) is currently in draft, the document proposes 80% coverage for PMTCT services by 2015. The Federal Ministry of Health through its HIV AIDS Division (HAD) has proposed to reach approximately 30% coverage by the end of the 2010 calendar year. The PEPFAR Nigeria team has already initiated discussions with the UN team, the National PMTCT Task Team, and the National Agency for the Control of AIDS (NACA), to partner resources in order to support the GoN in accelerating the pace of PMTCT activities.

Several opportunities are present for PMTCT scale-up to occur. Nigeria is one of few countries prioritized by PEPFAR to receive supplementary (plus-up) funds to accelerate PMTCT scale up. The USG PMTCT team is coordinating activities with multiple stakeholders, including the GoN and development partners, to ensure that the proposed supplementary funds to are put to efficient use. The plus-up funds provide an opportunity to scale up PMTCT coverage and effectiveness in Nigeria, and will capitalize on strategies that will strengthen sub-national levels of government to initiate, plan, implement and supervise the expansion of PMTCT activities. Priority will continue to be accorded to integrating PMTCT into IMNCH services as well as strengthening the delivery of PMTCT in line with the four prongs of PMTCT. Considering that PMTCT is an entry point into care and treatment, the USG team has also stressed the need to plan for additional clients identified through PMTCT scale up activities and who will end up enrolled on long-term treatment (i.e., HAART).

The USG team is also working closely with the UN team to ensure that activities to accelerate improved PMTCT coverage leverage the UNITAID initiative to Nigeria for cost savings. The UNITAID initiative supports the procurement of PMTCT commodities; this initiative is being implemented through UNICEF in Nigeria with $3m committed for year one, and $9m for year two. Another opportunity to leverage funds for the scale up of PMTCT activities in Nigeria is the recently approved Global Fund Round Eight grant for Health System Strengthening and PMTCT.

Accomplishments since last COP
USG support to PMTCT activities continues as a core HIV/AIDS prevention intervention in Nigeria. PMTCT services continue to expand by decentralizing services and working in tandem with Local Government Authorities (LGAs) to increase the number of service delivery sites. USG-supported PMTCT sites have increased by 38% between APR08 and APR09. Also, the number of pregnant women receiving TC for HIV through PEPFAR annually has increased by 34%.

Improved service quality and increased uptake of HIV positive pregnant women into PMTCT programs are the results of robust regular training programs, established mentoring programs and the use of innovative approaches. Couple counseling services have facilitated increased disclosure among couples and better support for infant feeding choices. State networking systems have allowed further expansion of PMTCT services by ensuring referral linkages and greater outreach efforts into local communities. Program linkages between PMTCT, OVC, family planning, care and treatment services have also been strengthened. There is an increased awareness among community caregivers and improved capacity to

enhance demand creation in the community. More Traditional Birth Attendants are engaged in the promotion of PMTCT services. The national child follow-up register for HIV exposed infants was recently revised in order to more effectively capture information related to EID rather than introducing a separate reporting system specifically for EID services.

PMTCT coverage across Nigeria remains a problem and there are significant barriers that still present as challenges for full program scale-up. The preliminary finding from the most recent DHS survey indicates little change in the preference for home deliveries, although ANC clinic attendance remains higher. Barriers to a more rapid increase in PMTCT demand are related to stigma, high level of poverty, poor male involvement especially in the face of a male dominated society, and personnel shortages due to frequent transfers and turnover of trained staff at health facilities. The necessity of developing appropriate PMTCT training materials for primary health care centers has slowed the pace of program roll out to these lower levels of care.

Goals and Strategies for the coming year
PEPFAR Nigeria's overarching prevention goal is to provide effective and sustainable evidence-based prevention programs and services that will contribute significantly to the reduction in the overall incidence of HIV in Nigeria. The plan is to achieve this through programs and services that promote safer sexual behavior through communication-related interventions working in alignment with the vision of the NSF 2 towards: appropriate use of male and female condoms and lubricants; prevention of biomedical transmission of HIV; HIV counseling and testing; prevention of mother-to-child transmission; early diagnosis and effective treatment of sexually transmitted infections; and positive health, dignity and prevention interventions by and for PLHIV.

The strategic focus for COP10 will be to support improved coverage of services by supporting states and Local Government Areas (LGAs) to adopt an expansion strategy through coordination of activities by a lead Implementing Partner (IP) in the states. There will be continued support for the provision of quality PMTCT services at lower level health facilities. Integration of services into IMNCH services within facilities in all states will be continued as an area of focus. As more primary health care facilities commence PMTCT services, emphasis will be placed on strengthening linkages between these lower levels to higher levels of care where more comprehensive services are available. The goal is to establish efficient networks of care that increase uptake of services closer to the communities and which facilitate more effective follow up of PMTCT clients.

In anticipation of the release of revised guidelines from WHO, the USG Nigeria team is poised to provide support to the national program to revise its PMTCT guidelines. These revised guidelines will be in alignment with the WHO guidelines and with the country context. In the meantime, activities will continue in adherence with the existing national guidelines. "Routine Opt-out" testing and counseling at points of service, with same-day test results, will continue to be strengthened for all pregnant women presenting at antenatal care (ANC) or labor and delivery (L&D). Pregnant women who are eligible for HAART based on their own disease will receive triple therapy, while those who do not qualify will receive AZT from 28 weeks or AZT+3TC from 34 -36 weeks, sdNVP during labor and a 7 day tail of AZT and 3TC. Women presenting in labor will receive sdNVP, single dose of AZT+3TC and the 7 day tail of AZT and 3TC. Infants will receive sdNVP at birth and AZT for 6 weeks. The use of Cotrimoxazole (CTX) prophylaxis for all HIV exposed children from the age of six weeks until proven HIV negative will continue to be strengthened.

Linkages between PMTCT services and services for OVC and Pediatric Care and Treatment will continue to be strengthened. Findings from the assessment of the EID initiative in Nigeria will be used to strengthen these linkages. Innovative strategies for identifying HIV exposed children, as well as retention in care, will continue to be explored. Also, USG Nigeria will continue to work with IPs to ensure that HIV positive pregnant women have access to Prevention with Positives services (PwP) either through linkage

or by integration into existing PMTCT programs.

Support will be strengthened for infant feeding messages to continue to be incorporated into counseling for PMTCT. In anticipation of the release of revised HIV and Infant Feeding guidelines from UNICEF, the USG Nigeria team is ready to provide support to the national program to revise its HIV and Infant Feeding Guidelines in order to be in alignment with the UNICEF guidelines and with the country context. USG Nigeria will continue its support to improve access to EID services. USG Nigeria will leverage on the UNITAID procurement of EID commodities for cost savings.

With the recent focus on improving access to PMTCT services at lower levels of care which have severe human resource constraints, USG Nigeria will support capacity building of health workers in Primary Health Care Centers to provide quality PMTCT services. Focus will be placed on on-site mentorship and supportive supervision for these lower tier sites in order to maintain high standards of the minimum package of care required at this level.

Funding Issues

Annual funding for PMTCT by the GoN does not appear to reflect the global concern with the poor coverage of PMTCT in Nigeria. Although the proposed plus-up funds presents an opportunity to stimulate a higher pace of PMTCT activities, the one-off nature of these funds creates uncertainty about the ability to sustain the pace of activities that is envisioned. USG Nigeria, particularly in the Partnership Framework process, has continued to impress the issue of sustainability of PMTCT service scale up on the GoN, as have other stakeholders.

**Technical Area:** Sexual Prevention

| Budget Code | Budget Code Planned Amount | On Hold Amount |
|---|---|---|
| HVAB | 14,604,587 | |
| HVOP | 20,749,479 | |
| **Total Technical Area Planned Funding:** | **35,354,066** | **0** |

**Summary:**
Context and Background
The 2008 ANC Sentinel Survey placed the prevalence of HIV among pregnant women attending ANC clinics in Nigeria at 4.6% (a slight increase over the 2005 rate of 4.4%), the 2007 National HIV/AIDS and Reproductive Health Survey (NARHS-Plus) which is general population based characterized the Nigerian HIV epidemic with an HIV prevalence of 3.6%. Prevalence was higher among females (4.0%) than males (3.2%); slightly higher in the urban area (3.8%) compared with the rural area (3.5%); highest in the North Central zone (5.7%) and lowest in the South East zone (2.6%); highest among respondents with primary education (4.6%) and lowest among respondents that had no education (2.7%); and highest among the 30-39 years age group (5.4%) and lowest among the 15-19 years age group. HIV prevalence was much higher than national average among females who were separated (10.8%), divorced (10.9%) or widowed (10.4%). Overall, only 2% of respondents rated their chances of being infected with HIV as high, 34% rated their chances low, and 60% believed that they were at no risk at all.

The prevalence of HIV was higher among those who rated themselves as high risk for infection than among those who felt they were at a low risk showing a fairly direct correlation between risk perception and HIV positivity. HIV prevalence was also higher among respondents who have exchanged sex for gifts

than among respondents who do not do so. Transactional sex may lead people to tolerate sex that entails considerable risk. Condom use with non-marital partners was generally low (49%) across the nation with the least use in the North-East, North-Central and North-West zones. Alcohol use on a daily basis was also reported to be highest in the North-Central (9.1%), North-East (4.8%) and South-South (4.7%) zones respectively.

The 2007 Integrated Bio-Behavioral Surveillance Survey (IBBSS) also identified Female Sex Workers (FSW) as the sub-population most affected by HIV/AIDS in Nigeria (30% Prevalence). HIV prevalence was also high among men who have sex with men (MSM) (13.5%), injecting drug users (IDUs) (5.6%), transport workers (3.7%), police (3.6%) and armed forces (3.1%). The IBBSS also revealed a generally low risk perception among these MARPs (< 20%). The available evidence from these recent studies suggest that the drivers of the epidemic in Nigeria include transactional sex, low risk perception, high risk behavior and sexual networks amongst MARPS, multiple and concurrent partnerships, poor STI management and vulnerability arising from economic challenges.

The USG continues to collaborate with the UN and other organizations for condoms and other commodities. Collaboration with DFID to leverage condoms from their social marketing programs will continue. UNFPA provides female and male condoms through federal and state government system under the National Condom Strategy. Quantification for condom supplies nationwide will be in line with the 5 year National Condom Strategy. In COP10, implementing partners will provide further assistance to establish quantifications, disaggregated according to male and female condoms.

The PEPFAR Prevention strategies are an integral component of the Partnership Framework. The strategies align strongly with Nigeria's revised National Strategic Framework (NSF2) for the National HIV Response, in keeping with the "Three Ones" principle, and derived from the National Prevention Plan.

The lack of an enabling policy environment to support a more open and robust program targeting mainly MSM and IDUs remains a significant challenge. These groups are criminalized by Nigerian law with the resultant homophobia, stigma, discrimination and constant harassment by law enforcement agents, driving most of these groups underground. The USG will continue exploring ways to reach these hard to reach populations with innovative programming.
Accomplishments since Last COP
Working in collaboration with the Government of Nigeria (GoN), the PEPFAR team has built the capacity of partners to implement the National Prevention Plan (NPP) and the Minimum Prevention Package (MPP). In particular, the USG led the way in developing an data collection to capture the Minimum Prevention Package. The GoN took the lead in rolling out the tool to pilot areas. This tool is a major break though for the GoN in being able to actually measure the implementation of the National Prevention Plan and the Minimum Prevention package.

The PEPFAR Prevention TWG provided substantial input into the revision of GoN's 2003 National Policy and National Strategic Framework both of which provide a comprehensive framework for HIV/AIDS control efforts. Results from the recent IBBS and NARHS –Plus studies now provide evidence for policy support for targeted programming for vulnerable populations (MSM, IDUs). However, victims of trafficking as a vulnerable group presents a gap that will require programmatic intervention. The National Prevention Technical Working Group (NPTWG) inclusive of the USG Prevention TWG is providing technical leadership and direction for HIV prevention activities in Nigeria. The 2007-2009 National Prevention Plan developed by the NPTWG has been given a two-year extension to provide programmatic guidelines for the National Prevention response until 2011. Efforts are ongoing by the USG team to further support the NPTWG to develop National Sexual Prevention curriculum and guidelines in an effort to ensure harmonization of prevention efforts in Nigeria.
Goals and Strategies for the Coming Year:

PEPFAR Nigeria's overarching prevention goal is to provide effective and sustainable evidence-based prevention programs and services that will contribute significantly to the reduction in the overall incidence of HIV in Nigeria. The plan is to achieve this through programs and services that promote safer sexual behavior through communication-related interventions, including: appropriate use of male and female condoms and lubricants; prevention of biomedical transmission of HIV; HIV counseling and testing; prevention of mother-to-child transmission; early diagnosis and effective treatment of sexually transmitted infections; and positive health, dignity and prevention interventions by and for PLHIV.

USG Nigeria's strategy for COP10 Sexual Prevention programming will be refined based on the emerging evidence from the just-concluded triangulation exercise. Using guidance from the combination prevention principles and to ensure programs employ behavioral, biological as well as structural approaches, focus areas will include: (1) to develop a comprehensive package of services to promote abstinence, fidelity and related community and social norms; (2) to develop a comprehensive prevention package of services for persons engaged in high-risk behaviors (PEHRBs) promoting correct and consistent use of condoms as well as STI management; (3) to implement the minimum prevention package of services targeting the general population and targeted programming for MARPS - guided by evidence from recent studies and taking into cognizance the drivers of the Nigerian epidemic; (4) to continue building the capacity of FBOs and CBOS to implement high-quality prevention programs; (5) to integrate comprehensive prevention programming in care and treatment services including Prevention with Positives; and (6) to support evidenced-based programming within the national and USG prevention portfolios.

USG Nigeria, through its Implementing Partners (IPs), will continue to provide a minimum package of services relying on lessons learned from a pool of established best practices appropriate to the population being targeted. Abstinence and Be-faithful activities will focus on these best practices and will include the peer education (PE) model; PE plus model; curriculum and non-curriculum based school programs; community awareness campaigns; interventions that address income generation activities, and build essential life skills; and workplace programs providing interventions targeting adult males and females and encouraging greater involvement of PLHIV.

Condom and Other Prevention activities will also capitalize on these best practices and include: appropriate social marketing of condoms; structured peer education; STI management; interventions addressing vulnerability issues like income generation activities and essential life skills for young women engaging in informal transactional sex; condom services including distribution, education of sex workers on water based lubricants, condom negotiation skills and use.

Inclusion of messages related to alcohol use and its dis-inhibition effects will feature as a cross cutting message for target populations. IPs will utilize a minimum of three interventions to count a target as 'reached', and these will be reinforced via mass media communication. High quality comprehensive prevention program with emphasize on intensity and appropriate measure of messages and services will remain the focus of COP10 interventions.

The USG will target specific high risk populations located within the 37 states of the Federation as guided by available epidemiological evidence. At the community level, the Condoms and Other Prevention program will target "hot spots" where high risk behaviors are more likely to occur. Activities will continue to address adult behavior focusing on male and female norms as it relates to mutual fidelity, and avoidance of multiple and concurrent partners, through targeted mass media approaches and specific community based interventions. For the youth populations, there will be a reinforcement of the successful Zip-up campaign and the peer education plus models. These will be complemented with the "parents as counselors" model that encourages "A" messaging from an early age. The expanded scope of curriculum-based school HIV/AIDS program achieved in COP 07, 08 and 09 will be sustained in COP 10.

In COP10, a second wave of IBBSS is being conducted with a broadened focus including a wider range

of MARP groups and a larger sample frame covering all the six geo-political zones of the country while retaining most elements (sampling methods, study variables, etc) of the earlier research model to allow for trend comparability. This year activities will also target special populations to address the 'bridge' phenomenon. Efforts aimed at transport workers, and adult males will be replicated in additional states and sites across the country; while current services to the military will be expanded to reach other uniformed services. The OP program will be strengthened to provide priority population groups (including female sex workers, male and female out of school youth, uniformed service men, incarcerated populations, long distance truck drivers, and taxi drivers) with direct access to quality CT services, STI treatment, and condom services, including messages on consistent and correct use as guided by the findings of the 2007 IBBSS.

Current work with FSW and MSM will be expanded to non-brothel settings. These interventions will include STI management, C&T services, provision of condoms and training on condom negotiation skills with appropriate information on use of water-based lubricants. Training of sex workers on vocational skills and savings will reduce dependence on commercial sex activity. Information will be provided and awareness created on the need for alcohol use reduction as well as condom use with boyfriends, spouses and non paying clients to ensure risk reduction.

Interventions with transport workers will be continued through successful peer education models. Condom services in motor parks, selected transport corridors and recreational spots of transport workers will also be supported. Mobile and "moonlight" VCT services will be provided along major transport corridors, truck stops and parks to encourage transport workers to know their status, and receive behavioral counseling on multiple partner reduction as well as correct condom use with every sexual encounter. STI treatment services will be provided along these routes.

Work with high risk-youth will be refined to develop gender sensitive programming to meet the prevention needs of young, unmarried out-of-school females and males. The peer education model will be used as a channel to offer appropriate condom messages, provide essential life skills training and address the risks of multiple partnerships, intergenerational and transactional sex. Messages promoting abstinence (primary or secondary) as the most effective form of prevention will also be given.

In COP07, a formal labor force program with AB and appropriate C messaging and condom distribution services was developed to reach men and women in the workplace. This mechanism was sustained in COP08 and COP09, and will be continued in COP10. The Partnership Office at USAID will continue to support the USG team to establish public/private partnerships that will leverage private funds to institute well-integrated workplace programming that reinforces key prevention messages. These efforts will complement workplace programs which promote fidelity, abstinence and stigma reduction.

To ensure comprehensiveness of HIV/AIDS services, COP10 will continue to integrate ABC interventions into care and treatment services. To this effect, treatment partners will continue to integrate prevention services into care and treatment settings, including the minimum package prevention services for people living with HIV through the adoption of a comprehensive Prevention with Positives (PwP) package. This PwP package will have a community component in keeping with the national response to be implemented through support groups and CBOs. Where feasible, partners will provide appropriate information on correct and consistent use of condoms, as well as provide condoms to PLWHA. The majority of costs associated with Prevention with Positives (PwP) activities will be offset under care and treatment. Other prevention services will also be integrated into clinical services, including family planning and reproductive health. STI treatment will be provided onsite in clinical settings for HIV positives and MARPS. This intervention will be implemented using the recently adapted HIV Prevention in Care and Treatment settings Prevention Package, which also contains several training packages and job aids.

In COP10, the principle of the "three-ones" will remain the overarching principle guiding USG

collaborations with GoN. It is anticipated that the partnership framework will motivate the GoN to provide an enabling policy environment and efficient coordination of an effective national response to the epidemic.

**Technical Area:** Strategic Information

| Budget Code | Budget Code Planned Amount | On Hold Amount |
|---|---|---|
| HVSI | 14,863,616 | |
| **Total Technical Area Planned Funding:** | **14,863,616** | **0** |

**Summary:**

COP10 Country Context: Partnership Framework (PF) As the focus of PEPFAR shifts to more sustainable, country-led initiatives, the Strategic Information (SI) goal for Nigeria will focus on the establishment of a unified and harmonized national M&E system as led by the Government of Nigeria (GoN). Efforts have already begun work towards this goal as HIV stakeholders participated in the development of the National HIV Strategic Framework (NSF 2) under the leadership of the National Agency for the Control of AIDS (NACA). Both the NSF 2 and the Partnership Framework (PF) include the goal of strengthening a harmonized M&E system that supports the continuous improvement of the national HIV response by providing: timely information on the nature of the epidemic, routine reporting, behaviors and access to services by key target groups including women, children and MARPs, as well as program performance assessments. With support from the USG, NACA engaged a desk review of the National M&E system and organized an in-depth systems assessment of the M&E building blocks. The reports will be used to reformulate and budget for a new National M&E Plan to accompany the NSF 2 for 2010-2015. Several important surveillance studies and program assessments financed by USG, in collaboration with the GoN, have recently expanded our knowledge about the HIV epidemic. These steps illustrate the leadership commitment by the GoN to using data for informing program improvements. National M&E System "Third One": The GoN-USG Partnership Framework targets five key areas for strengthening SI/M&E efforts in Nigeria: 1) enhanced leadership and managerial role of Federal, State and Local Government authorities for the delivery of an effective one national M&E system; 2) improved coordination and partnership; 3) continuously improved system performance and data quality by targeted activities in training, planned DQA, supportive supervision, mentoring; 4) improved efficiency and effectiveness of services using available data; and 5) improved program planning and decision-making including cost studies. SI partners in Nigeria include: NACA, Federal/State/Local authorities for health and women's affairs/social development, bilateral and multilateral agencies, HIV stakeholders such as civil society representatives, community and faith based organizations, implementing partners and the National M&E Technical Working Group which provides the framework for coordination, planning and implementing the M&E system. Under the PF, USG SI activities will continue to focus on national SI leadership, harmonized routine reporting, conducting periodic community based surveillance and behavior surveys, strengthening capacity of the Federal, State and local health information system (HIS) cadres, and using data sets to improve services. Accomplishments and Ongoing Activities since COP09: Surveillance and Surveys: The results from key community based surveys supported by USG are now available, and include the Demographic Health Survey of 2008 and the National AIDS and Reproductive Health Survey, which were both published and disseminated in 2009. The ANC Surveillance study has also been completed. EPP Spectrum estimates will be updated to incorporate the Nigeria-specific data sets. Program Assessments: Several key assessments were also conducted during the FY2009 period including a rapid assessment of the EID pilot program which indicated that the Nigeria program is making a significant impact on reducing mother to child transmission. However, the Nigeria Health Systems Assessment found that HIS capacity varies across the 36 states and Federal Capital Territory, that few states have an adequate supply of trained HIS cadres, and most states have very limited HIS budgets.

The Private Health Sector Assessment estimated that the private sector employs at least half of the qualified medical records/HIS staff in the country, but that these individuals would require additional HIS training to be able to report HIV activities to national, state and local authorities. The HIV/AIDS Program Sustainability Analysis Tool assessment that was conducted mid-year demonstrated that Nigeria is heavily dependent on donor funding and that strategies need to be considered for efficiency gains in service delivery. Routine Reporting: USG SI led the transition to Next Generation Indicators (NGI) by obtaining GoN review and comments on essential indicators being used for this fiscal year, conducting several trainings and orientations with implementing partners, and conducting a gap analysis to assess whether current tools not designed for NGI will still capture NGI data. USG SI supports the use of unique patient identifiers which are now in use by some implementing partners. To facilitate the development and use of a National Patient Identification program, USG began support for an evaluation of current partner experiences to assess applicability for a national system. Discussions began during COP09 and results of the evaluation are expected in COP10. Activities to strengthen HMIS systems include the piloting of a USG developed Prevention Intervention Tracking Tool begun this year. The National Prevention indicator requires a minimum of three interventions before an individual is counted, and implementing partners were having difficulties in tracking single individuals without this electronic data capture tool. Trainings and expansion of the LHPMIP e-reporting platform continues with the GoN contributing Global Fund resources to train their recipients on the effective use of LHPMIP for routine reporting. Discussions on how to integrate various reporting platforms were initiated by USG SI this reporting period and it is anticipated that a USG funded Technical Assessment will be conducted early next year to assess the feasibility of inter-communication or a common interface to share data between DHIS and LHPMIP. SI Capacity Strengthening: USG continues to support the expansion of M&E skills in Nigeria. In COP09, nearly 6,000 individuals were trained under PEPFAR support in the areas of M&E, surveillance and HMIS. Over 1,000 local organizations were provided SI technical assistance. For continued support to the states/local authorities and service delivery points, the USG SI team and our implementing partners continue to work with field partners in improving data quality and using data to improve services. USG partners continue to work with SACA/LACA and health authorities to conduct site visits to assess the use of national reporting registers and monthly reporting tools, data collection practices, management of data sets, timely reporting and coordination of referral services. Site visits with SACA/LACA representatives, supportive supervision and mentoring by our implementing partners are components of the data quality assessment (DQA) strengthening activities supported by USG. USG SI team members also participated in Joint DQA field visits using standardized DCTs with NACA and FMoH to selected sites providing HIV/AIDS services. The joint DQA was aimed at validating reported data, assessing the level of compliance with national SOPs, and assessing approaches used by state officials in routine reporting. The findings of the joint DQA will be useful in revising the National M&E Plan and the effort to harmonize indicators, patient tools, reporting platforms, and clearly identifying reporting chains. Data to Improve Quality of Services: USG SI supports HIVQual efforts in Nigeria. This year the GoN has taken a strong lead in expanding NHIVQual activities to include prevention, care and treatment programs in selected sites. Innovative approaches to identifying clients in need have been initiated for monitoring OVC activities and e-reporting lab results, which reduces handwriting transcription errors, and has automatic alerts on cohorts to identify clients with missed appointments, or remind when lab tests are due. Partners are also using e-data sets to identify possible improvements in services such as tracking trends in care and using demographics to identify potential defaulters who would receive additional attention to reduce loss to follow-up rates. Special Studies: Special studies with GoN leadership and USG technical and resource support that began under COP09, and will continue in COP10, include: Drug Resistance Monitoring, TB Multiple Drug Resistance, Threshold, Adult ART Outcome Evaluation, and Rapid Assessment of the Basic Care and Support M&E systems. Nigeria will continue to participate in four Public Health Evaluations: HOPE PMTCT, EMRG TB, SHARE Task Shifting and SWEPT PEPFAR Impact on Health Services and Health Systems. Prevention Data Triangulation SEARCH continues as well as the IBBS survey which will be completed during the COP10 period. USG SI includes expertise in program M&E, HMIS, research (including public health evaluations), survey and surveillance, and specialized skills in mapping, modeling and strategic planning. The USG SI team will continue to provide

planning and reporting guidance for SAPR, APR and COP efforts as in previous years. In addition to providing timely and accurate information from routine reporting and planning, SI also provides technical support to program evaluations, PHEs, surveillance and population- or community-based surveys as evidence for effective program and policy decision making by the USG PEPFAR team, and by extension, the GoN and HIV stakeholders. Goals and Strategies for the coming year:

Collaboration with GoN in Planning and Implementing SI Activities: USG SI began discussions on a concept paper for a five year SI strategy early in the COP10 process. Based on the current NSF 2 and the PF, the 2010-2015 USG SI strategy will reflect the USG activities in support of the National M&E Plan for the same period. In addition, the SI Plan will continue to focus on key issues such as the nature of the epidemic(s) in Nigeria, risk behaviors, prevention, care and treatment services, accessibility, utilization and geographic distribution of services, target group service needs, referral networks to assure continuum of care and assuring quality information for HIV program improvements. The strategy will include support to enhance GoN leadership at the federal, state and local levels; harmonization, alignment and strengthening routine monitoring within the context of a functional Third One; Joint DQA; appropriate scheduling of large surveys such as DHS, NARHS, IBBS, ANC; increasing capacity for effective M&E activities such as data management, analysis, dissemination and use, including pre-service training; special studies including cost effectiveness and cost efficiencies; health facility assessments; and a sustainability or transition plan of SI responsibilities to GoN. SI support for an annual, costed work plan for M&E activities is envisioned. Coordination of SI functions and activities between various stakeholders is achieved through a variety of mechanisms including the National Technical Working Group (NTWG). The USG intends to support the NTWG in its efforts to coordinate SI-related activities such as policy and standards development, regularly scheduled workshops, scheduling large surveillance and community based surveys, and establishing a HIV research agenda. USG will support technical assistance to the Strategic Knowledge Management Division at NACA and the DPRS at the FMoH in strengthening M&E policy and program implementation. Technical assistance will also be provided to other line ministries such as the Ministry for Women's Affairs and Social Development for routine reporting on OVC activities. USG technical and resource assistance will continue to assist state and local authorities to carry out CQI efforts on routine reporting including supportive supervision sites visits, mentoring, monthly reporting reviews and assuring timely reporting of monthly service delivery activities. Surveillance, Surveys and Program Assessments: Results from recent surveys such as ANC, DHS and IBBS will be used to update the EPP Spectrum Ten Year Prevalence Estimates, a cornerstone of "Knowing Your Epidemic". Planning for the second NARHS survey will begin in this period. A GoN-led socio-economic impact study will be carried out during this period thus further expanding our understanding of the epidemic. USG SI will be collaborating with GoN and other implementing partners to conduct secondary data analysis from the PEPFAR reporting data base, implementing partners' e-data sets generated by partner software such as IQCARE and further investigation of surveillance studies. USG SI will begin to explore cost studies in Nigeria to better utilize program limited resources.

A cost analysis/cost impact of laboratory practices will examine potential cost savings from standardized policies for training and equipment, lab procurement policies (to include competitive contracts awarded nationally), policies promoting testing efficiencies and lab quality management policies. A similar cost analysis/impact study will look at potential savings in national treatment standards. A study will be conducted to identify reasons why there is a slow-down in enrollment of children 0-15 on to pediatric treatment reported in the APR09 when the EID program is being scaled up. Support to M&E Training Institutions: The numbers of trained M&E professionals remains a major challenge to the abilities of state/local governments and individual facilities to fulfill their responsibilities for routine reporting. USG implementing partners will train at least 2,100 individuals in the areas of routine reporting, data base utilization, surveillance and HMIS. The range of professionals include clinicians, data entry clerks, records officers, pharmacists, laboratory staff, health facility staff, SACA and LACA M&E officers and epidemiologists. In addition, USG SI will continue to support two local training institutions to conduct general M&E workshops for M&E staff from government offices, community based organizations and HIV/AIDS implementing partners. Aiming to begin a more sustainable approach to training M&E

professionals, USG will provide support to these training institutions to develop training curricula into a modular track of M&E courses designed to be integrated into accredited public health degree programs. Courses will cover data quality, data use and data analysis in order to meet specific staffing needs.

**Technical Area:** TB/HIV

| Budget Code | Budget Code Planned Amount | On Hold Amount |
|---|---|---|
| HVTB | 9,795,201 | |
| **Total Technical Area Planned Funding:** | **9,795,201** | **0** |

**Summary:**
COP10 TAN TB/HIV

Nigeria is ranked 4th among the 22 high TB Burden Countries in the world (Global Tuberculosis Control – Epidemiology, Strategy and Financing WHO Report, 2009). HIV prevalence among TB patients in Nigeria is estimated at 27% (Global Tuberculosis Control – Epidemiology, Strategy and Financing WHO Report, 2009). The World Health Organization (WHO) estimates the incidence of TB in Nigeria to be 311/100,000 population and the incidence of smear positive cases to be 131/100,000 population. It is estimated that 1.8 % of new TB cases and 9.4 % of previously treated TB cases are multi-drug-resistant (Global Tuberculosis Control – Epidemiology, Strategy and Financing WHO Report, 2009).

USG Nigeria's strategy for COP10 TB/HIV services will build on COP09 activities and increase collaboration with the Government of Nigeria (GoN) through the National Tuberculosis and Leprosy Control Program (NTBLCP) and the National HIV/AIDS Division (HAD), as well as increase collaboration with other stakeholders such as the Global Fund for AIDS, TB and Malaria (GFATM) and the WHO. The areas of strategic focus during COP10 are: 1) strategic implementation of the new Partnership Framework with the GoN and other TB stakeholders; 2) reporting using Next Generation Indicators (NGIs) for TBHIV; 3) continuation of provider initiated HIV counseling and testing (PITC) in TB patients and TB suspects at the point of first clinical contact and to ensure adequate TB screening, diagnosis, and treatment for all HIV infected individuals at PEPFAR supported facilities; 4) strengthening TB and MDR TB diagnosis through AFB sputum microscopy, TB culture, Hains PCR assay, quality assurance and chest X-ray services; 5) continued strengthening and scale up of implementation of the 3 'I's strategy (Intensified TB case finding among HIV positive persons; TB Infection control to prevent TB transmission; scale up of Isoniazid Preventive Therapy (IPT) in PLHIV); 6) increased access to TB treatment via support of anti-TB drug and lab commodity procurement/logistics; 7) strengthening of pediatric TB/HIV management; and 8) strengthening of MDR-TB surveillance and management by support of surveillance and treatment facilities.

USG support has pioneered, strengthened and scaled up TB/HIV collaboration and services in Nigeria. The USG-supported TB/HIV program has scaled up from 256 sites in 35 states in 2008 to 675 sites in 36 states by APR09. In FY09, PEPFAR funds supported 33,324 HIV positive patients receiving TB treatment. Despite the rapid scale up of TB/HIV services, fewer than 30% of DOTS sites provide HCT services while more than 90% of ART sites are co-located with DOTS sites. Case detection rate for TB remains low at an estimated 30%. Infrastructure for TB services is often rundown, laboratory and X-ray diagnostic services are weak and there is minimal community awareness of TB/HIV co-infection. Despite the influx of new funds from the Global Fund, substantial gaps still remain in TB and TB/HIV programs. Access to cotrimoxazole and ART for HIV positive patients detected in DOTS centers remains limited, particularly in rural areas. Nigeria receives anti-TB drugs through the WHO Global Drug Fund; however, a weak drug and commodity logistics system has resulted in episodes of stock-out in health facilities in the

past. The USG, in collaboration with WHO, is providing ongoing support to develop and strengthen a functional drug and commodity logistics system. Human Resource challenges such as misdistribution of health care personnel, inadequate skill mix, high mobility, frequent rotation, poor retention of staff, lack of motivation and poor work environment continue to limit performance and sustainability of TB/HIV programs.

The USG will continue with its priority objective of integrating HCT into DOTS services. In COP10, the focus is to improve diagnosis and management of TB among HIV positive patients using the global 3 "I"s strategy, and to strengthen basic microscopy, TB culture and Hains PCR assay. The objective of this strategy is to intensify TB case finding among HIV positive patients for early treatment to prevent morbidity/mortality, and to prevent transmission of TB among HIV-positive patients.

REDACTED. In COP09, USG supported the implementation of National MDR-TB survey. This survey will be concluded in COP10, resulting in more accurate knowledge about the burden of MDR-TB in Nigeria. USG has supported the establishment of TB culture facilities and Hains PCR assay facilities in one national reference laboratory and a state laboratory. By COP10, the USG will support National MDR-TB surveillance and treatment in three facilities in Nigeria. REDACTED. MDR-TB surveillance will be supported with technical assistance, provision of diagnostic reagents and logistics. USG will support the treatment of patients detected in the MDR-TB survey with some second line anti-MDR-TB drugs from the Green Light Committee. However, the GoN will continue to be responsible for the management of all MDR-TB patients diagnosed outside the survey program. The USG is providing the technical lead for the MDR-TB survey in Nigeria.

The USG will continue to collaborate with GoN, WHO, GFATM, CIDA, ILEP partners and other donors to address ongoing challenges in TB/HIV implementation. Anti-TB drugs are provided through the WHO Global Drug Fund, and support for continued expansion of DOTS services is from the USAID TB funds, CIDA and Global Fund. USG is represented in the Technical Advisory Committee (TAC) of Global Fund, the national TB planning group and TB/HIV working group, MDR-TB working group and TB Laboratory working group. There is joint monitoring of TB/HIV activities by USG and other donors and stakeholders. USG will continue to contribute to the Partnership Framework by supporting the TB Control Strategic Framework (2008 -2010) by strengthening human resource development in management and leadership, and strengthening TB/HIV service delivery including commodity logistics and laboratory diagnosis. The USG will continue to advocate for increased budgetary commitment by the GoN to the TB/HIV program to ensure sustainability. In addition, REDACTED, support of quality equipment and commodities, training of health workers, the MDR-TB survey and surveillance, and upgrading of laboratory and treatment facilities elaborated above, USG support will enhance the sustainability of TB/HIV control in Nigeria.

With regard to TB program monitoring and evaluation, all USG partners report data on TB treatment through the national and state control programs. In addition, the joint USG, GoN, WHO, ILEP and GFATM supervisory and monitoring visits will help improve the quality of TB/HIV data collection and reporting.


**Technical Area Summary Indicators and Targets**
REDACTED

# Partners and Implementing Mechanisms

## Partner List

| Mech ID | Partner Name | Organization Type | Agency | Funding Source | Planned Funding |
|---|---|---|---|---|---|
| 7354 | Partnership for Supply Chain Management | Private Contractor | U.S. Agency for International Development | GHCS (State) | 87,657,220 |
| 7355 | TBD | TBD | U.S. Agency for International Development | Redacted | Redacted |
| 7356 | Abt Associates | Private Contractor | U.S. Agency for International Development | GHCS (State) | 2,300,000 |
| 7359 | John Snow, Inc. | Private Contractor | U.S. Agency for International Development | GHCS (State) | 2,145,000 |
| 7382 | US Department of Defense | Own Agency | U.S. Department of Defense | GHCS (State) | 7,022,218 |
| 10004 | Association of Public Health Laboratories | NGO | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHCS (State) | 400,000 |
| 10015 | National Blood Transfusion Services, Tanzania | Host Country Government Agency | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHCS (State) | 3,250,000 |
| 10019 | Safe Blood for Africa Foundation | NGO | U.S. Department of Health and | GHCS (State) | 1,000,000 |

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| | | | Human Services/Centers for Disease Control and Prevention | | |
| 10021 | CRS-7D | Implementing Agency | U.S. Agency for International Development | GHCS (State) | 3,809,396 |
| 10022 | Catholic Relief Services | FBO | U.S. Agency for International Development | GHCS (State) | 2,800,000 |
| 10025 | Christian Health Association of Nigeria | FBO | U.S. Agency for International Development | GHCS (State) | 265,206 |
| 10026 | Pact Nigeria | Implementing Agency | U.S. Agency for International Development | GHCS (State) | 2,202,732 |
| 10028 | Academy for Educational Development | NGO | U.S. Agency for International Development | GHCS (State) | 1,008,334 |
| 10029 | Family Health International | NGO | U.S. Agency for International Development | GHCS (State) | 52,844,762 |
| 10031 | Leadership Management Sustainability, Prevention Organizational Systems AIDS Care and Treatment Project (LMS ProACT) | Implementing Agency | U.S. Agency for International Development | GHCS (State) | 10,678,536 |
| 10032 | NELA | Implementing Agency | U.S. Agency for International Development | GHCS (State) | 603,064 |
| 10033 | University of North | University | U.S. Agency for | GHCS (State) | 2,410,000 |

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| | Carolina | | International Development | | |
| 10034 | Academy for Educational Development | NGO | U.S. Agency for International Development | GHCS (State) | 2,225,013 |
| 10036 | Safe Blood for Africa Foundation | NGO | U.S. Agency for International Development | GHCS (State) | 2,670,000 |
| 10096 | Harvard University School of Public Health | University | U.S. Department of Health and Human Services/Health Resources and Services Administration | GHCS (State), Central GHCS (State) | 27,681,758 |
| 10098 | UMD-IHVN-ACTION | Implementing Agency | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHCS (State) | 52,006,707 |
| 10100 | Catholic Relief Services | FBO | U.S. Department of Health and Human Services/Health Resources and Services Administration | GHCS (State), Central GHCS (State) | 23,045,535 |
| 10101 | Excellence Community Education Welfare Scheme (ECEWS) | NGO | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHCS (State) | 1,204,087 |

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| 10103 | The Axios Foundation, Inc. | Implementing Agency | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHCS (State) | 500,000 |
| 10104 | American Society of Clinical Pathology | Private Contractor | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHCS (State) | 400,000 |
| 10105 | Clinical and Laboratory Standards Institute | NGO | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHCS (State) | 350,000 |
| 10107 | American International Health Alliance | NGO | U.S. Department of Health and Human Services/Health Resources and Services Administration | GHCS (State) | 400,000 |
| 10110 | Population Council | NGO | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHCS (State) | 712,591 |
| 10111 | Vanderbilt | University | U.S. Department | GHCS (State) | 2,029,310 |

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|---|---|---|---|---|---|
| | University | | of Health and Human Services/Centers for Disease Control and Prevention | | |
| 10113 | Johns Hopkins University | University | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHCS (State) | 295,523 |
| 10114 | APIN LTD | Implementing Agency | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHCS (State) | 12,497,627 |
| 10115 | University Research Corporation, LLC | Private Contractor | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHCS (State) | 1,764,192 |
| 10116 | Pathfinder International | NGO | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHCS (State) | 253,418 |
| 10125 | TBD | TBD | U.S. Agency for International | Redacted | Redacted |

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| | | | Development | | |
| 10133 | Heartland Alliance | Implementing Agency | U.S. Agency for International Development | GHCS (State) | 1,507,000 |
| 10170 | Catholic Secretariat of Nigeria | FBO | U.S. Agency for International Development | GHCS (State) | 445,000 |
| 10171 | GECHAAN/The New Tommorrow's Project | Implementing Agency | U.S. Agency for International Development | GHCS (State) | 860,000 |
| 10172 | Pro-Health International | Implementing Agency | U.S. Agency for International Development | GHCS (State) | 1,472,389 |
| 10174 | Sesame Street Workshop | NGO | U.S. Agency for International Development | GHCS (State) | 400,000 |
| 10176 | Hope Worldwide Nigeria | NGO | U.S. Agency for International Development | GHCS (State) | 2,225,000 |
| 10243 | Pro-Health CDC | Implementing Agency | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHCS (State) | 50,000 |
| 10263 | American Society for Microbiology | Implementing Agency | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHCS (State) | 450,000 |
| 10328 | Partners for Development | NGO | U.S. Department of Health and | GHCS (State) | 1,068,357 |

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| | | | Human Services/Centers for Disease Control and Prevention | | |
| 10625 | International Center for AIDS Care and Treatment Programs, Columbia University | University | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHCS (State) | 25,769,304 |
| 10994 | TBD | TBD | U.S. Department of State/Bureau of African Affairs | Redacted | Redacted |
| 12446 | TBD | TBD | U.S. Agency for International Development | Redacted | Redacted |
| 12447 | Save the Children UK | NGO | U.S. Agency for International Development | GHCS (State) | 1,210,000 |
| 12448 | TBD | TBD | U.S. Agency for International Development | G Redacted | Redacted |
| 12449 | Central Contraceptive Procurement | Private Contractor | U.S. Agency for International Development | GHCS (State) | 306,217 |
| 12450 | TBD | TBD | U.S. Agency for International Development | Redacted | Redacted |
| 12451 | TBD | TBD | U.S. Agency for International Development | Redacted | Redacted |
| 12452 | World Health Organization | Multi-lateral Agency | U.S. Agency for International Development | GHCS (State) | 900,000 |

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|---|---|---|---|---|---|
| 12453 | TBD | TBD | U.S. Agency for International Development | Redacted | Redacted |
| 12454 | TBHIV FOLLOW ON | Implementing Agency | U.S. Agency for International Development | GHCS (State) | 600,000 |
| 12455 | TBD | TBD | U.S. Agency for International Development | Redacted | Redacted |
| 12456 | DQAEval | Implementing Agency | U.S. Agency for International Development | GHCS (State) | 950,000 |
| 12457 | TBD | TBD | U.S. Agency for International Development | Redacted | Redacted |
| 12458 | Management Sciences for Health | NGO | U.S. Agency for International Development | GHCS (State) | 2,636,000 |
| 12459 | University Research Corporation | Private Contractor | U.S. Agency for International Development | GHCS (State) | 600,000 |
| 12460 | Academy for Educational Development | NGO | U.S. Agency for International Development | GHCS (State) | 400,000 |
| 12461 | Program for Appropriate Technology in Health | NGO | U.S. Agency for International Development | GHCS (State) | 650,000 |
| 12462 | TBD | TBD | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Redacted | Redacted |

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|---|---|---|---|---|---|
| 12463 | TBD | TBD | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Redacted | Redacted |
| 12464 | TBD | TBD | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Redacted | Redacted |
| 12465 | TBD | TBD | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Redacted | Redacted |
| 12466 | Policy Enabling Environment Project | Implementing Agency | U.S. Agency for International Development | GHCS (State) | 2,018,660 |
| 12467 | Salesian Mission | FBO | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHCS (State) | 150,000 |
| 12468 | TBD | TBD | U.S. Department of Health and Human Services/Centers for Disease | Redacted | Redacted |

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|---|---|---|---|---|---|
| | | | Control and Prevention | | |

# Implementing Mechanism(s)

## Implementing Mechanism Details

| **Mechanism ID: 7354** | **Mechanism Name: USAID Track 1.0 SCMS** |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Contract |
| Prime Partner Name: Partnership for Supply Chain Management | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 87,657,220** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 87,657,220 |

## Sub Partner Name(s)

| | | |
|---|---|---|
| Booz Allen Hamilton | Management Sciences for Health | Map International |
| Northrup Grumman | North-West University | The Manoff Group |
| UPS Supply Chain Solutions | Voxiva | |

## Overview Narrative

SCMS is funded by the President's Emergency Plan for AIDS Relief (PEPFAR), and brings together 13 private sector, nongovernmental and faith-based organizations that are among the most trusted names in supply chain management and international public health and development. With offices in 17 countries and 350 dedicated staff members around the world, we are helping to improve the lives of people living with HIV/AIDS in some of the countries most severely impacted by the pandemic. SCMS procures essential medicines and supplies at affordable prices; helps strengthen and build reliable, secure and sustainable supply chain systems; and fosters coordination of key stakeholders.

Our Approach

• Working with and strengthening existing systems, not creating parallel or duplicate systems

• Building local capacity, empowering in-country partners to enhance and develop sustainable and appropriate responses for their own communities

• Delivering quality HIV/AIDS medicines and supplies at the best value by leveraging industry best practices for planning, procurement, storage and distribution

• Promoting transparency to ensure accurate and timely supply chain information is collected, shared and used to improve decision making
• Collaborating with in-country and international partners to identify needs, fill gaps, avoid duplication and share best practices
SCMS in Nigeria
As of the end of 2008, 250,000 of estimated 3.6 million adults and children in Nigeria living with HIV/AIDS were receiving antiretroviral therapy (ART). The government of Nigeria (GON) has set an ambitious goal to provide antiretroviral (ARV) treatment to 540,000 recipients by the end of 2014. Strengthening the country's supply chain system for ARVs is essential to making this happen.
Nigeria's HIV/AIDS supply chain is made up of multiple supply chains—many of which include separate procurement, warehousing, and distribution systems—owned and operated by various federal, state, nongovernmental, and faith-based stakeholders with oversight from the Federal Ministry of Health (FMOH) and the National Agency for the Control of AIDS (NACA). To improve visibility and coordination across these disparate supply chains, SCMS is working with the FMOH and PEPFAR-funded agencies and IPs to strengthen quantification and procurement planning, logistics data collection and management, inventory control, storage and distribution, and supply chain coordination for HIV/AIDS commodities.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 8,427,427 |

## Key Issues

TB

## Budget Code Information

| | | | |
|---|---|---|---|
| **Mechanism ID:** | **7354** | | |
| **Mechanism Name:** | **USAID Track 1.0 SCMS** | | |
| **Prime Partner Name:** | **Partnership for Supply Chain Management** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Care | HBHC | 3,918,330 | |
| **Narrative:** | | | |

ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS

SCMS Nigeria provides procurement, systems strengthening (SS) services and strategic information for USG and PEPFAR Implementing Partners (IPs). It also provides systems strengthening services for building logistics management capacity to 4 main GON departments (NASCP, FDS, DPRS, and NACA).

SCMS support PEPFAR programs in Nigeria by providing increased access to quality HIV/AIDS related commodities. Key SCMS activity under this program area includes: procurement, shipment, clearing, distribution and delivery of medical supplies and equipments used in ARV services and other commodities used to extend and optimize the quality of life of HIV infected adults and their families. SCMS also provides other supply chain management related activities such as technical assistance (TA) and system strengthening activities for PEPFAR IPs and the Department of Defense (DoD) to strengthen or build their supply chain management capacity within their respective programs. Through its continuous support to and strengthening of commodity security in PEPFAR treatment programs, SCMS works towards ensuring availability of needed commodities required by the PEPFAR supported programs to the target population of people living with HIV/AIDS and the general population through their families.

In COP09, SCMS procured medical supplies and equipments used in ARV services. Other commodities for the prevention, management and clinical monitoring of opportunistic infections (OI), except tuberculosis (TB); other HIV/AIDS related complications, including malaria, and the management of sexually transmitted infections (STIs) were also procured. Example of such commodities are pharmaceuticals (OI drugs, pain killers), insecticide treated nets, laboratory equipment and consumables, home based care kits, water guard, gloves and therapeutic food. SCMS also procured other medical and non medical supplies used in treatment and basic health care and support services (including home-based care), used to extend and optimize the quality of life of HIV infected adults and their families for two IPs and DoD. In COP 10, SCMS will continue to procure these materials as required by the IPs and DoD.

The funds allocated to SCMS by the IPs and DoD, for these services is as follows: DOD (#554.08), $XXX; CRS AidsRelief (#3688.08), $ XXX; Columbia University/ICAP (#2768.08), $ XXX; and University of Maryland (#632.08), $ XXX. The present budget will cover the cost of commodities, logistical and administrative services from the field office for the coordination and management of the procurements undertaken by SCMS and the cost of TA and SS.

In COP 10, SCMS will continue to support the IPs and DoD in the following areas of the supply chain cycle: product selection in accordance with the Federal Government of Nigeria's (GoN) national testing guidelines, marketing authorization status (NAFDAC registration) and GoN importation regulation. SCMS

will also be responsible for ensuring that commodities procured meet eligibility criteria under the USG acquisition rules and regulations including source and origin waivers and approvals or tentative approvals by the US Food and Drug Administration or other relevant stringent drug regulatory authorities. SCMS will assist in quantification and forecasting of requirements and will support the development of long term supply plans (considering in country stocks and anticipated consumption rates) for stock management, monitoring of stock levels and usage through the deployment of pipeline databases and delivery planning. Additionally SCMS will monitor product safety and maintain a tracking system for recalls (pharmacovigilance). Requests for commodities will continue to be addressed to and coordinated with SCMS field office directly.

Several challenges are still associated with the procurement of Opportunistic Infections (OI) drugs. A number of key OI medicines still remain banned from importation into Nigeria and hence by default, need to be procured from local manufacturers. However, the fact that none of these locally manufactured OI drugs (and indeed other pharmaceuticals products) has stringent drug regulatory authority approval places the PEPFAR IPs in a difficult situation. In COP 09, SCMS was able to secure approval to import some quantities of Cotrimoxazole. The actual quantity to be imported will depend on the requirements of each IP. In COP 10, SCMS will work with the IPs and GoN to identify key OI drugs that are required by PEPFAR supported treatment programs and initiate the process of pre-qualification towards identifying local sources. SCMS will also continue to work with GoN towards defining the modalities for use of opioids for pain management by HIV/AIDS programs. SCMS intervention in this area will ensure that required materials for Palliative care are available for use of the programs, thus improving the quality of life of PLWHA.

SCMS will continue to identify suitable sources of supply both internationally and nationally. SCMS will work with IPs in Nigeria to locally procure products that are either banned for importation or for which local procurement represents a key advantage in terms of cost, delivery and/or associated services (i.e. maintenance service).

SCMS will coordinate with the USG team to ensure selected products are appropriately registered in Nigeria. For products not yet registered by NAFDAC, SCMS will make suitable recommendations including waiver applications where appropriate. SCMS will take the lead to communicate with manufacturers on registration gaps in Nigeria.

SCMS procurement leverages global spend to provide best value and offers clients certainty of competitive prices and international quality standards. SCMS procurement strategy is articulated around buying generics whenever possible, pooling procurement for HIV/AIDS care, prevention and treatment programs across PEPFAR focus countries and negotiating long term contracts with suppliers.

SCMS will be responsible for the shipment of procured commodities into Nigeria through Abuja or other points of entry as required. SCMS will continue to follow laid down procedures for customs clearance as appropriate including management of the CC1, CC2 or CC3 duty exemption forms. SCMS will coordinate with the USG team to fulfill importation requirements and provide needed documentation to allow customs clearance in an efficient and timely manner.

Where appropriate, commodities requested by the IPs and USG will be supplied through the SCMS Regional Distribution Center (RDC) in Ghana. The warehousing of commodities in the RDC is a critical component of the SCMS technical solution. The use of the RDC will significantly reduce lead times and provide an important buffer between the supply from manufacturers and demands from the PEPFAR programs in Nigeria. The RDC also ensure that shipment quantities do not overwhelm their recipients in country, an increasing challenge in the context of program scale up. The RDC concept also brings an increased flexibility in stock management thus reducing risk of stock obsolescence or need for emergency replenishments, resulting in important savings. Finally, the RDC approach serves regional and national sustainability, as the RDC is designed to be a commercially viable entity, available to other health (and non-health) programs, whose benefit will last beyond SCMS. Where possible and appropriate, SCMS will road freight from the RDC Ghana to Abuja; a mode of delivery that provides further significant savings over airfreight. For local warehousing needs, SCMS will continue to use its pharmaceutically compliant warehouse (primarily as a cross-docking facility) in Abuja which additionally will be capable of redirecting potential overstocked items, if necessary, to avoid expiry and waste.

Delivery arrangements will continue to be negotiated with the IPs; SCMS will either deliver to a central location or to point of services as needed. It should however be noted that the current distribution system for GoN programs and IPs is still sub-optimal. In COP 09, SCMS commenced implementation of the recommendations from the distribution options study (conducted in COP 08). In COP 10, SCMS with support of USG and the IPs will design and implement a more harmonized transport system for identified commodities to be delivered to a series of regional warehouses from which each IP or site will pick up its commodities. This will result in significant reduction of distribution costs by eliminating overlapping IP-specific distribution routing from various regions to Abuja. It is envisaged that this area will provide an opportunity to work with private sector providers and support collaboration between them and the GoN and IPs in mutually rewarding Public Private Partnerships. It will also follow a model already in place in which GoN and GF commodities are distributed by private-sector third-party logistics providers. Finally in COP 10, SCMS will analyze last mile delivery options to further reduce redundancies in PEPFAR commodity distribution to sites in subsequent years, and to harmonize with the GON system as a step toward eventual integration. In order to efficiently manage the delivery of commodities as appropriate, SCMS will competitively source for and utilize the service of an efficient and safe in-country courier

services operator.

SCMS provides TA and SS services in all areas of the supply chain including product selection, marketing authorization status (NAFDAC registration), quantification, forecasting, supply planning, procurement, warehousing, customs clearance and delivery. In COP 10, SCMS will continue to provide TA and SS services to DoD and the IPs through training in the use of the ProQ or Quantimed forecasting and Pipeline supply planning tools. SCMS will continue to provide TA and SS services to DoD based on the recommendations that came out of a supply chain system's assessment carried out in COP07 including the establishment of a government owned, contractor operated warehouse, as part of SCMS strengthening of the host government's HIV program which is expected to bring a long term solution contributing to the sustainability of the military HIV/AIDS programs in Nigeria. By providing training and supporting capacity building of local organizations, SCMS addresses the emphasis area of human capacity development.

In COP 10, SCMS will continue to provide the USG team and the IPs with regular reports on medical supplies and equipments used in ARV services and other related commodity purchase as well as monthly financial reports and also assist IPs to monitor/report on stock levels and usage through the deployment of Pipeline databases. SCMS will also support the Supply Chain Support Teams (made up of technical SCMS staff and GoN or IP staff as appropriate) constituted by SCMS to work with the IPs in providing their trained logisticians with the capacity to monitor and support the performance of the supply chains at various levels. The Supply Chain Support Teams will use standardized indicators of logistics performance, to track performance of the supply chains and together, act as an early warning system to identify impending or imminent supply chain breakdowns and act to forestall these. By developing methodologies and tools for conducting these activities, SCMS will work with GoN and IPs to establish and institutionalize this activity thereby building the capacity to identify these problems and resolve them before service delivery is compromised. The automated web based procurement tracking database will ensure that the USG team and IPs have adequate visibility on SCMS procurement status since it provides an easy access to accurate and up to date information on procurement. It is envisaged that further procurement automation and harmonization will be facilitated through linkages with the Logistic and Health Program Management Information Platform system.

In COP07, SCMS undertook, under DoD's request, a feasibility study for a Government Owned Contractor operated (GOCO) warehousing facility to be used by HIV/AIDS Nigerian military and DoD programs. SCMS will provide technical oversight for the construction and managing the equipment of the facility, while the NMoD will finance the construction of the facility, DoD will finance the equipment of the warehouse through COP allocations to SCMS in the range of $XXX.  The establishment of a GOCO, as part of SCMS system strengthening to the host government's supply chain system, will bring a long term

solution contributing to the sustainability of the military HIV/AIDS programs in Nigeria. By providing training and supporting capacity building of local organization, SCMS addresses the emphasis area of human capacity development.

Under this program area, SCMS does not have targets of its own but supports PEPFAR IPs and DoD reaching their care planned targets.

EMPHASIS AREA
Human capacity development.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HKID | 121,652 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HTXS | 2,417,280 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HVCT | 187,882 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | PDTX | 377,550 | |

**Narrative:**

ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS
SCMS Nigeria provides procurement, systems strengthening (SS) services and strategic information for USG and PEPFAR Implementing Partners (IPs). It also provides systems strengthening services for building logistics management capacity to 4 main GON departments (NASCP, FDS, DPRS, and NACA).

SCMS supports PEPFAR programs in Nigeria by fostering increased access to quality HIV/AIDS related

commodities. Key SCMS activities under this program area includes: procurement, shipping, clearing, distribution and delivery of commodities for use in delivering paediatric ARV services (commodities for training, clinical monitoring, and community adherence services). SCMS is also involved with as other supply chain management related activities such as technical assistance (TA) and systems strengthening (SS) activities for PEPFAR IPs and the Department of Defense (DoD) to strengthen or build their supply chain management capacity within their respective programs. Through its continuous support to and strengthening of commodity security in PEPFAR treatment programs, SCMS works towards ensuring availability of ARV drugs required by the PEPFAR supported programs to provide care and treatment services for the target population of people living with HIV/AIDS.

In COP09, SCMS procured materials for use in providing paediatric ARV services (i.e. commodities for training, clinical monitoring, and community adherence services). In COP 10, SCMS will continue with this. The funds allocated to SCMS by the IPs and DoD, for these services is as follows: DOD (#554.08), $XXX; Harvard University School of Public Health (HSPH)/APIN+ (#544.08), $ XXX; University of Maryland (#632.08), $ XXX; CRS AidsRelief (#3688.08), $ XXX; Columbia University/ICAP (#2768.08), $ XXX; GHAIN (#XXXX.08), $ XXX; LMS (#XXXX.08), $ XXX; CHAN NiCAB (#XXXX.08), $ XXX; PFD (#XXXX.08), $ XXX; and URC (#XXXX.08), $ XXX. The budgets will cover the cost of commodities as well as logistical and administrative services from the field office for the coordination and management of the procurements undertaken by SCMS. The budget also supports the cost of TA and SS.

In COP 10, SCMS will continue to support the IPs and DoD in the following areas of the supply chain management cycle: product selection in accordance with the Federal Government of Nigeria's (FGoN) national treatment guidelines, marketing authorization status (NAFDAC registration) and FGoN importation regulation. SCMS will also be responsible for ensuring that commodities procured meet eligibility criteria under the USG acquisition rules and regulations including source and origin waivers and approvals or tentative approvals by the US Food and Drug Administration. SCMS will assist in quantification and forecasting of requirements and will support the development of long term supply plans (considering in country stocks and anticipated consumption rates) for stock management, monitoring of stock levels and usage through the deployment of pipeline databases and delivery planning. Additionally SCMS will monitor product safety and maintaining a tracking system for recalls (pharmacovigilance). Requests for commodities will continue to be responded to and coordinated with SCMS field office directly.

SCMS will identify suitable sources of supply and will coordinate with the USG team to ensure selected commodities are appropriately registered in Nigeria. For commodities not yet registered by NAFDAC, SCMS will make suitable recommendations including waiver applications where appropriate. SCMS will take the lead to communicate with manufacturers on registration gaps in Nigeria.

SCMS procurement leverages global spend to provide best value and offers clients certainty of competitive prices and international quality standards. SCMS procurement strategy is articulated around buying generics whenever possible, pooling procurement for HIV/AIDS care, prevention and treatment programs across PEPFAR focus countries and negotiating long term contracts with suppliers.

SCMS will be responsible for the shipment of procured commodities into Nigeria through Abuja or other points of entry as required. SCMS will continue to follow official procedures for customs clearance as appropriate including management of the CC1, CC2 or CC3 duty exemption forms. SCMS will coordinate with the USG team to fulfill importation requirements and provide needed documentation to allow customs clearance in an efficient and timely manner.

Where appropriate, commodities requested by the IPs and USG will be supplied through the SCMS Regional Distribution Center (RDC) in Ghana. The warehousing of commodities in the RDC is a critical component of the SCMS technical solution. The use of the RDC will significantly reduce lead times and provide an important buffer between the supply from manufacturers and demands from the PEPFAR programs in Nigeria. The RDC also ensure that shipment quantities do not overwhelm their recipients in country (an increasing challenge in the context of program scale up). The RDC concept also brings an increased flexibility in stock management thus reducing risk of stock obsolescence or need for emergency replenishments, resulting in important savings. Finally, the RDC approach serves regional and national sustainability, as the RDC is designed to be a commercially viable entity, available to other health (and non-health) programs, whose benefit will last beyond SCMS. Where possible and appropriate, SCMS will road freight from the RDC Ghana to Abuja; a mode of delivery that provides further significant savings over airfreight. For local warehousing needs, SCMS will continue to use its pharmaceutically compliant warehouse (primarily as a cross-docking facility) in Abuja which additionally will be capable of redirecting potential overstocked items, if necessary, to avoid expiry and waste.

Delivery arrangements will continue to be negotiated with the IPs; SCMS will either deliver to a central location or to point of services as needed. It should however be noted that the current distribution system for GoN programs and IPs is still sub-optimal. In COP 09, SCMS commenced implementation of the recommendations from the distribution options study (conducted in COP 08). In COP 10, SCMS with support of USG and the IPs will design and implement a more harmonized transport system for identified commodities to be delivered to a series of regional warehouses from which each IP or site will pick up its commodities. This will result in significant reduction of distribution costs by eliminating overlapping IP-specific distribution routing from various regions to Abuja. It is envisaged that this area will provide an opportunity to work with private sector providers and support collaboration between them and the GoN and IPs in mutually rewarding Public Private Partnerships. It will also follow a model already in place in

which GoN and GF commodities are distributed by private-sector third-party logistics providers. Finally in COP 10, SCMS will analyze last mile delivery options to further reduce redundancies in PEPFAR commodity distribution to sites in subsequent years, and to harmonize with the GON system as a step toward eventual integration. In order to efficiently manage the delivery of commodities as appropriate, SCMS will competitively source for and utilize the service of an efficient and safe in-country courier services operator.

In COP 10, SCMS will continue to provide TA and SS services to DoD and the IPs through training in the use of the ProQ or Quantimed forecasting and Pipeline supply planning tools. SCMS will continue to provide TA and SS services to DoD based on the recommendations that came out of a supply chain system's assessment carried out in COP07 including the establishment of a government owned, contractor operated warehouse, as part of SCMS strengthening of the host government's ARV program which is expected to bring a long term solution contributing to the sustainability of the military HIV/AIDS programs in Nigeria.

In COP 10, SCMS will continue to provide the USG team and the IPs with regular reports on procured commodities as well as monthly financial reports and also assist IPs to monitor/report on stock levels and usage through the deployment of Pipeline databases. SCMS will also support the Supply Chain Support Teams (made up of technical SCMS staff and GoN or IP staff as appropriate) constituted by SCMS to work with the IPs in providing their trained logisticians with the capacity to monitor and support the performance of the supply chains at various levels. The Supply Chain Support Teams will use standardized indicators of logistics performance, to track performance of the supply chains and together, act as an early warning system to identify impending or imminent supply chain breakdowns and act to forestall these. By developing methodologies and tools for conducting these activities, SCMS will work with GoN and IPs to establish and institutionalize this activity thereby building the capacity to identify these problems and resolve them before service delivery is compromised. The automated web based procurement tracking database will ensure that the USG team and IPs have adequate visibility on SCMS procurement status since it provides an easy access to accurate and up to date information on procurement. It is envisaged that further procurement automation and harmonization will be facilitated through linkages with the Logistic and Health Program Management Information Platform system.

Under this program area, SCMS does not have targets of its own but supports PEPFAR IPs and DoD reaching their planned treatment targets.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Other | HVSI | 1,100,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Other | OHSS | 7,613,384 | |

**Narrative:**

ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS
SCMS Nigeria provides procurement, systems strengthening services and strategic information for USG, PEPFAR IPs and GON (strengthening institutional capacity for logistics management in the following government departments: NASCP, FDS, DPRS, and NACA).

In COP 09, SCMS continued to build the capacity of PEPFAR Implementing Partners (IPs) and the Government of Nigeria (GoN) to manage a well-functioning HIV/AIDS program logistics system by providing supply chain services where necessary as well as technical assistance and capacity building in logistics functions to enhance management skills in analysing logistics data for decision-making. The capacity to plan and synchronize procurements to reduce product stock outs risks and expiration was improved while the project continued to assist appropriate national coordinating bodies and IPs to provide leadership role for logistics activities and where necessary, stimulate the formulation of appropriate frameworks and policies in the area of forecasting, procurement, distribution, storage, and logistics management information management practices to support a well-functioning HIV/AIDS program logistics system. All these activities were informed by several assessments conducted jointly with GoN, USG and other stakeholders.

To sustain these technical interventions, a variety of activities are planned for COP 10 to further build the capacity of GON to design, manage, lead and finance various technical interventions required to support a well-functioning HIV/AIDS program logistics system.

In COP 09, SCMS supported and provided an enabling environment for the coordinating committees (Logistic Technical Working Group, LTWG and the Logistic Steering Committee, LSC) established in COP 08, to function optimally. Specifically, SCMS hosted the secretariats and provided mentorship for members to strengthen the logistics management system as well as monitoring and supervisory activities for GoN ART centers. Working with SCMS, these oversight and technical bodies used logistics data from the various programs to make decisions to avert stock outs and also conduct National joint quantifications to develop robust long term (5 year) projections for ARVs and RTKs in a bid to ensure commodity security and also drive procurement actions. In COP 10, SCMS will continue to support these bodies (although the Honorable Minister for Health inaugurated a task force for HIV/AIDS, Malaria and

TB which has subsumed the LSC but with SCMS being recognized as a key player), and where appropriate, ensure that their membership are expanded to include other stakeholders (to help strengthen stakeholder coordination under the leadership of GON). Quarterly review of the consumption data will be held to update the 5 year forecasts and to inform procurement activities for identified HIV/AIDS commodities. This will enable the determination of identified national HIV/AIDS commodity requirements and improve medium to long term planning and resource mobilization, thus ensuring HIV/AIDS Commodity Security, an initiative begun in COP 08.

SCMS will use the environment created by these coordinating bodies to explore the options for more technical innovations, such as Coordinated Pooled Procurement (CPP) of HIV/AIDS commodities (in concert with GoN and other stakeholders) to support their HIV/AIDS program. In COP 09, SCMS (with support of USG and the IPs) expanded its pooled procurement portfolio from RTKs to include two commonly used ARVs in Nigeria i.e. Truvada and AZT/3TC/NVP (fixed dosed combination). This resulted in significant cost savings in transport, ensured more efficient order processing and it provides for a more reliable supply, that is flexible to absorb fluctuations in demand (whether positive or negative) therefore minimizing/eliminating the risk of stockouts of critical commodities. In COP 10, with approval of USG and the support of the IPs, additional ARVs and OIs will be included in the pooled procurement initiative. SCMS will also continue to work with clients to coordinate demand and synchronize procurements so as to take advantage of the economies of scale inherent in its client base.

The responsiveness of SCMS to USG and the IP procurement needs has been steadily improving. In COP 10, SCMS will continue to fine tune its procurement systems, to ensure that the gains are further consolidated. Local Indefinite Quantity Contracts and Bulk Procurement Agreements will be established as appropriate. These interventions will ultimately ensure that commodities continue to be available on-time and thus prevent stock-outs.

Several challenges are still associated with procurement of Opportunistic Infections (OI) drugs. Key OI medicines still remain banned from importation into Nigeria and hence by default, need to be procured locally. However, none of these locally manufactured OI drugs has stringent drug regulatory authority approval, this places the SCMS in a difficult situation. In COP 09, SCMS was able to secure approval to import some quantities of Cotrimoxazole. In COP 10, SCMS will work with the IPs and GoN to initiate the process of pre-qualification of identified key OI drugs required by PEPFAR supported programs and also continue to work with GoN towards defining the modalities for pain management by HIV/AIDS programs. SCMS intervention in this area will ensure that required materials for Palliative care are available for use of the programs, thus improving the quality of life of PLWHA.

Commodity warehousing and effective distribution are crucial determinants to optimal supply chain

performance. During COP09, SCMS leased a pharmaceutically compliant warehouse from MDS in order to improve its commodity receipt, storage, handling and distribution to IPs. This has enabled SCMS to hold larger volumes of commodities (including buffer stocks of some commodities in country by the project in order to effectively deal with emergent needs) for slightly longer periods than anticipated. This activity will also align and link with the Government Owned Contractor Operated (GOCO) initiative developed in COP08 for the Nigeria Ministry of Defense with support from the US Department of Defense HIV program. In COP 10, SCMS will continue to maintain the warehouse, work with the IPs to ensure they maintain proper warehousing and storage conditions in line with international standards. Appropriate warehouse management tools will be deployed as may be required by the IPs. In collaboration with GoN and other stakeholders, SCMS will develop, implement and institutionalize a system of certification and re-certification for warehouses in the country. These activities will ensure that commodities are properly managed (thereby minimizing damages and avoiding expiry that can arise from over stock) and stored in such a way to optimize the quality of the commodities.

The Federal Central Medical Stores (CMS) is crucial to the success of HIV/AIDS and other programs that depend on it for commodity handling and distribution. Hence it is a key determinant in ensuring the sustainability of various health interventions. However, an earlier assessment of the CMS had showed that it has a weak capacity to respond to the demands for warehousing, storage and distribution of products. In COP 09, while taking cognizance of the support from other partners such as the WHO, the SCMS project provided a series of on-going technical assistance to CMS to help in dejunking the stores, institutionalizing good warehouse practices to improve working practices. SCMS also provided focused training in warehouse management to 2 staff of the CMS and assisted the CMS to develop a strategic plan to guide future strengthening activities, particularly those related to infrastructure improvement and equipment installation included in the GF R8 HSS grant.

In COP 10, SCMS will assist in identifying warehousing requirements and also conduct a feasibility study for a warehouse in Abuja for use of both the USG and GON programs using the "warehouse in a box" approach. A longer term vision is that the CMS staff in Lagos will rotate through this Abuja warehouse to acquire relevant professional experience that will enhance their productivity. SCMS will also provide support to improve logistics data processing capability of the CMS to enhance its operational efficiency.

The current distribution system for GoN programs and IPs is still sub-optimal. In COP 09, SCMS commenced implementation of the recommendations from the distribution options study (conducted in COP 08). In COP 10, SCMS with support of USG and the IPs will design and implement a more harmonized transport system for identified commodities to be delivered to a series of regional warehouses from which each IP or site will pick up its commodities. This will result in significant reduction of distribution costs by eliminating overlapping IP-specific distribution routing from various regions to

Abuja. It is envisaged that this area will provide an opportunity to work with private sector providers and support collaboration between them and the GoN and IPs in mutually rewarding Public Private Partnerships. It will also follow a model already in place in which GoN and GF commodities are distributed by private-sector third-party logistics providers. Finally in COP 10, SCMS will analyze last mile delivery options to further reduce redundancies in PEPFAR commodity distribution to sites, and to harmonize with the GON system toward eventual integration.

The use of logistic data to monitor the performance of health supply chains and inform required remedial actions that are needed in a timely manner is crucial to avoid disruptions or interruptions to program delivery. However, the skill and commitment to such monitoring is lacking in the country. In COP 09 SCMS was to introduce the concept of Supply Chain Support Teams (SCST) comprising technical SCMS staff, GoN and IP staff as appropriate in the Nigeria program. They are to provide the capacity to monitor and support the performance of supply chains at various levels using standardized indicators of logistics performance to track performance of the supply chains and together, act as an early warning system to identify impending or imminent supply chain breakdowns and also take appropriate actions to forestall these. SCMS will continue to pursue this activity in COP 10, it will establish and institutionalize this capacity in collaboration with GoN and other stakeholders by developing monitoring plans, tools and a reporting template. It will also identify and recommend appropriate software packages that may be required at various levels of the supply chain. Support will also be provided to train ten logistics operators in the use of these software packages.

In order to provide the required manpower needed to manage local supply chains to support the rapid scale up of various health interventions in Nigeria and ensure a broader understanding of Supply chain issues, SCMS has been organizing in-country SCM courses to build the capacity of logistic operators since 2008. This highly effective and well tested course had always been oversubscribed since it commenced. In COP 10, SCMS will conduct its annual SCM overview course to train 48 individuals from GoN and the Implementing Partners, as well as refresher training on the national HIV/AIDS commodity logistics system. SCMS will sponsor 2 senior GoN staff on various International courses on SCM. Furthermore, SCMS will provide capacity building for SCM practitioners by supporting quarterly seminars during the meeting of the Association of Public Health Logisticians, Nigeria Chapter, whose membership now exceeds 40.

A supportive policy environment is required to enhance sustainability of SCM activities, SCMS will continue to collaborate with relevant GoN agencies and other stakeholders on the development of a harmonized national logistics policy. SCMS will identify various National policies and legislation that needs to be reviewed and actively work with GoN and the IPs to resolve them. This will lead to an improved environment for HIV/AIDS services delivery and uptake.

SCMS has been supporting GoN in taking a leading role in the transition to and implementation of a National Logistics system for use by all partners. In COP 09, SCMS worked with a few IPs on LMIS based on the result of the assessment conducted for the IPs. In COP 10, SCMS will continue to work with the IPs and GoN to ensure full adoption of the National Logistic system and also organize a refresher training for 44 persons (one from each of the GoN sites). The lab logistics system will also be developed and piloted. SCMS intervention will ensure that inventory control procedure and logistic management information systems are harmonized with the national system and strengthen information sharing among all players.

In COP 09, SCMS initiated activities geared towards harmonization of laboratory equipments, supplies and reagents by collecting data from sites on the type of equipment and reagents being used. The results will be presented to stakeholders to reach a consensus on assumptions to inform quantification for lab supplies, reagents and equipment. Thereafter, a series of workshops will be organized where manufacturer's representatives will meet with end users and others who can objectively evaluate the performance of the equipment, supplies and reagents. This intervention will be the basis for developing a guide towards harmonization and ensure that end users get greater value for their equipment and supplies. SCMS will continue to support this activity in COP 10.

IPs and GoN programs source their commodities from a wide variety of suppliers. Unfortunately, the quality of these commodities (especially drugs and laboratory materials) sourced locally from the open market has not been determined. This has obvious implications for the quality of laboratory results and treatment outcomes. In COP 10, SCMS will set up minilabs in collaboration with appropriate GoN agencies. Other options (e.g. liaising with external laboratories for QA activities, etc) to enhance quality assurance of laboratory materials and drugs will also be explored.

Currently, one major component that is lacking in various health interventions is the availability of facility for disposal of expired products (drugs or laboratory materials). This is because national capacity for doing this is either totally lacking or very weak where they exist. In COP 10, SCMS will work with GoN and other partners as appropriate.

SCMS will continue to maintain its office operations and staff development activities to ensure that required human resources are available to support the provision of the various technical interventions as planned.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HMBL | 750,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | MTCT | 2,674,916 | |

**Narrative:**

ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS

SCMS Nigeria provides procurement, systems strengthening (SS) services and strategic information for USG and PEPFAR Implementing Partners (IPs). It also provides systems strengthening services for building logistics management capacity to 4 main GON departments (NASCP, FDS, DPRS, and NACA).

SCMS supports PEPFAR programs in Nigeria by providing increased access to quality HIV/AIDS related commodities. Key SCMS activity under this program area includes: procurement, shipment, clearing, distribution and delivery of PMTCT related supplies and equipments including ARV prophylaxis for HIV-infected pregnant women and newborns, rapid test kits (RTKs), laboratory supplies and equipments, as well as other medical and non medical supplies used in PMTCT services. SCMS is also involved with other supply chain management related activities such as technical assistance (TA) and systems strengthening (SS) activities for PEPFAR IPs and the Department of Defense (DoD) to strengthen or build their supply chain management capacity within their respective programs. Through its continuous support to and strengthening of commodity security in PEPFAR treatment programs, SCMS works towards ensuring availability of needed commodities required by the PEPFAR supported programs for the target populations of pregnant women and children under 5 years old.

In COP09, SCMS procured PMTCT related supplies and equipments including ARV prophylaxis for HIV-infected pregnant women and newborns, rapid test kits (RTKs), laboratory supplies and equipments, as well as other medical and non medical supplies used in PMTCT services, for IPs and DoD through a pooled procurement arrangement. In COP 10, SCMS will continue to procure these PMTCT related supplies, equipments and medical supplies for IPs and DoD using the pooled procurement mechanism.

The budget is broken out as follows: 1) Provision of HIV test Kits to all PEPFAR PMTCT programs ($XXX): DoD (#554.08); Columbia University (CU)/ICAP (#2768.08); Family Health International (FHI)/GHAIN (#552.08); Harvard University School of Public Health (HSPH)/APIN+ (#544.08); University of Maryland (UMD)/Institute of Human Virology (IHV)/ACTION (#632.08); Catholic Relief Services (CRS)/AIDSRelief (#3688.08); Catholic Relief Services (CRS)/ 7 Dioceses (#3689); The International Foundation for Education and Self-Help (IFESH) (#555.08); LMS (#7144.08); Africare (#XXX); Society for

Family Health (SFH) (#XXX), TB-CAP (#XXX) and USAID's APS (#5236.08); and CDC's RFA (#5230) upon award. 2) Provision of other PMTCT related supplies, equipment or technical assistance for two IPs and DoD, each of which has attributed specific funds to SCMS for these services: DoD (#554.08), $XXX; ICAP(#2768.08), $ XXX, UMD/ACTION (#632.08), $ XXX; USAID's APS (#5236.08); and CDC's RFA (#5230) upon award $ XXX. The present budget will cover the cost of commodities as well as well as logistical and administrative services from the field office for the coordination and management of the procurements undertaken by SCMS related to this area of work. The budget also supports the cost of TA and SS as may be requested by DoD and the IPs.

SCMS will support the IPs and DoD in the following areas of the supply chain management cycle: product selection in accordance with the Federal Government of Nigeria's (FGoN) national HIV testing algorithm, marketing authorization status (NAFDAC registration) and FGoN importation regulation. SCMS will also be responsible for ensuring that commodities procured meet eligibility criteria under the USG acquisition rules and regulations including source and origin waivers and approvals or tentative approvals by the US Food and Drug Administration or other relevant stringent drug regulatory authorities, depending on the type supply or equipment.

SCMS will assist in quantification and forecasting of requirements and will support the development of long term supply plans (considering in country stocks and anticipated consumption rates) for stock management, monitoring of stock levels and usage through the deployment of pipeline databases and delivery planning. Additionally SCMS will monitor product safety and maintain a tracking system for recalls (pharmacovigilance). Requests for commodities will continue to be addressed to and coordinated with SCMS field office directly.

In addition to procuring required test kits for both training and use, SCMS will handle all the test kits donated by GoN to support PEPFAR programs.

SCMS will continue to identify suitable sources of supply both internationally and nationally. SCMS will work with IPs in Nigeria to locally procure products that are either banned for importation or for which local procurement represents a key advantage in terms of cost, delivery and/or associated services (i.e. maintenance service).

SCMS will coordinate with the USG team to ensure selected products are appropriately registered in Nigeria. For products not yet registered by NAFDAC, SCMS will make suitable recommendations including waiver applications where appropriate. SCMS will take the lead to communicate with manufacturers on registration gaps in Nigeria.

SCMS procurement leverages global spend to provide best value and offers clients certainty of competitive prices and international quality standards. SCMS procurement strategy is articulated around buying generics whenever possible, pooling procurement for HIV/AIDS care, prevention and treatment programs across PEPFAR focus countries and negotiating long term contracts with suppliers.

SCMS will be responsible for the shipment of procured commodities into Nigeria through Abuja or other points of entry as required. SCMS will continue to follow official procedures for customs clearance as appropriate including management of the CC1, CC2 or CC3 duty exemption forms. SCMS will coordinate with the USG team to fulfill importation requirements and provide needed documentation to allow customs clearance in an efficient and timely manner.

Where appropriate, commodities requested by the IPs and USG will be supplied through the SCMS Regional Distribution Center (RDC) in Ghana. The warehousing of commodities in the RDC is a critical component of the SCMS technical solution. The use of the RDC will significantly reduce lead times and provide an important buffer between the supply from manufacturers and demands from the PEPFAR programs in Nigeria. The RDC also ensure that shipment quantities do not overwhelm their recipients in country, an increasing challenge in the context of program scale up. The RDC concept also brings an increased flexibility in stock management thus reducing risk of stock obsolescence or need for emergency replenishments, resulting in important savings. Finally, the RDC approach serves regional and national sustainability, as the RDC is designed to be a commercially viable entity, available to other health (and non-health) programs, whose benefit will last beyond SCMS. Where possible and appropriate, SCMS will road freight from the RDC Ghana to Abuja; a mode of delivery that provides further significant savings over airfreight. For local warehousing needs, SCMS will continue to use its pharmaceutically compliant warehouse (primarily as a cross-docking facility) in Abuja which additionally will be capable of redirecting potential overstocked items, if necessary, to avoid expiry and waste.

Delivery arrangements will continue to be negotiated with the IPs; SCMS will either deliver to a central location or to point of services as needed. It should however be noted that the current distribution system for GoN programs and IPs is still sub-optimal. In COP 09, SCMS commenced implementation of the recommendations from the distribution options study (conducted in COP 08). In COP 10, SCMS with support of USG and the IPs will design and implement a more harmonized transport system for identified commodities to be delivered to a series of regional warehouses from which each IP or site will pick up its commodities. This will result in significant reduction of distribution costs by eliminating overlapping IP-specific distribution routing from various regions to Abuja. It is envisaged that this area will provide an opportunity to work with private sector providers and support collaboration between them and the GoN and IPs in mutually rewarding Public Private Partnerships. It will also follow a model already in place in which GoN and GF commodities are distributed by private-sector third-party logistics providers. Finally in

COP 10, SCMS will analyze last mile delivery options to further reduce redundancies in PEPFAR commodity distribution to sites in subsequent years, and to harmonize with the GON system as a step toward eventual integration. In order to efficiently manage the delivery of commodities as appropriate, SCMS will competitively source for and utilize the service of an efficient and safe in-country courier services operator.

In COP 10, SCMS will continue to provide TA and SS services to DoD and the IPs through training in the use of the ProQ or Quantimed forecasting and Pipeline supply planning tools. SCMS will continue to provide TA and SS services to DoD based on the recommendations that came out of a supply chain system's assessment carried out in COP07.

In COP 10, SCMS will continue to provide the USG team and the IPs with regular reports on commodity procurement as well as monthly financial reports and also assist IPs to monitor/report on stock levels and usage through the deployment of Pipeline databases. SCMS will also support the Supply Chain Support Teams (made up of technical SCMS staff and GoN or IP staff as appropriate) constituted by SCMS to work with the IPs in providing their trained logisticians with the capacity to monitor and support the performance of the supply chains at various levels. The Supply Chain Support Teams will use standardized indicators of logistics performance to track performance of the supply chains and together act as an early warning system to identify impending or imminent supply chain breakdowns and act to forestall these. By developing methodologies and tools for conducting these activities, SCMS will work with GoN and IPs to establish and institutionalize this activity thereby building the capacity to identify these problems and resolve them before service delivery is compromised. The automated web based procurement tracking database will ensure that the USG team and IPs have adequate visibility on SCMS procurement status since it provides an easy access to accurate and up to date information on procurement. It is envisaged that further procurement automation and harmonization will be facilitated through linkages with the Logistic and Health Program Management Information Platform system.

Under this program area, SCMS does not have targets of its own but supports PEPFAR IPs and DoD reaching their PMTCT planned targets.

EMPHASIS AREA
Human capacity development.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HLAB | 2,130,224 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HTXD | 66,107,376 | |

**Narrative:**

ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS
SCMS Nigeria provides procurement, systems strengthening (SS) services and strategic information for USG and PEPFAR Implementing Partners (IPs). It also provides systems strengthening services for building logistics management capacity to 4 main GON departments (NASCP, FDS, DPRS, and NACA).

SCMS supports PEPFAR programs in Nigeria by fostering increased access to quality HIV/AIDS related commodities. Key SCMS activities under this program area includes: procurement, shipping, clearing, distribution and delivery of antiretroviral (ARV) drugs. SCMS is also involved with as other supply chain management related activities such as technical assistance (TA) and systems strengthening (SS) activities for PEPFAR IPs and the Department of Defense (DoD) to strengthen or build their supply chain management capacity within their respective programs. Through its continuous support to and strengthening of commodity security in PEPFAR treatment programs, SCMS works towards ensuring availability of ARV drugs required by the PEPFAR supported programs to provide care and treatment services for the target population of people living with HIV/AIDS.

In COP09, SCMS procured ARV drugs (adult and pediatric formulations used in first and second line treatment regimens, salvage therapy, and post exposure prophylaxis) for IPs and DoD. SCMS also provided technical assistance in the area of product selection for GoN Product Selection Committee. Two commonly used ARVs in the PEPFAR supported programs in Nigeria were procured under a pooled procurement arrangement which resulted in significant cost savings and more efficient order processing. In COP 10, SCMS will continue with the pooled procurement of these ARVs and with guidance from USG, the number of ARVs to be procured using the pooled mechanism will be increased from the current 2 ARVs to XX. The funds allocated to SCMS by the IPs and DoD, for these services is as follows: DOD (#554.08), $XXX; Harvard University School of Public Health (HSPH)/APIN+ (#544.08), $ XXX; University of Maryland (#632.08), $ XXX; CRS AidsRelief (#3688.08), $ XXX; Columbia University/ICAP (#2768.08), $ XXX; GHAIN (#XXXX.08), $ XXX; LMS (#XXXX.08), $ XXX; CHAN NiCAB (#XXXX.08), $ XXX; PFD (#XXXX.08), $ XXX; and URC (#XXXX.08), $ XXX. The budgets will cover the cost of commodities as well as logistical and administrative services from the field office for the coordination and management of the procurements undertaken by SCMS. The budget also supports the cost of TA and SS for USG and PEPFAR partners.

In COP 10, SCMS will continue to support the IPs and DoD in the following areas of the supply chain management cycle: product selection in accordance with the Federal Government of Nigeria's (FGoN) national treatment guidelines, marketing authorization status (NAFDAC registration) and FGoN importation regulation. SCMS will also be responsible for ensuring that commodities procured meet eligibility criteria under the USG acquisition rules and regulations including source and origin waivers and approvals or tentative approvals by the US Food and Drug Administration. SCMS will assist in quantification and forecasting of requirements and will support the development of long term supply plans (considering in country stocks and anticipated consumption rates) for stock management, monitoring of stock levels and usage through the deployment of pipeline databases and delivery planning. Additionally SCMS will monitor product safety and maintaining a tracking system for recalls (pharmacovigilance). Requests for ARV drugs will continue to be responded to and coordinated with SCMS field office directly.

SCMS will identify suitable sources of supply and will coordinate with the USG team to ensure selected ARV drugs are appropriately registered in Nigeria. For ARV drugs not yet registered by NAFDAC, SCMS will make suitable recommendations including waiver applications where appropriate. SCMS will take the lead to communicate with manufacturers on registration gaps in Nigeria.

SCMS procurement leverages global spend to provide best value and offers clients certainty of competitive prices and international quality standards. SCMS procurement strategy is articulated around buying generics whenever possible, pooling procurement for HIV/AIDS care, prevention and treatment programs across PEPFAR focus countries and negotiating long term contracts with suppliers.

SCMS will be responsible for the shipment of procured commodities into Nigeria through Abuja or other points of entry as required. SCMS will continue to follow official procedures for customs clearance as appropriate including management of the CC1, CC2 or CC3 duty exemption forms. SCMS will coordinate with the USG team to fulfill importation requirements and provide needed documentation to allow customs clearance in an efficient and timely manner.

Where appropriate, commodities requested by the IPs and USG will be supplied through the SCMS Regional Distribution Center (RDC) in Ghana. The warehousing of commodities in the RDC is a critical component of the SCMS technical solution. The use of the RDC will significantly reduce lead times and provide an important buffer between the supply from manufacturers and demands from the PEPFAR programs in Nigeria. The RDC also ensure that shipment quantities do not overwhelm their recipients in country (an increasing challenge in the context of program scale up). The RDC concept also brings an increased flexibility in stock management thus reducing risk of stock obsolescence or need for emergency replenishments, resulting in important savings. Finally, the RDC approach serves regional and national sustainability, as the RDC is designed to be a commercially viable entity, available to other

health (and non-health) programs, whose benefit will last beyond SCMS. Where possible and appropriate, SCMS will road freight from the RDC Ghana to Abuja; a mode of delivery that provides further significant savings over airfreight. For local warehousing needs, SCMS will continue to use its pharmaceutically compliant warehouse (primarily as a cross-docking facility) in Abuja which additionally will be capable of redirecting potential overstocked items, if necessary, to avoid expiry and waste.

Delivery arrangements will continue to be negotiated with the IPs; SCMS will either deliver to a central location or to point of services as needed. It should however be noted that the current distribution system for GoN programs and IPs is still sub-optimal. In COP 09, SCMS commenced implementation of the recommendations from the distribution options study (conducted in COP 08). In COP 10, SCMS with support of USG and the IPs will design and implement a more harmonized transport system for identified commodities to be delivered to a series of regional warehouses from which each IP or site will pick up its commodities. This will result in significant reduction of distribution costs by eliminating overlapping IP-specific distribution routing from various regions to Abuja. It is envisaged that this area will provide an opportunity to work with private sector providers and support collaboration between them and the GoN and IPs in mutually rewarding Public Private Partnerships. It will also follow a model already in place in which GoN and GF commodities are distributed by private-sector third-party logistics providers. Finally in COP 10, SCMS will analyze last mile delivery options to further reduce redundancies in PEPFAR commodity distribution to sites in subsequent years, and to harmonize with the GON system as a step toward eventual integration. In order to efficiently manage the delivery of commodities as appropriate, SCMS will competitively source for and utilize the service of an efficient and safe in-country courier services operator.

In COP 10, SCMS will continue to provide TA and SS services to DoD and the IPs through training in the use of the ProQ or Quantimed forecasting and Pipeline supply planning tools. SCMS will continue to provide TA and SS services to DoD based on the recommendations that came out of a supply chain system's assessment carried out in COP07 including the establishment of a government owned, contractor operated warehouse, as part of SCMS strengthening of the host government's ARV program which is expected to bring a long term solution contributing to the sustainability of the military HIV/AIDS programs in Nigeria.

In COP 10, SCMS will continue to provide the USG team and the IPs with regular reports on ARV drugs as well as monthly financial reports and also assist IPs to monitor/report on stock levels and usage through the deployment of Pipeline databases. SCMS will also support the Supply Chain Support Teams (made up of technical SCMS staff and GoN or IP staff as appropriate) constituted by SCMS to work with the IPs in providing their trained logisticians with the capacity to monitor and support the performance of the supply chains at various levels. The Supply Chain Support Teams will use standardized indicators of

logistics performance, to track performance of the supply chains and together, act as an early warning system to identify impending or imminent supply chain breakdowns and act to forestall these. By developing methodologies and tools for conducting these activities, SCMS will work with GoN and IPs to establish and institutionalize this activity thereby building the capacity to identify these problems and resolve them before service delivery is compromised. The automated web based procurement tracking database will ensure that the USG team and IPs have adequate visibility on SCMS procurement status since it provides an easy access to accurate and up to date information on procurement. It is envisaged that further procurement automation and harmonization will be facilitated through linkages with the Logistic and Health Program Management Information Platform system.

Under this program area, SCMS does not have targets of its own but supports PEPFAR IPs and DoD reaching their planned treatment targets.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HVTB | 258,626 | |

**Narrative:**

None

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 7355** | **Mechanism Name: USAID Track 2.0 FS ABE/LINK** |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Contract |
| Prime Partner Name: TBD | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: Yes | Global Fund / Multilateral Engagement: No |

Total Funding: Redacted

| Funding Source | Funding Amount |
|---|---|
| Redacted | Redacted |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Education | REDACTED |
| Human Resources for Health | REDACTED |
| Water | REDACTED |

## Key Issues

Increasing gender equity in HIV/AIDS activities and services

Increasing women's access to income and productive resources

## Budget Code Information

| | | | |
|---|---|---|---|
| **Mechanism ID:** | **7355** | | |
| **Mechanism Name:** | **USAID Track 2.0 FS ABE/LINK** | | |
| **Prime Partner Name:** | **TBD** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Care | HKID | Redacted | Redacted |
| **Narrative:** | | | |
| None | | | |

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| | |
|---|---|
| **Mechanism ID: 7356** | **Mechanism Name: USAID Track 2.0 FS Health** |

| | |
|---|---|
| | **20/20** |
| Funding Agency: U.S. Agency for International Development | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Abt Associates | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 2,300,000** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 2,300,000 |

## Sub Partner Name(s)

| | | |
|---|---|---|
| Aga Khan Foundation | Bitran y Asociados | BRAC University |
| Broad Branch Associates | Deloitte Consulting Limited | Forum One Communications |
| Research Triangle International | Training Resources Group | Tulane University' School of Public Health and Tropical Medicine |

## Overview Narrative

The Health Systems 20/20 cooperative agreement, funded by the U.S. Agency for International Development (USAID) for the period 2006-2011, helps USAID-supported countries address health system barriers to the use of life-saving priority health services. Health Systems 20/20 works to strengthen health systems through integrated approaches to improving financing, governance, and operations, and building sustainable capacity of local institutions.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 150,000 |

## Key Issues

(No data provided.)

## Budget Code Information

| | | | |
|---|---|---|---|
| **Mechanism ID:** | **7356** | | |
| **Mechanism Name:** | **USAID Track 2.0 FS Health 20/20** | | |
| **Prime Partner Name:** | **Abt Associates** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Other | HVSI | 700,000 | |

**Narrative:**

1. Assess the role of non-state actors in HIV/AIDS prevention and mitigation
In Nigeria, similar to other low income countries, the role of non-state actors in HIV/AIDS prevention, treatment, care, support and control is expected to be substantial. Among others, these stakeholders include NGOs, CSOs and FBOs. It is important for policy to assess the role of non-state actors, how many resources are they mobilizing, from what sources, as well as for what purpose. Further, in which HIV/AIDS services are non-state actors' resources allocated and used. The study will also track the number of people that are benefiting from each of the NGO interventions and services, and estimation of the unit costs will also be conducted. Based on evidence generated from the survey, recommendation will be made to improve contribution of non-state actors in HIV/AIDS as well as to facilitate consultation and dialogue on improving policy and operational environment. A comprehensive report of the study will be produced and disseminated/presented for relevant stakeholders.
• Method/Strategies: Survey of a sample of FBOs and NGOs working in HIV/AIDS and their facilities
• Deliverables: Sample NGOs and FBOs Survey report; Presentation of survey findings and facilitation of discussion
Budget: $300,000

2. Assessing the role of non-health sector government ministries and agencies and mainstreaming of HIV/AIDS
HIV/AIDS is multisectoral by nature and in addition to the National AIDS Control Agency and the Federal Ministry of Health,
other departments and government agencies are expected to mainstream and play their roles in HIV/AIDS prevention and control.
Assessment of key relevant Ministries (including Defense, Education, Transport, Mining, Energy, Police, Prison, etc.) will be conducted
and their roles in HIV/AIDS will be assessed. In this process, sectoral policies, strategic and annual work plans and budgets of selected
Ministries and agencies as well as their performance and financial report will be assessed to understand the level of mainstreaming of

HIV/AIDS.
• Method/Strategies: Survey of selected federal and state level non-health sector ministries;
Review of government expenditure and audit reports
• Deliverables: • Ministries and Agencies survey report; Presentation of survey reports and facilitation of discussion to strengthen
mainstreaming of HIV/AIDS
Budget: $60,000

3. Cost-effectiveness of ART Service Delivery in Nigeria
As the resource implications of expanding anti-retroviral therapy (ART) are likely to be large, there is a need to explore its
cost-effectiveness. Also, there is a need to tie the cost-effectiveness information on ART to different modes of delivery, i.e.,
through lower level health facilities vs. higher level facilities. This may inform the procedure or appropriateness of a plan to
decentralize ART or other HIV-related curative/care services in the future. So far, there is no such information available from
Nigeria, where such services remain highly centralized.
Objective
To assess the cost-effectiveness of ART service delivery across a sample of disparate delivery settings (secondary facility,
and an expanded primary care facility) in Nigeria.

Methods
Estimate the unit cost of HIV-related care from the 2009/10 fiscal year expenditure of three different health care facilities
in Nigeria, across tertiary, secondary, and primary levels. The study will include both direct and overhead costs. The study
will utilize service records for the cohorts of patients accessing ARV Treatment. Service costs will be included from the
point of identification of an HIV+ individual as 'eligible' to the continuing period of treatment up to a potential of seven years
on treatment (or other maximum number for the cohorts in the facilities). The health effect of incremental years of life
gained (YLG) will be estimated for patients receiving ART compared with those not receiving such treatment.
Cost-effectiveness for the average patient in each of facilities will be estimated as the dollars per

incremental YLG,
and compared. For capturing the uncertainties inherent in the model, the study will apply appropriate techniques,
ranging from Markov Modeling to Monte Carlo methods, as appropriate.
Budget: $250,000

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Other | OHSS | 1,600,000 | |

**Narrative:**

1. Public Expenditure Tracking Survey in Nigeria (3 states)
Description: This activity is continuing from Year 3 of the Health Systems 20/20 Project. The Health Systems Assessment
tool was successfully applied in Nigeria during FY 2008-9. Nigeria's assessment results indicated an acute weakness in
resource tracking for health across state and LGA levels, with a lot of missing information on resource pass-through and
utilization, as well as findings on inadequacy of resource availability at frontline service delivery points. Health Systems 20/20 proposes to conduct a Public Expenditure Tracking Survey (PETS) in three high-priority states, using the basic methodology developed by the World Bank over several years and since then used in various countries for health, education, and other social sectors. A prior PETS in Nigeria (World Bank, 2002) tracked extensive leakages in the allocation of health-related budgets, especially for salaries, in two states (Kogi and Lagos). The proposed HS 20/20 survey, aimed at a sample of health facilities in each of the three priority states, will track the link between health related resource flows and outcomes. The proposed activity will complement the activity to conduct a Public Expenditure Review
in four PATHS-2 states in Nigeria (a DFID supported project). The states chosen by HS 20/20 for PETS will be separate and in addition to the
four PATHS-2 states. Joint development of tools will reduce costs to USAID, while the joint product across seven states will
produce a richer source of public expenditure related information for policymakers. The PETS is intended to address issues
such as the following at the facility level:
• Spending inconsistent with allocation (leakage?)
• Inconsistency of records between different levels (leakage?)
• Patterns of actual allocation of resources across districts and facilities (equity and efficiency?)
• Delays in financial transfers or distribution of material
• Ghost workers and absenteeism based on salary payments

• Collection of user fees inconsistent with projected demand (leakage?)
Budget: $400,000

2. System Wide Effects of HIV/AIDS Programming - Opportunities for Vertical-Horizontal Integration/Improvement
Description: HS 20/20 was requested by NACA to assist in a review of Nigeria's experience with GFATM grants over the
past several years, focusing on the effects on the wider health system, and especially on the discovery of opportunities
for enhanced vertical-horizontal integration. This request was matched by interest in the USG mission in Nigeria towards
identifying similar opportunities for integration and improvement of PEPFAR-related activities with the wider health system
in Nigeria. The System Wide Effects methodology – developed under the PHRPlus project – is well-suited to answer these
questions. HS 20/20 proposes to apply the methodology, with a 'backward' looking focus to understand the experience
with the GFATM grants; and a 'forward' looking focus to identify opportunities for better integration of both GFATM and
PEPFAR programming with the wider health system. For both backward and forward-looking parts, HS 20/20 will focus on:
• Effects upon the policy environment and opportunities therein
• Effects upon the public-private mix and opportunities for greater PPM
• Effects upon human resources, and how to mitigate them or achieve better integration
• Effects upon pharmaceuticals and commodities, how to mitigate them or achieve better integration

HS 20/20 will implement SWEF in Nigeria with a quantitative facility survey (of health centers
and clinics managers and with health workers) and a qualitative survey consisting of in-depth
interviews with key informants who were policymakers, program heads and implementers from
government offices (national and regional), health facilities, non-governmental organizations
(NGO,) donors, the Nigeria Country Coordinating Mechanism (CCM), and key program experts.
Budget: $225,000

3. Priority Interventions from the Nigeria HSA: Developing Decision-Support Software to Enhance the Use of the DHIS in Nigeria
Description: This activity is continuing from Year 3 of the Project. The Health Systems Assessment tool was successfully applied

in Nigeria during FY 2008-9. A crucial piece of conducting a Health Systems Assessment is the ability to respond to urgent priorities
identified. Nigeria's assessment results indicated an acute weakness in the quality, availability and utilization of HMIS data for facility
management and performance. As part of a targeted intervention, HS 20/20 was requested to strengthen capacity of federal and state
institutions to use HMIS data in order to improve planning and management, services and programs in three states with highest needs,
and the federal level. Nigeria has begun implementing the open-source 'District Health Information System' (DHIS) in a phased manner,
with included HIV/AIDS modules. The proposed activity will focus on building a suite of "Data aggregating / Data Analysis" tools which
will take as inputs the HIV/AIDS data from the DHIS and produce decision-support evidence for higher level policymakers at the state
and federal level (NACA). The work will include the following steps:
1) identifying policymaking users for the DHIS data on HIV/AIDS in the three states and federal level (NACA),
2) developing decision support software to facilitate the aggregation, analysis and utilization of facility level HIV/AIDS DHIS data by
state & federal level managers
3) pilot testing and implementing the new software system in the three states and federal level (NACA),
4) conducting training and capacity building of state and federal level (NACA) users of the policymaking data based on DHIS,
5) preliminary impact analysis of the improved decision-support system for the DHIS.
Budget: $350,000

4. Developing & Implementing a State Level HRIS in Nigeria in Three Priority States
Description: Human resources for health are a critical component of any health system. Strengthening management of HRH allows
countries to adequately deploy, manage and reward staff. Computerized human resource information systems are an essential tool for
capturing HR data on personnel profiles, access to training, and information on past and current positions/deployments etc. When used
properly, an HRIS is an excellent tool for HR planning and management. In Nigeria, HS 20/20 was requested to assist in HRIS development.
his activity will complement state-level HRIS investments in capacity-building that the PATHS-2 project (a DFID supported initiative) is

implementing in its four focal states. The states chosen by HS 20/20 will be in addition to the four PATHS-2 states. The joint development
of initial 'needs' assessment instruments and coordination of HRIS activities will reduce costs for USAID. In sum, HS 20/20 proposes to
implement the HRIS in 3 priority states. The activity will have the following phases:
• Phase 1. Assessment of existing HRIS and customization of HRIS solution to state needs (Month 1-Month 4). The HS 20/20 team will
work with national and state level stakeholders to build consensus on the scope, sequencing, and design and customization of the HRIS.
The team will analyze the current system, develop a preliminary sketch of the state level HRIS, map data flows, identify strengths and
weaknesses and liaise with key stakeholders involved in HRIS management (state civil service, LGA, SMOH etc). The results of these
state assessments will provide information to guide the customization of the HRIS. A requirements engineering process will be carried
out in conjunction with an infrastructure assessment to inform an investment plan. An M&E plan will also be developed during this phase.
• Phase 2. Pilot test, adapt and roll-out HRIS (Month 5 – Month 12). Phase 2 will involve piloting the system in selected states, addressing
software issues, developing training curricula and guides, developing standard operating procedures and beginning roll-out of the HRIS
• Phase 3. Provide ongoing support and extend roll-out to additional states (Month 12 -18) Phase 3 will involve establishing a support
infrastructure, extending the HRIS to additional states, training state level managers on data use and M&E of activity implementation.
• Phase 4. Document experience and lessons learned (Month 18-20) HS 20/20 Project will document the Nigeria state level experience with
HRIS development, identify key lessons learned and disseminate the information in national and international forums.
Budget: $375,000

5. Training of Trainers and Mentored Roll-out of Training on Financial Management for Health System Managers (Pilot)
Description: For health managers at the state and LGA levels in Nigeria to have adequate training in stewarding the financial resources
available to them for programmatic spending is of the highest priority. Health system managers with task-oriented training in this

respect will be better able to ensure on-budget delivery of services, better tracking of resource spending, and generally provide for
more efficient and transparent public health systems. The HS 20/20 project was requested to assist in training 'trainers' (also mentors)
who will provide one-on-one coaching and mentoring to a certain number of key health managers in some pilot LGAs and states. The
trainers/mentor will be retired Nigerian civil servants or senior business managers who are respected as a manager and change agent.
He/she will be further trained by the project to be an effective mentor. Trainers/mentors will address the unique needs of each staff member,
empowering all staff to perform financial management optimally. The Mentors will be supported by project staff and other short term
technical assistance from HS 20/20. Training curricula/materials will be based on existing materials widely used in sub-Saharan Africa,
adapted to the Nigerian context.
• Phase 1. Adapt existing health-related financial management curricula for Train-the-trainers - to the Nigerian context.
• Phase 2. Training of a cohort of selected trainers/mentors in Abuja (one week training)
• Phase 3. Orientation of health managers who will receive training in pilot LGAs and state-level health offices.
• Phase 4. Roll-out of mentors/trainers to the pilot LGAs and state-level health offices; with monitoring from HS 20/20 for up to 8 months.
Review of the experience with the LGAs and state-level health managers, focusing on improvements in financial management.
Budget: $250,000

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 7359** | **Mechanism Name: USAID Track 2.0 FS AIDSTAR Prevention** |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Contract |
| Prime Partner Name: John Snow, Inc. | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |

| | |
|---|---|
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 2,145,000** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 2,145,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## Key Issues

Addressing male norms and behaviors

Increasing gender equity in HIV/AIDS activities and services

## Budget Code Information

| **Mechanism ID:** | **7359** | | |
|---|---|---|---|
| **Mechanism Name:** | **USAID Track 2.0 FS AIDSTAR Prevention** | | |
| **Prime Partner Name:** | **John Snow, Inc.** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Prevention | HVAB | 2,145,000 | |

**Narrative:**

ACTIVITY DESCRIPTION: AIDSTAR will be required to identify and build planning and managerial capacity of local partners as well as strengthen local technical capacity to deliver high-quality comprehensive AB prevention programs and services aimed at promoting partner reduction and preventing transactional sex. Specific activities will entail the identification and building the capacity of

indigenous faith-based and community-based organizations (FBOs and CBOs) to provide high quality prevention programming that will bring about effective behavior change as it relates to reduction of multiple sexual partners and transactional sex. In addition, AIDSTAR will undertake community based activities to facilitate normative changes that enhance the practice of abstinence and mutual fidelity. These activities will address adults, and men in particular, with messages that promote fidelity, discourage male norms that encourage risky behaviors, encourage partner reduction through risk reduction messages and personal risk perceptions skills. Activities will also focus on unmarried young men and women across the board who are at high risk owing to contextual factors (domestic workers, street vendors, etc.). Messages will be tailored to each target group. Activities to prevent transactional sex and or protect youth involved in transactional sexual relationships will focus on skills based HIV education for vulnerable young women and young men with broad based community activities that create supportive normative environment for the practice of abstinence and fidelity. Influencers of young people, including parents, teachers, religious leaders and community leaders will also be reached. These interventions will be reinforced with mass media activities that highlight the importance of mutual fidelity, risk behavior reduction and avoidance of transactional sex. AIDSTAR will concentrate activities in areas that will be identified through secondary analysis of national behavioral data generated through the Project SEARCH data triangulation exercise and the NARHS+ survey. AIDSTAR will utilize a minimum package of interventions identified from a pool of best practices in the national prevention plan to provide high quality prevention interventions for the population group identified. These interventions include: peer education interventions, peer education plus models, workplace programs, community awareness campaigns, school based program approaches, intervention programs to address issues of vulnerability, provision of STI management, and infection control measures in clinical settings. The national prevention plan 2007-2009 recommends that a minimum of three of these interventions be used to reach each target while mass media activities will serve as reinforcement. The AIDSTAR prevention program will build capacity of community-based, faith-based, and other non-governmental organizations (CBOs, FBOs and NGOs) to provide this minimum package intervention for the specific population groups. Technically this will entail familiarizing the organizations with the minimum package modules and adopting a program approach that ensures delivery of the package. AIDSTAR will reach 97,500 individuals utilizing minimum package interventions that promote abstinence and/or being faithful (AB) with 32,500 individuals reached through interventions that promotes abstinence only (a subset of total reached with AB). 500 individuals will be trained to promote HIV/AIDS prevention programs and 25 organizations will receive capacity building toward high quality prevention programs for identified high risk population. AIDSTAR will document and disseminate best practices; successful and innovative approaches with lessons learned and share these with their implementing agencies as well as other partners within the PEPFAR program in Nigeria. In COP 09, a particular focus will be on lessons learned on effective approaches for improving linkages between clinical services and community based services to provide basis for strengthening the prevention with positives programs and other specific interest high risk groups programs. Implementation

| |
|---|
| will be through NGOs, CBOs and FBOs whose capacity has been built by AIDSTAR and who have the capacity for rapid scale up. Within the initial 6 months of implementation, capacity-building for provision of prevention (AB) services for identified FBOs and CBOs will be carried out, followed by development of materials on prevention of cross generational and transactional sex. AIDSTAR interventions will be in line with national priority plan and national prevention plan. Geographic location will be negotiated with the GON with South-South, South-East and North-Central states considered as prime regions for selection, considering gaps in the PEPFAR response and based on the location of identified high risk groups from review of behavioral surveillance data of prevalence among these groups. CONTRIBUTIONS TO OVERALL PROGRAM AREA The programs and activities implemented will increase the reach of AB interventions into epidemiologically important populations to better address gaps in coverage and to better address specific behaviors within underserved populations. This AIDSTAR prevention program, delivered through implementing agencies, will contribute to strengthening and expanding the capacity of the Nigerian response to the HIV/AIDS epidemic and increasing the prospects of meeting the Emergency Plan's goal of preventing 1,145,545 new infections. LINKS TO OTHER ACTIVITIES This activity also links with OVC and SI activities (i.e., the Project SEARCH activity for data informed program design). POPULATIONS BEING TARGETED: Populations targeted in these AB activities will include younger unmarried men and women and their corresponding figures-of-influence (parents, teachers and religious leaders) and adult males to better address issues around cross-generational and transactional sex. KEY LEGISLATIVE ISSUES ADDRESSED: Key legislative issues will address male norms and behaviors, and increased equity and access to information and services for women. EMPHASIS AREAS: The service delivery component will focus on information, education, and communication in the community and will build linkages with other sectors and initiatives. |

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 7382** | **Mechanism Name: DoD Track 2.0 DoD Agency** |
|---|---|
| Funding Agency: U.S. Department of Defense | Procurement Type: Contract |
| Prime Partner Name: US Department of Defense | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 7,022,218** | |
|---|---|
| **Funding Source** | **Funding Amount** |

| | |
|---|---|
| GHCS (State) | 7,022,218 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

The Walter Reed Army Institute of Research US Military HIV Research Program (USMHRP) maintains a fully serviced agency in Abuja Nigeria. This office is known as the Department of Defense HIV Program in Nigeria (DODHPN). The office is dedicated to PEPFAR country-level management activities (partners with the CDC and the USAID). These include participation in USG technical working group activities; strategic vision development and Country Operational Plan development. In addition to the USG country-level management activities, the office also directly implements PEPFAR activities in partnership with the Emergency Plan Implementation Committee (EPIC) of the Nigerian Ministry of Defence (NMOD). The partnership is dedicated to the provision of comprehensive HIV Prevention, Care and Treatment services to the Nigerian Military personnel, their dependents and catchment populations.

The Military to Military health diplomacy & partnership that serves as the foundation of the program is providing a working model for the current efforts at development of a partnership framework for Nigeria. Key examples from this program will be factored into the design of the framework.
The DOD HIV program and services are offered through 20 military sites that are located across 15 States of the Federation (Edo, Benue, Cross River, Rivers, Delta, Enugu, FCT, Kaduna, Lagos, Oyo, Plateau, Sokoto, Kano, Imo, and Anambra) and the Federal Capital territory. Primary target population includes military personnel, their dependents and the catchment population around the facilities. An estimated 2,200,000 people fall within this catchment population.

Human capacity development through regular training both locally and international for Military health personnel is a key HSS activity of the program that speaks to Human resources for Health issues within the military. Also a cohort of temporary  National Youth Service Corps (NYSC) Personnel who had been hired to bridge human resource gaps at sites have been facilitated to be absorbed by the Nigerian Military . Also a cadre of transition (contractor) staff (site administrators and data entry clerks) is currently in service at the sites and it is anticipated that these personnel will be absorbed also by the NMOD-EPIC program in the long term. The salaries of this cadre mirror the Government of Nigeria pay scale and can be sustained by the government in the future.
REDACTED. These activities are aimed at ensuring ownership and sustainability of the Nigerian Military response to the HIV epidemic and they are cross-cutting across several technical areas.

Cost efficiencies have been progressively achieved through a pooled procurement mechanism currently

in use in the Nigerian PEPFAR program. ARV drugs and test kits are centrally procured while the SCMS mechanism is used to do further procurements of other commodities in a pooled fashion.
Plans are in progress to commence the Government Owned-Contractor Operated (GOCO) warehousing mechanism that has cost saving attributes and sustainability potential for procurement, storage and delivery of HIV and other health related materials.

For monitoring and evaluation purposes, the program has a functional SI unit that provides technical support to the NMOD-EPIC team. Collectively they have developed harmonized tools for use in the program.
Routine Data quality audits (RDQA) and data dictionaries are built into the tools to allow for similar interpretation of both the National and PEPAR indicators.
Data quality assurance exercises are also conducted on a biannual basis at the sites during which the data collection sources, processes are reviewed and data integrity and reliability efforts are evaluated. Hands on training for data personnel are provided during such encounters.
Dedicated data entry specialists were recruited and deployed to the sites to further improve on the data gathering and use processes with training and re-training a major feature in the units' workplan.
An electronic medical records system (The Registry) is currently being developed and will soon be piloted in 10 selected sites. On complete deployment across the program, it will further simplify the data collation and use process. These activities are aimed at ensuring ownership and sustainability of the Nigerian Military response to the HIV epidemic and they are cross-cutting across several technical areas.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Construction/Renovation | REDACTED |
| Human Resources for Health | 720,000 |

## Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Military Population
TB

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **7382** |
| **Mechanism Name:** | **DoD Track 2.0 DoD Agency** |
| **Prime Partner Name:** | **US Department of Defense** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HBHC | 750,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HTXS | 2,450,000 | |

**Narrative:**

ACTIVITY ONGOING FROM FY2009
• Narrative combined; Targets updated

ACTIVITY DESCRIPTION:
This activity relates to activities in HCT, PMTCT, Basic Care and Support, and TB/HIV activities.

The Nigerian Military provides prevention, care and treatment to its service members and the surrounding civilian community (constituting approximately 75% of the Military's patient load). During COP10, the U.S. Department of Defense (DOD) – Nigerian Ministry of Defense (NMOD) HIV Program will continue to provide free care and treatment services in 20 military hospitals.

In COP10, DOD – NMOD will provide comprehensive ART services to a total of 11,577 adult patients. A total of 2,513 new patients will be enrolled on ART during the reporting period. Clinicians across the 20 sites will be assisted to promptly initiate support for ART eligible patients. Each site is an integrated hospital supporting HCT, laboratory, TB and other services. Linkages with both NMOD and other partner facilities will support referral of complicated or stable patients to ease overcrowding and maximize facility abilities. Care and support services will be provided to 19,700 HIV+ adults and children.

A major component of this activity is human capacity development - both in increasing numbers of providers and the training provided to them. The NMOD has committed to increasing and developing a sustainable treatment program by hiring 100 new health care professionals dedicated directly for PEPFAR goals (30 each physicians and nurses, 20 each laboratory scientists and pharmacists). In COP10, the DOD will support the training of an additional 100 health care workers, including doctors,

pharmacists, nurses, laboratory technicians, site administrators, commanders, and team leaders in the areas of ART services and 100 in care and support. Additional temporary staff through the National Youth Service Corps (NYSC) will be utilized. The base of training has included the three week ART training at the Infectious Disease Institute in Uganda and may continue to serve as a training component for COP10. This will complement local training utilizing the GON national guidelines and training manual/curriculum. Adherence counseling for ARVs and instruction of side effects and contra-indications is part of the NMOD internal ART course and each pharmacist is provided with initial and refresher training through this course. DOD will collaborate with the NMOD and the Institute of Human Virology, School of Medicine, University of Maryland to set up a Clinical Training Centre at the Nigerian Army Reference Hospital, Kaduna. The centre will provide didactic and clinical training for Health Care Workers and also serve as a mentorship site. It is envisaged that the centre when fully operational will provide the Nigerian Military with sustainable on-going in service capacity building.

In order enhance quality of care; the DOD will conduct on-site clinical mentoring via centrally located staff and DOD HQ Technical Assistance rotations. Dedicated Infectious Disease physicians will provide mentoring and continuing medical education courses through centralized in-country and on-site trainings on HIV/AIDS care and support, treatment, adherence and laboratory monitoring.

The third tenet of capacity development is infrastructural capacity building. This will be increased through refurbishments at each site as required by each site to improve patient flow and throughput. This will be accomplished through bilateral planning of both the NMOD and DOD funding. To date US DOD funding has provided refurbishments at seven sites and the NMOD has funded refurbishments at seven sites. One site was jointly refurbished (44 NARHK) due to its size and dual use as a NMOD treatment site and as a referral center for all of Kaduna State. Additional infrastructural upgrade will be carried out at the 44 NAHRK to accommodate the Clinical Training Centre.

The DOD-NMOD Technical Working Group will integrate with USG and MOH advisors to ensure that all activities and support are in compliance with national policies, curricula and guidelines. In addition, the DOD will ensure that routine meetings with all hospital staff involved in HIV/AIDS patient care occur monthly (or more frequently, as needed). This will support monitoring and evaluation of clinical outcomes and allow for dissemination of information and lessons learned to improve care
In COP 2010, the DOD will implement a Quality Improvement Program (QIP) consisting of an annual cross sectional Outcomes & Evaluation (O&E) exercise, the GON/USG supported HIVQual monitoring and quarterly Continuous Quality Improvement (CQI) activities in order to improve and institutionalize quality interventions. Activities will include standardizing patient medical records to ensure proper record keeping, evaluations of infection control, monitoring the utilization of National PMM tools and guidelines, efficiency of clinic services, referral coordination, and use of standard operating procedures across all disciplines and continuity of care at all supported sites. On-site technical assistance (TA) with more

frequent follow-up monitoring visits will be provided to address weaknesses when identified during routine monitoring visits.

Laboratory services provided will include CD4 ascertainment and follow up, liver function tests, hepatitis screening and management of abnormalities (e.g., elevated liver function, decreased hemoglobin/hematocrit) as appropriate. All patients will be screened for TB and malaria. Prophylaxis, treatment, and linkages to wraparound or other program areas will be provided appropriate.

In COP10, the DOD's "prevention for positives" program will be continued at all 20 military sites. Providers at each site will provide adherence counseling, syndromic management of STIs in line with National STI control policy and guidelines; risk assessment and behavioral counseling to achieve risk reduction; and prevention messaging to include partner reduction and/or mutual fidelity, correct and consistent condom use for PLWHAs, disclosure and partner testing. Condoms will be provided free of charge. Providers will counsel clients on their disclosure of HIV status and partner/family notification with an emphasis on client safety. Partner referrals for CT (individual and/or couple) will be provided. Also, referrals to community-based and barracks-based support groups will be provided to HIV+ clients. Linkages to support groups and services will also be enhanced by counselors who are members of PLWHA support groups. Referrals to family planning services will be provided as appropriate, as well as access to pregnancy testing when needed. Care kits for PLWHA will include preventative items, such as: an ITN, Waterguard, water vessels, soap, ORS, and condoms. These interventions will be implemented using the recently adapted HIV Prevention in Care and Treatment Settings Prevention Package, which includes several training packages and job aids.

NMOD and DOD participation in the USG ARV/Treatment and Care & Support Technical Working Groups to address care and treatment issues will promote harmonization with the GON and other Implementing Partners, thus strengthening the referral linkages and networks between partners close to NMOD sites. The program will also establish networks for community volunteers, including People Living with HIV/AIDS, to ensure cross-referrals. The DOD will continue to work with the GoN and other national stakeholders to develop networks for purposes of addressing sustainability issues, stigma reduction, treatment, and prevention activities. Linkages with other basic care partners and prevention groups (particularly prevention for positives) will also be supported. NMOD/DOD will also participate in National ART evaluation efforts, as well as provide input into the development of new guidelines such as the national HIV/nutrition guidelines.

Consumables and other supplies will be provided by a combination of two approaches. While the supply of some consumables will continue to be sourced by DOD from local vendors, the majority of funding for drugs and consumables will be invested in the Supply Chain Management Systems (SCMS). The DOD

program will continue support to the Nigerian Ministry of Defense (NMOD)-owned, contractor (SCMS) operated warehouse developed under COP07 funding. NMOD customs agents will clear imported supplies. Under training and supervision by SCMS contractors, the facility will distribute supplies directly to all NMOD Points of Service. The warehouse will function as both a receiving/distribution center and as a storage facility for buffer stock of critical items maintained in-country to protect against unforeseen shortages. This program fully adheres to USG and FGON policies and acquisition regulations, minimizes indirect costs and accomplishes NMOD capacity building in supply chain management. The program design ensures continued USG visibility and accountability at all levels of implementation.

A component of this activity will be supporting and maintaining links with active community-based organizations, home-based care providers (HBCs) and faith-based organizations (FBOs) that will provide at home follow up of patients attending ART clinics. While efforts will be strengthened to provide services to individuals in the community who cannot access ART services, a strong component of these efforts will be linking with local CBOs and FBOs since HBCs are limited in number at sites. Volunteers will be recruited and trained from existing PLWHA support groups. DOD will also work with, and support, the NMOD and its other partners in further developing internal guidelines, protocols and standard operating procedures (SOPs), using evidence-based interventions, particularly in the area of pediatric care and implementation of a preventive-care-package.
DOD has allocated $1,175,000 of its Adult ARV Services budget and $400,000 of its Adult Care and Support budget to SCMS for procurement of commodities. This amount is captured under the SCMS ARV Services and the SCMS Care and Support activities.

By the end of COP10, DOD will support 20 NMOD facilities in Anambra, Benin, Benue, Borno, Cross River, Delta, Enugu, the Federal Capital Territory (FCT), Imo, Kaduna, Kano, Lagos, Oyo, Plateau, Rivers, and Sokoto (15 states and FCT).

CONTRIBUTION TO OVERALL PROGRAM AREA:
Support of ART services will contribute to achieving 2010 PEPFAR targets and goals. The training of health care workers and community volunteers will contribute to human resource development to ensure the sustained delivery of high quality care and support and ART services in Nigeria.

LINKS TO OTHER ACTIVITIES:
This activity is linked to all prevention activities, HIV/AIDS/TB treatment and care services, drugs and laboratory infrastructure, and SI.

POPULATIONS TARGETED:
This activity will target all adults and their caregivers in the 20 military communities served, as well as the

civilian population in the surrounding communities, who are diagnoses as HIV+ and clinically assessed as suitable for treatment.
EMPHASIS AREAS:
This activity focuses on improving quality of care for those on ART, promoting adherence and measuring clinical outcomes.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HVCT | 65,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | PDCS | 75,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | PDTX | 100,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Other | HVSI | 100,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Other | OHSS | 140,002 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | MTCT | 283,436 | |

**Narrative:**

ACTIVITY ONGOING FROM FY2009

• Targets revised for COP10

ACTIVITY DESCRIPTION

The Nigerian Military provides prevention, care and treatment to its service members and the surrounding civilian community (constituting approximately 75% of the Military's patient load). The Department of Defense (DOD) – Nigerian Ministry of Defence (NMOD) HIV Program will provide free comprehensive PMTCT services, which will follow the revised national guidelines (2008), to 20 existing sites in COP10. 15,000 pregnant women will receive HIV counseling and testing for PMTCT and receive their test result. 600 women will receive a complete course of antiretroviral prophylaxis in a PMTCT setting. 120 individuals will be trained to provide these services.

A family-centered network approach will continue to be used and group health information with routine "opt out" counseling and testing will be provided to pregnant women presenting for antenatal services. Testing will be done following the National testing algorithm with same day results. Post-test counseling will include prevention counseling and education for both HIV+ and HIV- women. Partner testing will be promoted. DOD will promote couples counseling and testing to promote disclosure, address discordance and to increase support for infant feeding choices. Staff will counsel clients on their disclosure of HIV status and partner/family notification with an emphasis on client safety. Partner referrals for HCT (individual and/or couple) will be provided. Also, referrals to community-based and barracks-based support groups will be provided to HIV+ clients. Linkages will also be enhanced by counselors who are members of PLWHA support groups.

HIV testing will be offered to all women of unknown HIV status presenting for labor and delivery and in the postpartum period. In accordance with National guidelines, a full course of ARV prophylaxis will be provided to approximately 600 women. ARV prophylaxis will include ZDV at 28 weeks or 3TC/ZDV at 34/36 wks and single dose Nevirapine (sdNVP) and AZT/3TC in labor with a 7 day 3TC/ZDV tail. All HIV positive clients will be commenced on cotrimoxazole prophylaxis commencing after the first trimester and stopping at 36 weeks gestation. All infants born to HIV+ women will be provided with sdNVP at birth and ZDV for 6 weeks. HIV-exposed infants will be provided with cotrimoxazole (CTX) prophylaxis from 6 weeks and will be discontinued once confirmed HIV- and no longer breastfeeding. Post partum women who are clinically eligible for ART will be referred for ARV services at the sites. Family planning and other reproductive health best practices will be promoted while linkages to OVC activities will be enhanced.

Infant feeding education and counseling will begin in the antenatal period in accordance with National

guidelines, accompanied by appropriate prevention messages and education to all pregnant women and family members. After delivery, mothers and infants will be followed up to monitor the mother's health and to support the mother's compliance of her infant feeding option as well as to provide nutritional support for both. DOD will actively participate in Early Infant Diagnosis (EID) as a component of its pediatric care and treatment program, using revised national guidelines (2007).

In support of DOD's commitment to build capacity and long-term sustainability in the NMOD, formal training for an additional 120 staff from the existing 20 sites, covering physicians, nurses, midwives and others involved in PMTCT services will be conducted. Trainings will be done in line with the revised National PMTCT training curriculum (2007). By training uniformed members and civilian employees that are in a career track in the Government of Nigeria, this program fosters a generation of skilled workers who are more likely to remain in the military. This contributes to fulfilling PEPFAR goals for independent and sustainable programs.

In addition, commodities and equipment that are required in PMTCT services will be procured via SCMS ($150,000). Depending on site inventories and needs, commodities may include gloves, soap or other disinfectant and other medical consumables. Commodities will be provided to all 20 military sites.

By the end of COP10, the DOD will support 20 NMOD sites in Edo, Benue, Borno, Cross River, Rivers, Delta, Enugu, FCT, Kaduna, Lagos, Oyo, Plateau, Sokoto, Kano, Imo, Anambra and the FCT (15 states and FCT).

CONTRIBUTION TO OVERALL PROGRAM AREA
The DOD PMTCT program will providing HIV counseling and, testing to 15000 pregnant women and provide ARV prophylaxis to 600 women. This contributes to the goal of preventing new HIV infections in Nigeria. The PMTCT services identify HIV+ women who may need HAART for their own health, thus contributing to PEPFAR Nigeria's care and treatment goals.

LINKS TO OTHER ACTIVITIES
This activity relates to activities in adult and pediatric care and treatment, laboratory infrastructure, safe blood, TB/HIV, FP, Malaria,
Cervical cancer screening and strategic information. Pregnant women who present for counseling and testing services will be provided with information about the PMTCT program and referred accordingly. ART treatment services for infants and mothers will be provided through ART services. Basic pediatric care support, including TB care, is provided for infants and children through pediatric care and treatment activities. Linkages to OVC services will be made for orphans and vulnerable children.

POPULATIONS BEING TARGETED
This activity targets pregnant women and their family members. Activities also target military personnel, civilian employees, dependents and the general population in the communities surrounding the 20 sites.

EMPHASIS AREAS
This activity will address gender equity in HIV/AIDS programs by specifically targeting pregnant women and girls for counseling, testing and treatment.

In COP10, under 'PEPFAR Nigeria's accelerated PMTCT plan', DoD, will strengthen its support to PMTCT service delivery by implementing activities that further improve the coverage and quality of PMTCT services. These activities will be directed towards increasing utilization of PMTCT services at existing service outlets through demand creation in collaboration with community resources and ensuring the upgrade of existing supported PHCs offering stand alone HIV counseling and testing to render at least minimal package of PMTCT services. In order to leverage resources, priority will be given to PHCs located in the selected focal states with presence of other donor agencies and in local government areas already earmarked for HSS support through GFATM. Where new sites are envisioned, those that are used for national ANC sero-sentinel surveys but yet to commence PMTCT services as well as PHCs located in communities with high HIV prevalence rates above the National average will be given priority.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HLAB | 2,447,200 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HTXD | 511,580 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HVTB | 100,000 | |

**Narrative:**

None

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 10004** | **Mechanism Name: HHS/CDC Track 2.0 APHL** |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Association of Public Health Laboratories | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 400,000** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 400,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

APHL Narrative from CDC-Nigeria

Association of Public Health Laboratories (APHL) over the past four years has provided technical assistance and technical support to the CDC, Global AIDS Program (GAP) in building laboratory infrastructure in Nigeria through the President's Emergency Plan for AIDS Relief (PEPFAR).
During the last four years, laboratory testing services have been scaled up in order to match the increasing need for HIV treatment services. In the course of scale up, the numbers of Implementing Partners (IPs) supporting laboratory services in Nigeria has more than doubled. IPs are responsible for providing technical assistance through training laboratory scientists, providing technical advice, supervision and mentoring and have also provided support in the past through supplying equipment, reagents and general consumables.
In COP09, APHL has continued to provide technical assistance for evaluation of the recently adopted HIV diagnostic algorithm, quality assurance activities associated with sentinel surveillance activities and mentoring/training to the Government of Nigeria (GON) and Nigeria Central Public Health Lab (NCPHL).

Activities

In COP10 APHL will propose to use funds for technical assistance in three major areas;
1. Senior laboratory advisors to provide CDC/GAP with on-going technical assistance to improve quality and access to laboratory services in Nigeria. This activity will include supporting persons with the appropriate expertise and experience to provide CDC/GAP Nigeria with continuous technical assistance for laboratory operations and for coordination of laboratory programs.
2. Technical assistance support to the Government of Nigeria (GON) for surveillance and test evaluation activities.
3. Technical support to the Nigeria Central Public Health Laboratory, the provision of TA for the continued evaluation of the recently adopted HIV diagnostic algorithm, quality assurance activities and mentoring and training.
4. Technical assistance for the development and implementation of a National Laboratory Policy and a National Laboratory Strategic Plan and the implementation of Quality Management Systems.
APHL Co-operative Agreement Goals that Activities relate to:

Activity 1, activity 2 and activity 3 support the following APHL goals:
• Goal 5 (SOPs) which calls for 15 national public health laboratories and their 1st tier (provincial and regional hospital laboratories) using approved SOPs for all testing services.
• Goal 6 (Safety) which calls for 15 national public health laboratories and laboratories at all tiers in the health system have appropriate safety procedures incorporated in SOPs.
• Goal 11 (Technical Assistance) which calls for 100 supervisory supportive assistance visits to laboratories per year in each PEPFAR supported country.
• Goal 13 (Quality Systems) which calls for 15 countries having a trained National Quality Assurance Manager by 2012.
Activity 4 supports the following APHL goal:
• Goal 1 (Strategic Planning Implementation) which calls for all ministries of health in PEPFAR supported countries to have 5 year national laboratory strategic plans completed by end of 2010.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 260,000 |

## Key Issues

Impact/End-of-Program Evaluation

## Budget Code Information

| Mechanism ID: | 10004 | | |
|---|---|---|---|
| Mechanism Name: | HHS/CDC Track 2.0 APHL | | |
| Prime Partner Name: | Association of Public Health Laboratories | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Treatment | HLAB | 400,000 | |

**Narrative:**

APHL COP 10 Budget
The total cost estimates for each activity are listed below;
Activity 1 and 2 require two or more senior lab advisors to provide continued support to CDC Nigeria and GON. The cost for two advisors, each providing 6-months TA, is estimated at $216,000.
Activity 3 requires TA for mentoring and training and should be provided by consultant through two 2-week trips for a total estimated cost of $30,000.
Activity 4 can be supported by the senior lab advisor but should be supplemented by additional senior laboratory consultants. The cost of two or more additional consultants to provide TA for two visits would be an estimated $74,000.

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 10015** | **Mechanism Name: HHS/CDC Track 1.0 MoH NBTS** |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: National Blood Transfusion Services, Tanzania | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 3,250,000** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 3,250,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 97,000 |

## Key Issues

(No data provided.)

## Budget Code Information

| | | | |
|---|---|---|---|
| **Mechanism ID:** | **10015** | | |
| **Mechanism Name:** | **HHS/CDC Track 1.0 MoH NBTS** | | |
| **Prime Partner Name:** | **National Blood Transfusion Services, Tanzania** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Prevention | HMBL | 3,250,000 | |
| **Narrative:** | | | |
| None | | | |

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| | |
|---|---|
| **Mechanism ID: 10019** | **Mechanism Name: HHS/CDC Track 1.0 SBFAF** |
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |

| Prime Partner Name: Safe Blood for Africa Foundation | |
|---|---|
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 1,000,000** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 1,000,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

CONTINUATION OF ACTIVITY FROM FY 2009

The Safe Blood for Africa Foundation (SBFAF) is providing technical assistance services in Nigeria in the prevention program area of Medical Transmission/Blood Safety (BS). SBFAF activities reinforce the National Blood Transfusion Service's (NBTS) long-term strategy. SBFAF assists the NBTS in implementing its primary objective of migrating fragmented hospital-based blood services to centralized NBTS-based blood services nationwide. A key feature of this program is the development of a nationwide voluntary donor recruitment system (VNRD). The NBTS zonal and state centers are primarily supported by VNRD. SBFAF will continue to provide technical support to NBTS in the VNRD system.

Capacity-building is one of the key mechanisms to achieving the objectives of the NBTS long-term strategy. SBFAF has conducted a robust training program that has strengthened the NBTS. In FY09, SBFAF activities have been primarily focused on: capacity-building for blood safety activities at all NBTS centers and USG-supported hospitals in Nigeria; support of NBTS in developing and implementing a hospital blood bank exchange and distribution system; and promotion of coordinated blood safety activities across all partners.

SBFAF has facilitated the development of an NBTS/hospital blood exchange program through training in logistics and cold chain management with an emphasis on improved storage and handling. This training was first introduced in FY07 to NBTS and USG-supported facilities' drivers and medical laboratory scientists. The NBTS/hospital blood exchange program put a system in place whereby NBTS centers develop and implement a delivery system with hospitals, including select USG-supported hospitals, which have appropriate blood banking facilities in place. NBTS centers pick up unscreened blood units that the hospitals have appropriately collected and stored and transport these units back to NBTS centers where

they are screened for the 4 transfusion transmissible infections (TTIs) of HIV I and II, hepatitis B, hepatitis C and syphilis using ELSIA techniques. In addition to collecting unscreened units, NBTS deliver to the hospitals their requested order of screened units for blood banking and use at the facilities. Furthermore, NBTS also provide monthly feedback on rates of the 4 TTIs found by ELISA screening of blood units collected by the facility. This is intended to facilitate improvement of donor prescreening and deferment. This program has already commenced at select facilities with each USG treatment partner and will be expanded as NBTS absorptive capacity improves. The goal is that 80% of blood transfusions that occur at these hospitals will be with NBTS-screened blood units, while only 20% will be emergency transfusions whereby the hospital will screen the donated blood on site using rapid test kits. Given that only a fraction of facilities are capable of piloting such an exchange program with NBTS in the initial year, all other facilities were supported to improve their collection practices and on site lab screening practices, including utilizing the blood donor setting as another point of service for HCT for deferred blood donors. This support activity will continue in FY10.
Technical support will be given to NBTS to revise IEC materials to create awareness and promote blood safety and also advocacy packages for health professionals.

The Government of Nigeria has made efforts to increase accessibility to safe blood through establishment of more NBTS centers. There are presently 17 centers which will increase to 19 at the end of FY09. SBFAF will continue to provide TA in the infrastructural developments of the new centers to ensure uniform quality nationwide.

SBFAF will continue to assist the NBTS in its monitoring and evaluation program. Annual technical audits of the NBTS centers will be done to ensure quality of services and laboratory processes. SBFAF and the NBTS will introduce the principles of quality management processes with site-specific written Standard Operating Procedures, proper maintenance logs of equipment, validation of processes and a secure method of record keeping.

In the past has been worked through the National Technical Committee to develop a safe blood related policy. In FY10, entrenching the policy into law and advocacy to make the NBTS autonomous will be pursued. This will significantly improve NBTS regulatory capabilities. It is NBTS's intent to regulate and institute consistent blood banking standards and practices on a national basis. SBFAF will continue to strengthen the technical and managerial capacity of the NBTS through its TA program to ensure its sustainable, independent operation and increased leadership role in the safety of Nigeria's healthcare system.

CONTRIBUTIONS TO OVERALL PROGRAM AREA: SBFAF BS activities for COP10 will contribute to the overall Emergency Plan blood safety targets for Nigeria and will form a bridge to the sustainability

plan for PEPFAR II . Activities will increase VNRD, create an enabling environment, and improve access to quality blood transfusion systems and practices. Technical support by SBFAF in linkages and synergies between the NBTS and service outlets will improve the quality of blood transfusion practices in Nigeria. The NBTS/USG supported hospital blood exchange program will also improve access to safe blood. Monitoring and evaluation activities will determine the number of blood units screened by NBTS and the number of outlets adhering to the appropriate use of guidelines and SOPs provided through regular audits at these centers.

LINKS TO OTHER ACTIVITIES: SBFAF VNRD activities have direct links to counseling and testing and abstinence/be faithful programmes. SBFAF TA activities are linked to policy analysis and system strengthening activities. SBFA also provides technical assistance and support to other USG partners implementing emergency blood screening activities under this program area.

POPULATIONS BEING TARGETED: Low risk populations targeted to become regular VNRD include select youth groups and select cohorts of adult men and women. SBFAF will assist the NBTS to engage with organizations such as FBOs, business/private sector and community and religious leaders. SBFAF skills development programmes and capacity building activities will target host country government workers and other health care providers.

KEY LEGISLATIVE ISSUES ADDRESSED: Key issue addressed by SBFAF activities is based on volunteers. Development of a sustainable VNRD base is by definition entirely dependent on recruiting and retaining volunteers. This activity is community based and focused on the recruitment of suitable low-risk voluntary donors to supply centralized blood collection facilities.

EMPHASIS AREAS: This program includes major emphasis on blood safety training in all areas of the program. Emphasis is also being expended in the area of blood policy and oversight. Community Mobilization/Participation and Supportive Supervision will be areas of minor emphasis.

ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS:
• In COP10, SBFAF will continue to provide capacity building activities to the NBTS but rather provide classroom type trainings, the technical assistance will be provided through a skills development, hands-on "wet-type" training whereby, the SBFAF technical team and specialists will spend working weeks each and at each time impacting different areas of expertise at each NBTS center. SBFAF will consolidate on all the trainings and prior technical assistance provided to the NBTS and will provide on-site mentoring throughout the fiscal year. SBFAF will provide expertise in various fields that are appropriate to achieve the desired goals of the NBTS. SBFAF will provide extended technical assistance and mentoring in the areas of donor recruitment, blood collection and donor care, pre and post donation counseling, clinical

aspects and appropriate blood use, components production, quality systems, laboratory operational systems and management operational systems.
• In COP10, SBFAF and NBTS will approach the hospital linkage programme (HLP) under a re-designed strategy developed by both parties. One pilot hospital will be selected in each of the six geo-political zones and Abuja and the progress of the HLP will be closely tracked by SBFAF.
• In COP10, advocacy to make the NBTS autonomous will be conducted. An independent agency/commission status will significantly improve NBTS regulatory capabilities. SBFAF will fund several technical committee meetings to develop a legislative bill to transform the NBTS into an agency or a commission. It is hoped that this document will be passed to the National Assembly for adoption into law.
• Another key area for the successful future of the NBTS will be to develop a Blood Safety Training Manual. This manual is an integral component of the development of sustainable and replicable best practices in transfusion medicine. SBFA will also fund a series of sub-committee meetings to engage all stakeholders involved and utilizing the same methodology as was used for the development of the 'Guidelines for Blood Transfusion Practices in Nigeria' developed in COP 07. The training manual will also be based on this same document.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 122,145 |

## Key Issues

(No data provided.)

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **10019** |
| **Mechanism Name:** | **HHS/CDC Track 1.0 SBFAF** |
| **Prime Partner Name:** | **Safe Blood for Africa Foundation** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HMBL | 1,000,000 | |

**Narrative:**

CONTINUATION OF ACTIVITY FROM FY 2009

The Safe Blood for Africa Foundation (SBFAF) is providing technical assistance services in Nigeria in the prevention program area of Medical Transmission/Blood Safety (BS). SBFAF activities reinforce the National Blood Transfusion Service's (NBTS) long-term strategy. SBFAF assists the NBTS in implementing its primary objective of migrating fragmented hospital-based blood services to centralized NBTS-based blood services nationwide. A key feature of this program is the development of a nationwide voluntary donor recruitment system (VNRD). The NBTS zonal and state centers are primarily supported by VNRD. SBFAF will continue to provide technical support to NBTS in the VNRD system.

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CONTRIBUTIONS TO OVERALL PROGRAM AREA: SBFAF BS activities for COP10 will contribute to the overall Emergency Plan blood safety targets for Nigeria and will form a bridge to the sustainability plan for PEPFAR II . Activities will increase VNRD, create an enabling environment, and improve access to quality blood transfusion systems and practices. Technical support by SBFAF in linkages and synergies between the NBTS and service outlets will improve the quality of blood transfusion practices in Nigeria. The NBTS/USG supported hospital blood exchange program will also improve access to safe blood. Monitoring and evaluation activities will determine the number of blood units screened by NBTS and the number of outlets adhering to the appropriate use of guidelines and SOPs provided through regular audits at these centers.

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POPULATIONS BEING TARGETED: Low risk populations targeted to become regular VNRD include select youth groups and select cohorts of adult men and women. SBFAF will assist the NBTS to engage

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KEY LEGISLATIVE ISSUES ADDRESSED: Key issue addressed by SBFAF activities is based on volunteers. Development of a sustainable VNRD base is by definition entirely dependent on recruiting and retaining volunteers. This activity is community based and focused on the recruitment of suitable low-risk voluntary donors to supply centralized blood collection facilities.

EMPHASIS AREAS: This program includes major emphasis on blood safety training in all areas of the program. Emphasis is also being expended in the area of blood policy and oversight. Community Mobilization/Participation and Supportive Supervision will be areas of minor emphasis.

ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS:
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• In COP10, SBFAF and NBTS will approach the hospital linkage programme (HLP) under a re-designed strategy developed by both parties. One pilot hospital will be selected in each of the six geo-political zones and Abuja and the progress of the HLP will be closely tracked by SBFAF.
• In COP10, advocacy to make the NBTS autonomous will be conducted. An independent agency/commission status will significantly improve NBTS regulatory capabilities. SBFAF will fund several technical committee meetings to develop a legislative bill to transform the NBTS into an agency or a commission. It is hoped that this document will be passed to the National Assembly for adoption into law.
• Another key area for the successful future of the NBTS will be to develop a Blood Safety Training Manual. This manual is an integral component of the development of sustainable and replicable best practices in transfusion medicine. SBFA will also fund a series of sub-committee meetings to engage all stakeholders involved and utilizing the same methodology as was used for the development of the 'Guidelines for Blood Transfusion Practices in Nigeria' developed in COP 07. The training manual will

| |
|---|
| also be based on this same document. |

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 10021** | **Mechanism Name: USAID Track 2.0 CRS 7D TBD** |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Cooperative Agreement |
| Prime Partner Name: CRS-7D | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 3,809,396** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 3,809,396 |

## Sub Partner Name(s)

| | | |
|---|---|---|
| Adoka Maternity, Adoka | Anthony Cardinal Okogie Clinic, Lagos | Archdiocese of Abuja |
| Archdiocese of Benin City | Archdiocese of Jos | Archdiocese of Kaduna |
| Catholic Diocese of Idah, Nigeria | Catholic Diocese of Kafanchan, Nigeria | Catholic Diocese of Lafia, Nigeria |
| Catholic Diocese of Makurdi, Nigeria | Catholic Diocese of Minna, Nigeria | Catholic Diocese of Otukpo, Nigeria |
| Catholic Diocese of Shendam | Catholic Secretariat of Nigeria | Divine Mercy, Minna |
| Irruan ANC Bakpor, Ogoja | Sisters of Nativity Jikwoyi, Abuja | St. Elizabeth, Vandekiya |
| St. Kizito Clinic, Lekki Idi-Araba | St. Kizito, Lekki | St. Mathias, Naka |
| St. Thomas Hospital, Ihugh | St. Timothy Clinic, Ojodu, Lagos | St. Zeno Clinic, Iwo |
| Virgilius Memorial Health Centre, Namu | | |

## Overview Narrative

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Food and Nutrition: Commodities | 39,263 |
| Human Resources for Health | 185,609 |
| Water | 42,833 |

## Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
Mobile Population
Safe Motherhood

## Budget Code Information

| | | | |
|---|---|---|---|
| **Mechanism ID:** | **10021** | | |
| **Mechanism Name:** | **USAID Track 2.0 CRS 7D TBD** | | |
| **Prime Partner Name:** | **CRS-7D** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Care | HBHC | 1,374,015 | |
| **Narrative:** | | | |
| None | | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Care | HVCT | 90,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Other | HVSI | 50,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVAB | 1,662,405 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | MTCT | 632,976 | |

**Narrative:**

MTCT: PMTCT:
In COP010, the 7D-PMTCT project will continue to increase access to PMTCT services for pregnant women by building community support for PMTCT and increasing the capacity of health facilities to provide PMTCT services. 7D will use existing diocesan AIDS structures and Parish AIDS Volunteers (PAVs) to create demand for PMTCT services through social mobilization campaigns in two ways. Firstly, PMTCT Point of Services (POS) will establish a network of Primary Health Care Centers that will provide basic ANC and Counseling and Testing Services for everyone including pregnant women. Secondly, educational sessions on PMTCT followed with Counseling and Testing (CT) will be done during outreach activities.

The PMTCT package will include Group CT using opt-out strategy with same day results in ANC, Labor and delivery. Other include partner counseling and testing, OI treatment and prophylaxis, like malaria and Pneumocystis Jiroveci Pneumonia prophylaxis using cotrimoxazole and management of diarrhea. The project will also provide infant feeding counseling during first and subsequent ANC visits with key messages like exclusive breast feeding for the first 6 months or avoiding all breastfeeding if replacement feeding is acceptable, feasible, affordable, sustainable and safe. ART prophylaxis for pregnant women using Zidovudine at 28 weeks with single dose Nevirapine at onset of labour for mother and single dose Nevirapine and one week of Zidovudine for the infant or a combination of Zidovudine and Lamivudine at 34 weeks for mother with the same regimen one week post partum for mother and single dose

Nevirapine and one week Zidovudine for the infant will be provided.

Free baseline hematinics, STD screening, CD4 Count to assist with determining need for immediate therapy and viral loads where possible for monitoring HIV progression, will be conducted to all pregnant women accessing PMTCT in 7D supported sites. ARV treatment when indicated during pregnancy improves the health of the woman and decreases the risk of HIV transmission to the infant; where these services are not available, they will be referred to facilities including AIDS Relief (AR) ART sites and other IPs.
A significant numbers of 7D PMTCT Sites are positioned within AIDS Relief (AR), FGON and IPs' ART networks to which women who need ART will be referred. Since 7D and AR PMTCT Team functions as a unit and are co-located in 90% of sites, seamless transition of patients between the two will be initiated. This will happen in two ways. The first way is through the existing co-location in facility. Since 7D PMTCT and AR ART are already located in the same facilities in current 7D PMTCT sites, women determined by a lower CD4 Count (<350) to be eligible for ART in accordance with the national PMTCT guidelines, will be taken up by AR for full ART. Secondly, for co-location in geographic area, 7D PMTCT attendants who qualify for ART will be referred to an AR sites where they will receive ART. This referral mechanism will function since 7D and AR PMTCT Teams currently function as an integrated team that plans and executes tasks as one unit. To prevent double counting or loss of clients to AR, all clients from 7D that access services from AR sites are required to provide proper documentation (like a referral note) before the client is taken up by AR; the same will apply for AR clients seeking treatment at 7D sites.

For clients with CD4 count >350 and not requiring ART, the nationally recommended short course will continue to be available. This includes Zidovudine from 28 weeks, and single does NVP at onset of labor for mother and single dose Nevirapine and one week Zidovudine for infants; All HIV-exposed infants will be provided with cotrimoxazole from 6 weeks for at least 6 months, preferably until HIV infection has been ruled out. 7D PMTCT sites will abide by existing national guidelines on PMTCT. It will also ensure that all 7D PMTCT sites have the approved PMTCT registers and other required M&E tools.

7D will refer clients for HIV infant diagnosis testing in line with the nationally recommended Early Infant Diagnosis Initiative from 6 weeks of age using Dry Blood Spots. Infants will also be linked to immunization services to access the WHO/UNICEF and FGON recommended set of vaccines. This will be done in health facilities that provide immunization services in areas where 7D operates.

7D will continue to collaborate with Traditional Birth Attendants (TBAs) through trainings using nationally recommended curricula and provision of PMTCT HBC kits and information packs for effective support of pregnant women who choose to give birth outside health facilities. Trained TBAs are expected to work in partnership with the health center with back and forth linkages. Two TBAs from each of the 13 PMTCT

sites will receive refresher trained and one TBA from 12 partner arch/dioceses will also be trained resulting in 38 re-trained TBAs. The expected outcome of the TBA training will be improved obstetric practices and awareness on key PMTCT issues.

To ensure quality, supervisory visits will be made by diocesan and CRS staff monthly to each site. These will continue through COP010. M&E tools will be standardized with national tools and disseminated to all arch/dioceses in COP09 and maintained through COP010. Volunteers will continue to be sensitized on PMTCT, maternal nutrition and safe infant feeding practices for correct PMTCT service provision. Volunteers will support mothers' infant feeding choices through on-going counseling. CRS will also ensure all PMTCT sites benefit from the ongoing collaboration between SUN and MARKET on nutritional support to four OVC's project partners. These are Makurdi, Otukpo, Jos and Shendam.

Support and capacity building given to Abuja, Ibadan and Makurdi provincial structures in COP09 will continue in COP010. This support has encompassed engagement of key points of staff including PMTCT and financial management specialists.

Targets for COP010 include 11,455 pregnant women counseled, tested and receiving results, 650 pregnant women placed on ARV and retraining of 30 health care workers using national PMTCT curriculum in 13 sites. Test kits will be procured centrally through the USG supply chain management system.

All collaborative initiatives put in place with AR from the era of COPO7 Plus Up funds through COP09 will be improved upon in COP010. These initiatives enabled 7D collaboration with AR in leveraging resources and expertise through forming a PMTCT Team that plans and responds to 7D, AR and partner PMTCT needs coherently. Partner PMTCT capacities have been enhanced through training of POS staff and archdiocesan PMTCT Co-ordinators. Site antenatal clinic refurbishment and laboratory support have also been done. These activities will continue throughout COP010

CONTRIBUTIONS TO OVERALL PROGRAM AREA
Activities that were conducted in year 2009 that will continue in 2010 include CT, HBC, and Support Groups for HIV positive pregnant women. Infant feeding counseling in all sites will be undertaken; this will be done right from the time pregnant women start their antenatal visits. These PMTCT services will continue to contribute to several of the PEPFAR goals. The goal of preventing new infections by offering CT services to pregnant women, as well as providing PMTCT prophylaxis to prevent infecting the newborn child is already contributing to prevention of new infections.

Issues of violence against women after disclosure of HIV status are a grim reality which will be tackled

during Couple Counseling sessions as a pre emptive measure. PMTCT-specific HBC, are being provided to pregnant women by PAVs. Support groups provide participants with coping mechanisms for addressing stigma and discrimination towards PLHWA. These activities will continue in COP10.

LINKS TO OTHER ACTIVITIES

PMTCT activities will be linked to CT (3.3.09), ART (3.3.10 and 3.3.11) services, care and support (3.3.06), TB/HIV (3.3.07), and OVC (3.3.08) services. 7D has established referral linkages with TB DOTs centers and other health care facilities to ensure that PMTCT clients are treated for TB, STIs and other opportunistic infections. However there will be STI and opportunistic infection treatment in 7D supported health facilities. 7D will work closely with AR for ART services where project activity areas overlap. Referral coordinators have been employed to ensure timely referrals to services offered by other implementing partners. This area has been identified as a "best practice" that needs support both at state and national levels. 7D will continue linking with the GON by sending copies of her reports to them and attending PMTCT Task team meetings on a regular basis. Also there are plans to link the sites to GON drug program for sustainability even when the present source ceases.

POPULATIONS BEING TARGETED

Pregnant women and HIV + pregnant women, HIV-exposed infants, care givers, partners, religious leaders and affected children are the populations being targeted.

KEY LEGISLATIVE ISSUES ADDRESSED

Gender-activities have been organized with the aim of addressing inequalities between men and women and subsequent behaviors that increase the vulnerability to and impact of HIV/AIDS. Women's legal rights and access to income and productive resources will be carried out through linking care and support programs to income generation activities within 7D SUN programs.

Work has been done to reduce the stigma associated with HIV status and discrimination faced by PMTCT mothers and their families through support group membership. This aspect is will be enhanced in the COP010.

EMPHASIS AREAS

The major emphasis area is developing the capacity of Partners to effectively manage the PMTCT program with a focus on sustainability. The minor emphasis areas are: improving linkages /networks/referral systems between the communities and the 7D PMTCT sites

In COP10, under 'PEPFAR Nigeria's accelerated PMTCT plan', CRS 7D, will strengthen its support to PMTCT service delivery by implementing activities that further improve the coverage and quality of

| |
|---|
| PMTCT services. These activities will be directed towards increasing utilization of PMTCT services at existing service outlets through demand creation in collaboration with community resources and ensuring the upgrade of existing supported PHCs offering stand alone HIV counseling and testing to render at least minimal package of PMTCT services. In order to leverage resources, priority will be given to PHCs located in the selected focal states with presence of other donor agencies and in local government areas already earmarked for HSS support through GFATM. Where new sites are envisioned, those that are used for national ANC sero-sentinel surveys but yet to commence PMTCT services as well as PHCs located in communities with high HIV prevalence rates above the National average will be given priority. |

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| | |
|---|---|
| **Mechanism ID: 10022** | **Mechanism Name: USAID Track 2.0 CRS OVC TBD** |
| Funding Agency: U.S. Agency for International Development | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Catholic Relief Services | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 2,800,000** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 2,800,000 |

## Sub Partner Name(s)

| | | |
|---|---|---|
| Archdiocese of Abuja | Archdiocese of Benin City | Archdiocese of Jos |
| Archdiocese of Kaduna | Catholic Diocese of Idah, Nigeria | Catholic Diocese of Kafanchan, Nigeria |
| Catholic Diocese of Lafia, Nigeria | Catholic Diocese of Makurdi, Nigeria | Catholic Diocese of Minna, Nigeria |
| Catholic Diocese of Otukpo, Nigeria | Catholic Diocese of Shendam | Catholic Secretariat of Nigeria |

## Overview Narrative

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 134,400 |
| Water | 33,600 |

## Key Issues

Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **10022** |
| **Mechanism Name:** | **USAID Track 2.0 CRS OVC TBD** |
| **Prime Partner Name:** | **Catholic Relief Services** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HKID | 2,750,000 | |
| **Narrative:** | | | |
| None | | | |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Other | HVSI | 50,000 | |
| **Narrative:** | | | |
| None | | | |

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 10025** | **Mechanism Name: USAID Track 2.0 CHAN** |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Christian Health Association of Nigeria | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 265,206** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 265,206 |

## Sub Partner Name(s)

| | | |
|---|---|---|
| Civil Society on HIV/AIDS in Nigeria (CiSHAN), Gombe | Daughters of Mary Mother of Mercy,Umuahia | Holy Family Clinic, Sokoto |
| Management Sciences for Health | Network of People Livng With HIV/AIDS in Nigeria (NEPWAN) | NKST Hospital, Anyiin |
| NKST Hospital, Mbaakon | NKST Hospital, Zaki- Biam | Our Lady Catholic Hospital, Iseyin |
| Sancta Maria Clinic, Bali, Taraba | SDA Hospital, Aba | St. Anne's Anglican Hospital, Ibadan |
| St. Francis, Okpala Inland, Delta State | St.Joseph Catholic Hospital, Asaba | UMCN RHP Hospital Zing |

## Overview Narrative

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Food and Nutrition: Commodities | 2,052 |
| Food and Nutrition: Policy, Tools, and Service | 2,052 |

| | |
|---|---|
| Delivery | |
| Human Resources for Health | 61,562 |

## Key Issues

Increasing gender equity in HIV/AIDS activities and services

Malaria (PMI)

TB

Family Planning

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **10025** |
| **Mechanism Name:** | **USAID Track 2.0 CHAN** |
| **Prime Partner Name:** | **Christian Health Association of Nigeria** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | MTCT | 60,000 | |

**Narrative:**

ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS:

In COPs 08 and 09, the Christian Health Association of Nigeria (CHAN) Nigeria Indigenous Capacity Building (NICaB) project used drugs donated by the Clinton Foundation and leveraged training resources from other USG-funded IPs to provide PMTCT services at 12 facilities in 6 states of Abia, Benue, Delta, Oyo, Sokoto and Taraba. Services provided included HIV counseling and testing at the maternity, EID and infant feeding counseling. Prophylaxis was given to pregnant mothers, while those who needed HAART for their own health were referred to the ART clinic. Community health workers promoted PMTCT, and followed up Mother/infant pairs within the community to provide support for infant feeding choices and provide referrals in case of complications. In COP 2010 this activity will continue as before, conducting EID and infant feeding counseling components under the pediatrics care and support program area. Additionally, NICaB will continue to facilitate the formation of PMTCT committees where this committee does not already exist and facilitate their monthly meetings with the aim of supporting the states to develop a scale up and implementation plan.

The Christian Health Association of Nigeria (CHAN) Nigeria Indigenous Capacity Building (NICaB)

project utilizes a network model with PMTCT care centers linked to secondary level CHAN member institution health facilities "hub sites" that provide more complex PMTCT care and lab testing, to reach HIV+ women with HIV related services. In COP2010, 6819 women will receive PMTCT counseling & testing and receive their results through networks that include 12 hub and 12 spoke sites, giving a total of 24 PMTCT sites supported in 6 states of Abia, Benue, Delta, Oyo, Sokoto and Taraba. This activity will take advantage of all women being tested and counseled including negative women - so they stay negative and positive women to avoid cross infection due to increased vulnerability during pregnancy.

As part of the USG local government area (LGA) coverage strategy in PMTCT, CHAN NICaB will support PMTCT services at sentinel survey sites in Abia state slowly expanding to primary health center level as resources become available. PMTCT stand alone points of service in the network are linked to adult and pediatric ARV care through utilization of a PMTCT consultant coordinator and the health facility coordinator in each network based at the hub site, network referral SOPs, monthly PMTCT network meetings, and incorporation of team approaches to care in all training and site monitoring. Meetings with the State Action Committees will be facilitated that will lead to the formation of a state PMTCT committee in order to strengthen the scale up and implementation plans in 3 NICaB states of Abia, Sokoto, and Delta. In line with the National PMTCT guideline, HIV+ pregnant women with CD4 cell count of 350 or less require HAART for their own health and they will be linked to an ARV point of service at CHAN member institutions (MIs), and facilitate linkages between HIV exposure status on mother's and child's health card for mother/infant pairs. Particular emphasis will be placed on the involvement of community health workers who are the primary source of care for women in the pre and post-partum period and are integral to a program that seeks to engage women where they seek care. This program will work closely with the care and support team to maximally engage community based PMTCT and ARV linkages. In addition to receiving PMTCT services, each HIV+ pregnant woman will be referred to OVC services in order to facilitate care for all of her affected children.

Provider initiated testing and counseling with opt-out option and with same day test results will be provided to all women presenting for ANC and untested women presenting for labor and delivery. All women would be provided pre-test group health information services on prevention of HIV infection including the risks of MTCT using members of mother to mother support as lay counselors. Male involvement in PMTCT will be strengthened by promoting couple counseling and partner testing will be offered as part of counseling through referral to on-site HCT centers. A step down training of couple counseling and prevention for positives package will be utilized in all sites. This will provide an opportunity to prevent heterosexual transmission, and reduce incidence of violence against positive partners, especially in discordant couples. Master trainers for HCT already trained in COPs 08 and 09 at CHAN comprehensive sites will in turn train labor and delivery staff in the use of HIV rapid tests for women who present at delivery without antenatal care.

An anticipated 259 HIV+ pregnant women will be identified and provided with a complete course of ARV prophylaxis (based on CHAN NICaB's current program 5%). HIV+ women will have access to lab services including CD4 counts without charge. This will be available on-site or within the network through specimen transport. Women requiring HAART for their own health care will be linked to a network ARV center. For the anticipated 2/3 of women not requiring HAART, the current WHO recommended short course ARV option will be provided which includes ZDV from 28 weeks or ZDV/3TC from 34/36 weeks, intra-partum NVP, and a 7 day ZDV/3TC post-partum tail. Women presenting in labor will receive single dose Nevirapine (sdNVP) and a 7 day ZDV/3TC post-partum tail. All HIV+ women will be linked post-partum to an HIV/ARV point of service, which will utilize a family centered care delivery model whenever feasible, co-locating adult and pediatric care and providing linkage to family planning services. Positive pregnant women with CD4 <350 will be placed on co-trimoxazole preventive therapy in the 2nd and 3rd trimesters.
Women frequently face barriers to facility-based treatment access as a result of demands on them for child care and to contribute to the family economic capacity. To address this, mobile clinic outreach as described in the ARV service provision and care and support narratives will be integrated at the community level to bring services to women who otherwise will opt-out of care and treatment.

Health workers at facilities and community levels will be trained to counsel HIV+ women pre- and post-natally regarding exclusive breast feeding during the first six months of life or exclusive breast milk supplements (BMS) if Acceptable, Feasible, Affordable Sustainable and Safe (AFASS) using the WHO UNICEF curriculum adapted for Nigeria. Couples counseling or family member disclosure will be utilized to facilitate support for infant feeding choices. Consistent with national policies on importation of infant formula and recent concerns regarding appropriate use of BMS, CHAN NICaB will not utilize emergency program funds to purchase BMS. As part of OVC programming CHAN NICaB will provide safe nutritional supplements as well as water guard, bed nets and other home based care items. HIV+ women will be linked to support groups in their communities which will provide both education and ongoing support around infant feeding choices and prevention for positives. PLHA are currently engaged at CHAN NICaB ARV points of service as treatment support specialists. The use of dedicated treatment support specialists for PMTCT in the clinic and community will be expanded based upon the successful "Mothers to Mothers" model in Southern and East Africa. This will ensure that HIV+ women remain in care throughout pregnancy and receive appropriate services for herself and her infant during follow up.

Infant prophylaxis will consist of single dose NVP with ZDV for 6 weeks in accordance with Nigerian National PMTCT Guidelines. Cotrimoxazole suspension is provided to all exposed infants pending a negative virologic diagnosis. CHAN NICaB will collaborate with USG supported laboratories for DNA PCR. Testing of infants will be carried out using dried blood spot (DBS) specimen collection. DBS specimens from PMTCT sites in the network will be pooled at the hub sites from where they will be taken

to nearby USG supported labs by trained lab personnel for DNA PCR. A systematic coordinated approach to program linkage will be operationalized at the site level and program level including linkages to adult and pediatric ART services, OVC services and basic care and support. Quality monitoring will be undertaken through site visits using an existing assessment tool and routine monitoring and evaluation indicators. Hospital coordinators will supervise activities on a daily basis while the NICaB clinical coordinator will collaborate with the USG TWG and GON to conduct quarterly site visits. Reports of activities will be sent to the USG and copies to NACA. The NICaB project will work with community based workers including traditional birth attendants to support the already wide spread practice of male child circumcision

The CHAN NICaB project will train and provide refresher training to an average of 4 health care workers (HCWs) from each of the 24 sites including 48 nurse/midwife, 12 community-based health workers and 12 trained traditional birth attendants (TBAs) in the provision of PMTCT services and infant feeding counseling. The national PMTCT training curriculum, national infant feeding curriculum and new national training tools currently under development will be utilized. TBAs will be trained using a version of the PMTCT National Curriculum that has been adapted and modified for TBAs which focuses on HCT and referral of HIV+ women. Thus the total direct training target is 72.

CONTRIBUTIONS TO OVERALL PROGRAM AREA:
This activity will provide counseling & testing services to 6819 pregnant women, and provide ARV prophylaxis to 259 mother and infants pairs. With 72 operational sites, the PMTCT activity is in line with the desire of the GON to have 1,200 PMTCT sites operational by 2009 and the USG's target of having 80% PMTCT coverage.

LINKS TO OTHER ACTIVITIES:
This activity is linked to care and support BC&S, OVC , ARV services, laboratory infrastructure, condoms & other prevention, AB , and SI. Prevention for positives counseling will be integrated within PMTCT care for HIV+ women. The basic package of care provided to all HIV+ patients will be available to HIV+ pregnant women. Positive pregnant women will be linked with nutritional support for women where they exist. CHAN NICaB lab staff will ensure that HIV testing provided within the PMTCT context is of high quality by incorporating PMTCT sites into the laboratory QA program. CHAN NICaB will collaborate with UNICEF in the support of PMTCT services at some sites, leveraging their training expertise and other resources without duplication and creating a more sustainable service support structure.
POPULATIONS BEING TARGETED:
This activity targets pregnant women who will be offered HCT, HIV+ pregnant women for ARV prophylaxis and infant feeding counseling, and exposed infants for prophylaxis and EID. Couple counseling will be used to reach partners of pregnant women so as to reduce instances of violence

following disclosure and family members will be counseled to provide support of pregnant and breast feeding mother.

EMPHASIS AREAS
The key emphasis area is training as most supported personnel are technical experts. A secondary emphasis area is network/ referral systems as networks of care will be supported which are critical to ensuring quality of care at the PHC level, identifying women in need of HAART, and ensuring access to HAART within the network. In addition, partners and PABAs will be identified for linkage to care and support services. In addition, this activity addresses gender since treatment will be provided to women and will focus on family centric issues including male involvement in PMTCT programming.

In COP10, under 'PEPFAR Nigeria's accelerated PMTCT plan', CHAN, will strengthen its support to PMTCT service delivery by implementing activities that further improve the coverage and quality of PMTCT services. These activities will be directed towards increasing utilization of PMTCT services at existing service outlets through demand creation in collaboration with community resources and ensuring the upgrade of existing supported PHCs offering stand alone HIV counseling and testing to render at least minimal package of PMTCT services. In order to leverage resources, priority will be given to PHCs located in the selected focal states with presence of other donor agencies and in local government areas already earmarked for HSS support through GFATM. Where new sites are envisioned, those that are used for national ANC sero-sentinel surveys but yet to commence PMTCT services as well as PHCs located in communities with high HIV prevalence rates above the National average will be given priority.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HTXD | 205,206 | |

**Narrative:**

None

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| Mechanism ID: 10026 | Mechanism Name: USAID Community Reach |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Pact Nigeria | |

| | |
|---|---|
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 2,202,732** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 2,202,732 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

Pact REACH-(Rapid and Effective Action Combating HIV/AIDS) Nigeria Program is a five year program focusing on enhancing the scale and quality of a comprehensive civil society response to HIV/AIDS in Nigeria. The REACH Nigeria program will draw on one of Pact's core competencies of grants management, providing sound stewardship of donor resources; and building organizational and technical capacities of civil society organizations. Pact REACH Nigeria program has the capacity to engage local partners through grants, and this will ensure quality and comprehensive OVC and AB prevention services at the grassroots level. It will also build project management capacity to facilitate the graduation of indigenous sub partners to prime partners.

The goal of this five-year REACH Nigeria Program is to contribute to enhancing the scale and quality of a comprehensive civil society response to HIV/AIDS in Nigeria, with a focus on addressing gaps in HIV prevention and OVC programming. It will mobilize and support community-based responses to AB and OVC programming through an effective and transparent grant award and administration system for the provision of responsive, fast-track grant-making assistance to organizations responding to the Emergency Plan and will provide HIV/AIDS implementers with access to financial resources and high quality technical expertise to assist in achieving and effectively reporting results.
Pact will build sustainability through provision of technical assistance to local sub-grantees in their capacity to deliver quality OVC and AB services at the grassroots level and will strengthen referrals and linkages for increased access to AB and OVC programming through capacity-building of sub-grantees; document evidence-based best practices, lessons learned and new approaches, tools and methodologies by engaging with local sub-grantees; create economic advancement opportunities through the active engagement of private or business sectors in work force development for persons affected by HIV/AIDS and other Caregivers.

Pact's OVC programming will affirm the agenda for responding to the OVC challenge using National

guidelines and SOP. The approach will be child centered and family and community focused, thereby strengthening the capacity of families to cope with their problems, mobilizing and strengthening community-based responses, increasing the capacity of children to become proactive in meeting their own needs, and integrating care services for children within existing prevention and care programs. The principles adopted for program design and implementation will be based on comprehensive multi-sectoral and sustainable approaches that seek to meet immediate and long-term support that will promote the safety, survival, well-being and development of OVC, families and communities. In view of the complexities of the needs of the children, collaborative approaches that demand partnerships and community involvement will be utilized. Linkages will be facilitated with relevant government departments and implementing agencies for micro-economic strengthening of families and communities, sustainable livelihood development for youth (vocational training) and legal support for the protection of the rights of OVC (through FIDA- International Federation of Female Lawyers, local legal aid services will be engaged to train child forums and volunteers in basic legal aid support for OVC and families, such as wills, succession planning, identity documents including birth certificates).

Pact REACH Nigeria program will utilize a variety of assessment tools to act as a start point to improving the capacity of partners utilizing a participatory process that leads to institutional strengthening plans. It will contribute to health system strengthening by training a core of community care volunteers and peer educators to provide continuum of care within the community.

Pact REACH Nigeria program will build the skills of parents/caregivers, community volunteers and other selected community focal persons to facilitate access to a range of essential services pertaining to their general welfare, care providers will be trained, including direct providers and supervisors at local and state government levels to provide the various aspects of OVC care services (psychosocial support, basic care and support Community integrated management of childhood illnesses (C-IMCI), on stigma and discrimination reduction and gender issues etc);

AB HIV Prevention programming will utilize the Nigeria's HIV Prevention Plan for its implementation. There will be a particular focus on reaching rural populations with key AB messages. The goal of the AB program is to contribute to reduction in HIV prevalence amongst young people and also promote mutual fidelity amongst married adults. The proposed AB strategies includes: PEP plus model for the school based curricular and non-curricular based approach, Life skills, interventions that address age-appropriate income generation activities and community awareness campaigns. Each individual will be reached with a minimum of three interventions from the five models indicated. The target group and nature of the community will determine the intervention mix. However the core strategy will be Peer Education.

Pact will be programming in the following geo-political zones: North Central-Nasarawa, Niger and Kwara States; South-West-Ekiti and Ondo States; South East-Ebonyi and Enugu States; South South-Bayelsa and Rivers States. The states focusing on OVC are Nasarawa, Niger, Kwara, Ebonyi, Enugu, Ekiti and River States and states focusing on Prevention are Ekiti , Ondo and Bayelsa States

For the 5 years the REACH Nigeria program will:  reach 50, 000 OVC, train 21, 026 Care Givers reach 79, 000 persons with AB Prevention messages, train 1, 500 persons to provide AB prevention messages and sub grant to and build capacities of 200 CBOs/ FBOs. REACH Nigeria will implement SI activities by supporting local organization at the national level and in focus states; through the institution/establishment of a Monitoring and Evaluation system that is aligned with the National frameworks. The M&E system will enhance monitoring and management of the program thereby making quality data available at all levels for monitoring, evaluation, guiding program management and communicating program achievements.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Construction/Renovation | REDACTED |
| Economic Strengthening | 50,105 |
| Education | 100,209 |
| Food and Nutrition: Commodities | 12,526 |
| Food and Nutrition: Policy, Tools, and Service Delivery | 25,052 |
| Gender: Reducing Violence and Coercion | 2,505 |
| Human Resources for Health | 400,837 |
| Water | 2,505 |

## Key Issues

Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **10026** |
| **Mechanism Name:** | **USAID Community Reach** |
| **Prime Partner Name:** | **Pact Nigeria** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Care | HKID | 2,000,000 | |

**Narrative:**

Pact REACH Nigeria program will work in collaboration with national, state, LGA and community partners including faith based organizations and support groups of persons living with HIV/AIDS, to strengthen and support the capacity of communities and families to respond to the individual needs of OVC (0 - 17 years) by assessing children's current needs, monitor improvement in specific dimensions of child well being and identify areas of concern that can be served by the Pact program intervention, in order to make an actual difference in the child's well being and in the process build communities committed to quality improvement for OVC.

In country operational plan 2010 (COP 2010) REACH Nigeria will provide services to 1,725 OVC (HIV+ children, children orphaned by HIV/AIDS, street children, children with disabilities, caregivers of OVC and PLWAs and HIV/AIDS affected families) by supporting twenty (20) CBOs/NGOs/ FBOs in Ekiti, and Ebonyi states of Nigeria to ensure access for OVC to essential quality services, including education, health care, nutrition, psychosocial support, protection, shelter and care and household economic activities. Each child will receive at least a minimum of three services, based on individual needs.

The principles adopted for program design and implementation will be based on comprehensive multi-sectoral and sustainable approaches that seek to meet immediate and long-term support that will promote the safety, survival, well-being and development of OVC, families and communities. In view of the complexities of the needs of the children, collaborative approaches that demand partnerships and community involvement will be utilized. Linkages will be facilitated with relevant government departments and implementing agencies for micro-economic strengthening of families and communities, sustainable livelihood development for youth (vocational training) and legal support for the protection of the rights of OVC (through FIDA- International Federation of Female Lawyers, local legal aid services will be engaged to train child forums and volunteers in basic legal aid support for OVC and families, such as wills, succession planning, identity documents including birth certificates).

Pact Nigeria will build the skills and outreach of parents/caregivers, community volunteers and other selected community focal persons to facilitate OVC access to a range of essential services pertaining to their general welfare, altogether 863 care providers will be trained, including direct providers and supervisors at local and state government levels to provide the various aspects of OVC care services (psychosocial support, basic care and support Community integrated management of childhood illnesses (C-IMCI), conduct an orientation of program managers of CBOs, FBOs and service providers to enable them understand OVC issues and project management guidelines, National guidelines and SOP will be distributed, build the capacity of caregivers, teachers, health workers, CBOs, FBOs and community

volunteers on stigma and discrimination reduction and gender issues etc); the project will aim to create or improve referral systems to and from health facilities (PMTCT,HCT,TB/HIV) as well as adult and pediatric treatment services), government services, and other community child services.Pact recognizes that all services must be age appropriate and that OVC services and needs will change as a child grows. All referrals will be recorded, actively followed up and reported to ensure accurate data compilation.

Strategic Behavioral Change strategies will be used by Pact and will include a combination of SBC, advocacy, community mobilization, social marketing (through other partners) and social mobilization. This will support the maintenance of positive behaviors and promote behavior change within the extensive range of strategies that fall under the identified programs for orphans and vulnerable children. Appropriate media within the environs will be used to address the local factors that fuel stigma, discrimination and inhibit disclosure. Most of the messages will be integrated into broader prevention and care, support campaigns at all levels but some will be specifically targeted at the community level based on formative research.

Pact will in addition carry out organizational capacity assessments (OCAT) for the 20 CBOs/NGOs/FBOs identified for the project. This will enable them recognize their own potential and address long term organizational sustainability needs as well as to address the immediate technical needs of the care providers using the MCAT.

Kids clubs will be established which will incorporate specific age appropriate life building skills such as life goal planning, personal empowerment, caring for others, public speaking, writing skills and homework support. Under guidance from the state ministry of women affairs, support will first focus on the communities through a phased-in mechanism. In addition, resources will be leveraged from corporate organizations for the provision of nutritional supplements and school supplies. Pact Nigeria will strengthen gender equity in HIV/AIDS care and support programs using a comprehensive approach; addressing the specific needs of children in this regard and emphasizing male involvement in care initiatives to ensure sustainability. Pact will collaborate with other USG implementing partners to wrap around good governance by securing services that protect the rights of the child, enhance food supply, improve sanitation in communities, provide clean water and insecticide treated nets (ITN), and strengthen non-HIV health services, including child health and nutrition.

This project will contribute towards reaching 50,000 OVC out of the USG overall strategic plan for Nigeria. It will also contribute to strengthening the national, state and local level systems for implementing quality OVC programs. The Child Status Index (CSI) will be used for monitoring the OVC in order to assess the impact of the program and improve OVC programming using the National guidelines.
The household approach where orphans and vulnerable children along with their caregivers will be

registered to benefit from appropriate services will be used. OVC and their caregivers will be recruited into the program by CBOs and FBOs. The community volunteers working for these organisations will identify children and households that fit the criteria of those in need. Children will be identified during day to day interactions at health facilities, churches, mosques and other public places. All sectors of the community including community leaders, women groups, youth leaders, religious/traditional leaders and other key persons will be sensitised to give them an understanding of the project and gain their commitment. The criteria for orphans and vulnerable children who are eligible will be shared with them. REACH Nigeria will implement OVC Monitoring and Evaluation activities by supporting local organizations in the focus states; through the institution/establishment of a Monitoring and Evaluation system that is aligned with the National OVC Monitoring and Evaluation framework. The M&E system will enhance monitoring and management of OVC making quality data available at all levels for monitoring, evaluation, guiding program management and communicating program achievements. Effective data collection, collation, analysis and reporting services will be carried out by Pact to continually assess the programs overall progress towards measurable outcomes. Regular M&E training and mentoring of service providers will also be carried out.

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| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVAB | 202,732 | |

**Narrative:**

None

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 10028** | **Mechanism Name: USAID Track 2.0 AED Workplace** |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Academy for Educational Development | |

| | |
|---|---|
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 1,008,334** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 1,008,334 |

## Sub Partner Name(s)

| | | |
|---|---|---|
| National Union of Chemical Footwear Rubber Leather and Non Metallic Products Employees | National Union of Petroleum and Natural Gas Workers | National Union of Road Transport Workers (NURTW) |
| National Union of TeOld Sitetile Garment and Tailoring Workers of Nigeria | Nigerian Business Coalition Against AIDS | Senior Staff Association of Nigerian Universities |

## Overview Narrative

ACTIVITY UNCHANGED FROM FY 2009

ACTIVITY DESCRIPTION

The rate of economic growth in Sub-Saharan Africa has fallen by as much as four percent because of AIDS, and labor productivity has dropped 50% in the hardest hit countries. Some Sub-Saharan African countries will see a drop of 25% in their workforce by 2020 due to AIDS, and in some countries AIDS is already costing employers over 20% of their total earnings. HIV/AIDS is heavily impacting upon the workforce and the national and state economies of Nigeria. Nigeria's burden of care related to HIV and AIDS now ranks third in the world.

Nigeria, with a national HIV prevalence of 4.6% (HSS 2008) and HIV prevalence exceeding 5% in some states, would be characterized as having a concentrated epidemic. While Nigeria's prevalence is lower than its neighbouring countries, it nonetheless represents a higher number of infections, given the large population, Nigeria now has the highest number of HIV/AIDS –infected adults in West Africa and faces many challenges in tackling the epidemic, including poverty, lack of prevention, knowledge, lack of female empowerment, the vulnerability of youth with 60% of the population under 24, and strong stigma and discrimination against people living with and affected by HIV and AIDS.

HIV/AIDS is heavily impacting upon the workforce and the national and state economies of Nigeria. Nigeria's burden of care related to HIV and AIDS now ranks third in the world. With 66 million individuals participating in Nigeria's public and private sector labor force, the workplace is an ideal setting for effectively addressing HIV/AIDS through sensitization programs, prevention messages, and linkages to care and treatment for a large percentage of Nigerians infected and affected by HIV.

Since 2001, with initial funding from the US Department of Labor, AED implemented the SMARTWork Program in Nigeria to support workplace HIV/AIDS prevention education programs at the enterprise and national levels. Under the current USAID's PEPFAR project, AED is working in partnership with Nigerian Business Coalition Against AIDS (NIBUCAA) and five labor unions - the National Union of Chemical Footwear, Rubber, Leather and Non-Metallic Products Employees (NUCFRLANMPE), the National Union of Textile Garment & Tailoring Workers of Nigeria (NUTGTWN), the National Union of Road Transport Workers (NURTW), the National Union of Petroleum and the Natural Gas Workers (NUPENG), and the Senior Staff Association of Nigerian Universities (SSANU) to expand HIV/AIDS workplace anti-stigma and discrimination training, Abstinence, Be Faithful, and Condom (ABC) sensitization programs and HCT service delivery across sixteen states..

The overall goal of USAID/Nigeria - SMARTWork Program is to expand access to comprehensive high-quality prevention, care and support services to the working population by increasing local indigenous groups' capacity to implement these services in Nigeria while its objectives are:

1. To increase the technical, organizational and managerial capacity of local partners to deliver high quality HIV prevention, care and support services
2. To engage multiple public and private sector employers, including small and medium enterprises (SMEs) to develop and implement workplace HIV prevention programs
3. To promote healthy behavior change using workplace interventions to reduce the transmission of HIV/AIDS
4. To increase the uptake and accessibility of high-quality HIV counseling and testing (HCT) services through workplace (mobile and fixed) and government facilities.
5. To ensure greater uptake of care and treatment services through effective referral networks.

With the ultimate goal of sustainability and building partners' systems, a management and infrastructural audit of partners was conducted through the administration of a management questionnaire. Findings indicated that a lot of challenges bewildering the partners include lack of technical skill and competency, weak infrastructure, poor management information systems, absence of audit report and weak financial base to adequately support workplace HIV/AIDS programs. AED will continue to provide technical and organizational capacity building support in COP2010 to ensure that project partners have the systems

and technical expertise that clearly meets US government regulations, that each partner passes external audits and will have the ability to effectively compete for, and access, a US government funded agreement.

AED will continue to work with NIBUCAA and the unions to identify and prioritize critical capacity gaps and needs, as well as strengths and develop organizations specific capacity building targets and objectives in the action plans and periodically evaluate progress towards meeting objectives. Further efforts will also be made to strengthen the ability of the partners to conduct prevention and HCT scale up activities through direct technical assistance, mentoring during regularly conducted site visits; ongoing supervision; meetings to share lesson learned, problem solve and plan future activities.

In COP 2010, HTC strategies will continue to focus on providing HTC services for workers and their families and linking those who test positive to care, treatment and other appropriate HIV/AIDS services. AED will provide HTC services through two mobile HTC units, seven enterprises' clinics and six regional public hospitals. AED/SMARTWork will coordinate capacity building, infrastructure improvements and logistics management information systems (LMIS) in HTC sites to ensure quality service provision. Linkages will also be established and strengthened with other service providers in the referral network to ensure a continuum of care for HIV positive clients and families.

In partnership with NIBUCAA and five labor unions, the project will provide two models of HTC (client and provider-initiated HIV testing and counseling) implemented according to national testing protocols. AED and NIBUCAA will jointly manage and directly implement the HTC component of the project while the unions will mobilize workers and their families to access services. Additionally, AED will assist in tracking referrals of positive workers and family members into care and support.

In COP 2010, AED/SMARTWork will focus more on reaching the target populations with a minimum of three interventions in the workplace. Intervention strategies will promote sexual prevention through abstinence for unmarried individuals and fidelity for married individuals and those in long-term sexual partnerships. The risk and vulnerability of the target groups to HIV are propelled by behaviors like multiple sexual partnerships, drug/alcohol use and demographics associated with high mobility and long periods away from their families, limited access to health care services and condom availability. In addition, lack of information about risky behavior, risk perception and risk personalization may inadvertently put them at risk of STIs including HIV.

In COP 2010, SMARTWork partners (NIBUCAA, NUPENG, NURTW, NUTGTWN, SSANU and NUCFRLANMPE) will target employees and their family members with HIV prevention interventions on abstinence and/or being faithful and condoms; 75,000 individuals will be reached with HIV prevention

interventions that are primarily focused on abstinence and/or being faithful and 10,000 individuals with other HIV prevention interventions. AED will strengthen interactions and key referrals between health care facilities and the community as part of sexual prevention activities in the workplace programs. AED will work with the unions, the SMEs and enterprises to identify the right strategy and mix of interventions pooling from a broad range of identified best practices.

NIBUCAA conducted participatory needs assessment with each of the participating SMEs in COP 2009 prior to the launch of programmatic activities. AED and NIBUCAA will continue to provide technical support to all 85 enterprises (35 large enterprises and 50 SMEs) and financial support to the SMEs for workplace HIV prevention program implementation in COP 2010. AED and NIBUCAA will initiate and sustain regular meetings, promote resource and tool sharing and discuss barriers faced in program implementation with networks of individuals across SMEs. Each enterprise will conduct at least 1 community outreach during the period.

AED will continue to support partners through the process of condom procurement and storage, along with establishing stronger collaboration with Society for Family Health to ensure a consistent condom supply for 50 condom outlets established in COP 2009. AED will also provide necessary guidance to NIBUCAA and the five unions on distribution of relevant IEC/BCC materials to reinforce messages on abstinence, faithfulness and /or consistent and correct condom use. Dissemination strategies include distribution of materials at workshops, seminar, company-level presentations, special events like World AIDS Campaign, Workers Day, and integration of HIV/AIDS preventive messages into workplace newsletters, journals and other periodicals.

AED's workplace project is well positioned to address the unique needs of men and women in preventing and dealing with HIV. Gender plays an integral role in determining an individual's vulnerability to HIV infection, his or her ability to access care, support or treatment and the ability to cope with HIV when infected or affected. In Nigeria, HIV transmission and negative impacts of HIV in the country are fuelled by various factors that include gender inequities. The inequities are often not acknowledged or recognized, and, combined with other factors, poses a significant challenge in HIV programming in the workplace. Given the critical relationship between gender and effective HIV prevention, it has become imperative to incorporate gender considerations into workplace HIV programming.

Women are an increasing part of the formal workforce in developing countries and account for 61.5% of the adults living with HIV in Nigeria. Women and young girls are subject to all forms of sexual abuse, rape, forced sex and intimidations. They are sometimes infected as a result of gender-based violence in the workplace and elsewhere. Workplace education programs need to include gender-balance and gender-sensitive information both male and female workers, sometimes provided in separate sessions.

Female workers should have equal access to prevention education, care and support services. Efforts to attain gender equity in all aspects of the workplace include:

• Advocacy / lobbying initiative to spark policy changes to women empowerment via greater involvement in decision making concerning gender issues in workplaces.
• Advocate for active participation of female representatives in HIV/AIDS committees, policy development, implementation and monitoring of individual enterprise HIV/AIDS programs.
• Integrate gender sensitive HIV/AIDS prevention programs into every enterprise's HIV/AIDS activities.
• Enhance the educational campaign targeted to labor unions, employers and government agencies to mainstream relevant gender issues in their workplace HIV/AIDS activitie
• Promote female controlled methods such as female condoms that offer women more control in negotiating safe sex as well as prevention of STI including HIV and unplanned pregnancy.

AED will continue to work with the Federal Ministry of Labor, National Agency for the Control of AIDS, Nigeria Labor Congress and the Nigeria Employers' Consultative Association on advocacy and capacity building initiative to ensure that workplace effectively address the concerns of different at risk and vulnerable groups, sensitively address issue of stigma and discrimination and effectively monitor and evaluate their programs.

LINKAGES WITH OTHER PEPFAR ACTIVITY
SMARTWork will continue to collaborate with other organizations including Network of People Living with HIV/AIDS in Nigeria (NEPWHAN), GHAIN for care and treatment especially ART and PMTCT; Society for Family Health on condom logistics, the Supply Chain Management System project on HIV test kit logistics, JSI/MMIS on safe injection techniques for health workers in workplace clinics and regional hospitals.

POPULATION TARGETED
The populations targeted are the Nigerian working population and union members.

KEY LEGISLATIVE ISSUES ADDRESSED
Working with enterprises to develop effective policies will lead to an increased understanding of workplace HIV/AIDS prevention efforts and will assist in removing barriers toward HIV/AIDS prevention through ensuring workplace protection and guaranteed human rights of workers infected and /or affected by HIV/AIDS. AED hopes to work with other organizations to work on the National Assembly to pass the anti-stigma law.

COP 2010 PEPFAR ACTIVITY TARGETS:

PEPFAR Indicator P8.1.D: Number of the targeted population reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required (10,000 individuals will be reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required in COP 2010)

PEPFAR Indicator P8.2.D: Number of the targeted population reached with individual and/or small group level preventive interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required (75,000 individuals will be reached with individual and/or small group level preventive interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required in COP 2010)

PEPFAR Indicator P10.1.D: Number of enterprises implementing an HIV/AIDS workplace program, providing at least one of the 4 critical components (25 enterprises will implement HIV/AIDS workplace programs, providing at least one of the 4 critical components)

PEPFAR Indicator P10.2.D: Estimated number of people reached through work place programs (85,000 people will be reached through work place programs in COP 2010)

PEPFAR Indicator P11.1.D: Number of individuals who received Testing and Counseling (T&C) services for HIV and received their test results (20,000 individuals will receive Testing and Counseling (T&C) services for HIV and their test results in COP 2010)

PEPFAR Indicator H2.3.D: Number of health care workers who successfully completed an in-service training program (60 health care workers will successfully complete an in-service training program on HTC in COP 2010)

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Gender: Reducing Violence and Coercion | 20,167 |
| Human Resources for Health | 16,133 |

## Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Increasing women's legal rights and protection
Mobile Population
Workplace Programs

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **10028** |
| **Mechanism Name:** | **USAID Track 2.0 AED Workplace** |
| **Prime Partner Name:** | **Academy for Educational Development** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HVCT | 90,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Other | OHSS | 200,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVAB | 564,167 | |

**Narrative:**

ACTIVITY UNCHANGED FROM FY 2009

ACTIVITY DESCRIPTION:

In COP 2010, AED will continue to focus on strategic HIV prevention interventions targeted at reaching specific workplace populations. AED's activities (abstinence and/or being faithful) under sexual prevention are designed to support prevention among working adults and equip them with the skills and

information to promote prevention with their children and partners. AED/SMARTWork will focus more on reaching the target populations with a minimum of three interventions in the workplace as outlined in Nigeria's National Prevention Plan. Intervention strategies will promote sexual prevention through abstinence for unmarried individuals and fidelity for married individuals and those in long-term sexual partnerships.

Nigeria, with a national HIV prevalence of 4.6% (HSS 2008) and HIV prevalence exceeding 5% in some states, would be characterized as having a concentrated epidemic. With 66 million individuals participating in Nigeria's public and private sector labor force, the workplace is an ideal setting for effectively addressing HIV/AIDS through sensitization programs, prevention messages, and linkages to care and treatment for a large percentage of Nigerians infected and affected by HIV/AIDS.

IBBSS 2007 revealed that among predominantly male occupational groups (transport workers, armed forces and police), multiple partnerships are quite common while condom use with girlfriends was lowest with police (45%) and transport workers (45.4%). Although syphilis levels were low across the board (0.8%), the prevalence was highest among transport workers (1.7% according to the 2007 IBBSS). To reduce risky behavior, SMARTWork will continue to work with the National Union of Road Transport Workers (NURTW) including their motorcycle riders' unit who are predominantly youths to provide their members with HIV prevention interventions. Stereotypical characteristics of the workplace target audience include male dominance, physical strength, virility, and risk taking. Other associated risk factors, such as drug and alcohol use, play a role in diminishing inhibitions, and contribute to unsafe sexual behavior and sexual violence. The risk and vulnerability of the target groups to HIV are propelled by behaviors like multiple sexual partnerships, drug/alcohol use and demographics associated with high mobility and long periods away from their families, limited access to health care services and condom availability. In addition, lack of information about risky behavior, risk perception and risk personalization may inadvertently put them at risk of STIs including HIV.

AED will continue to pursue interventions that encourage youth to delay sexual debut till marriage, engage in secondary abstinence and reduce sexual risk taking while recognizing that abstinence is the only certain way to avoid sexually transmitted HIV infection. Interventions targeting sexually active adults at higher risk of HIV-infection will encourage behavior change to reduce the number of sexual partners (especially casual sexual partnerships) and promote marital fidelity. AED will reach out to PLHAs through promotion of their enrollment in and adherence to ART programs and/or promoting abstinence and consistent condom use with sexual partners to prevent re-infection.

In COP 2010, SMARTWork partners (NIBUCAA, NUPENG, NURTW, NUTGTWN, SSANU and NUCFRLANMPE) will target employees and their family members with HIV prevention interventions on

abstinence and/or being faithful; 75,000 individuals will be reached with HIV prevention interventions that are primarily focused on abstinence and/or being faithful. AED will strengthen interactions and key referrals between health care facilities and the community as part of sexual prevention activities in the workplace programs. AED will work with the unions, the SMEs and enterprises to identify the right strategy and mix of interventions pooling from a broad range of identified best practices.

AED will conduct community/enterprise awareness campaigns to clarify strategies and activities of the SMARTWork approach and educate the management of each enterprise. These meetings will take place prior to launching program activities in each establishment, in order to build awareness of HIV/AIDS issues and to answer any concerns participants may have. Enterprises and unions will be encouraged to undertake HIV/AIDS program outreach activities for their individual host communities where the enterprise is domiciled and reach out to the workers' family members with necessary information and education on HIV/AIDS. Capacity building activities may vary based on individual partner/enterprise needs but AED will support each enterprise and partner to conduct a series of two-day seminars for the community on abstinence and being faithful, interpersonal communications, community mobilization methods, peer education strategies and linking programs with counseling, testing and care and treatment centers as well as efforts at partner reduction and mutual fidelity Each enterprise will conduct at least 1 community outreach during the period.

AED/SMARTWork will continue to support each partner enterprise to establish a team whose members represent various aspects of the workplace and who share a commitment to addressing HIV/AIDS, with skills to "sell" the program to others in the workplace. The planning committee will include men and women from different departments and levels, as well as workers living with HIV/AIDS. The joint management-labor committee ensures that differences are taken into account and policies and programs can be developed that work for all areas of the workplace. AED will provide assistance in identifying the appropriate persons to represent the diverse interests and needs of workforce. In addition, AED will conduct a three-day capacity building training for members of the HIV/AIDS Planning Committee. The training will include all aspects of HIV/AIDS policy and program development and equip committee members with ability to play leading role in the management of the enterprise's HIV/AIDS workplace program.

AED will continue to provide technical support to the HIV/AIDS Planning Committee members of the enterprises to sensitize all the employees in the company's key locations about basic HIV/AIDS prevention and transmission information, voluntary counseling and testing, workplace issues related to stigma and discrimination, and mainstreaming HIV programs into workplace.

Peer educators will continue to conduct informal education and training activities for their co-workers.

AED will provide technical assistance to enterprises and unions in selecting appropriate staff to participate in a three-day peer educators training promoting HIV prevention through abstinence and/or being faithful. A proportion of staff in ratio of 10:1 peer educators will be reached through informal small groups and one-on-one interactions to discuss HIV/AIDS, teach safer sex practices, answer questions, distribute materials, and generally foster an environment of greater awareness and understanding about HIV/AIDS.

AED will continue to provide necessary guidance to NIBUCAA and the five unions on distribution of relevant IEC/BCC materials to reinforce messages on abstinence, faithfulness and /or consistent and correct condom use. AED will continue the distribution of extensive catalogue of behavior change tools and materials for the workplace that enables immediate implementation of activities and important leveraging of existing resources for use by the workers. Dissemination strategies include distribution of materials at workshops, seminar, company-level presentations, special events like World AIDS Campaign, Workers Day, and integration of HIV/AIDS preventive messages into workplace newsletters, journals and other periodicals.

AED/SMARTWork will continue to encourage parents to be active supporters of youths' health choices by addressing adults' knowledge, attitudes, communication and other parenting skills; and be part of an integrated approach in promoting a healthy lifestyle for young people. Youth focused awareness creation activities including lectures, drama and mascot will focus on behavior change, risk reduction and adoption of safer sex practices. AED will further assist the enterprises' developmental initiatives such as enterprise family days. Family days are often employer-sponsored events for employees to gather together with their families to celebrate the enterprise's yearly performance. During these family day events, trained peer educators will conduct HIV/AIDS education activities. AED will work with the partners to assist the HIV/AIDS Planning Committees at each enterprise level to make substantial input into the planning and implementation of the family days.

Greater Involvement of People Living with HIV/AIDS (GIPA) is critical to halting and reversing the HIV epidemic in Nigeria, AED-SMARTWork therefore will mainstream GIPA into workplace HIV/AIDS programs. Additionally, PLWHA have directly experienced factors that increase vulnerability to HIV infection, hence their involvement in program development and policy making will improve the relevance, acceptability and effectiveness of program. During workshops and trainings, the project will continue to collaborate with Network of People Living with HIV/AIDS in Nigeria (NEPWHAN) through PLWHA's participation in workplace HIV/AIDS programs which ultimately will assist in changing perception and provide valuable experiences and knowledge sharing. Openly acknowledging their sero-status addresses myths and misconceptions about HIV/AIDS and PLWHAs as well as encourages infected workers to combat fear and shame by disclosing their status. PLWHA will also be advocates for the development of

HIV/AIDS policy as well as law and policy reforms. The partners and enterprises including the 50 SMEs will be encouraged to continue to engage qualified PLWHA in workplaces.

Additionally, reaching men who are in the majority in workplaces in Nigeria with HIV/AIDS messages is one of the innovative ways of dealing with HIV/AIDS pandemic particularly aiming at capacity building in healthy lifestyles skills, information gathering and sharing , monitoring the pandemic and establishing how men's behavior, attitudes and practices change over time.

LINKAGES WITH OTHER PEPFAR ACTIVITY
SMARTWork will continue to collaborate with other organizations including Network of People Living with HIV/AIDS in Nigeria (NEPWHAN), Society for Family Health on condom distribution, the Supply Chain Management System project on HIV test kit logistics, CEDPA on palliative care, JSI/MMIS on safe injection techniques for health workers in workplace clinics and regional hospitals.

POPULATION TARGETED
The populations targeted are the Nigerian working population and union members.

COP 2010 PEPFAR ACTIVITY TARGETS:

PEPFAR Indicator P8.2.D: Number of the targeted population reached with individual and/or small group level preventive interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required (75,000 individuals will be reached with individual and/or small group level preventive interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required in COP 2010)

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVOP | 154,167 | |

**Narrative:**

None

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| Mechanism ID: 10029 | Mechanism Name: USAID Track 2.0 GHAIN |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Family Health International | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| Total Funding: 52,844,762 | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 52,844,762 |

## Sub Partner Name(s)

| | | |
|---|---|---|
| Abia State University Teaching Hospital | Abuja Municipal Area Council, Federal Capital Territory | Achieving Health Nigeria Initiative |
| Agbani District Hospital | Ajeromi LGA HAST | Anyimgba Diag and Ref Hospital |
| Axios International | Bamaiyi Memorial Medical Centre | Catholic Archdiocesse of Abuja (CACA) HAST |
| Central Hospital Auchi, Edo | Central Hospital Bassa | Central Hospital Benin |
| Central Hospital Sapele | Central Hospital Warri | Civil Service Hospital |
| Community Health Project (St. Theresa) Amukoko | Comprehensive Health Centre Ikom, Cross River | Crusade for Greater Nigeria |
| District Hospital, Enugu Ezike | District Hospital, Udi | Dr Lawrence Henchaw Hospital |
| Eja Memorial Joint Hospital, Itigidi | FaCE PaM Bauchi HAST | Federal Medical Center Gusau |
| Federal Medical Center Owerri, Imo State | Federal Medical Center Owo | Federal Medical Center Yenagoa |
| Federal Medical Center, B/Kebbi | Federal Medical Center, Jalingo | Federal Medical Center, Umuahia |
| Federal Medical Center, Yola | First Referral Hospital, Mutum-Biyu | FOMWAN Kachia |
| Fortress for Women | General Hospial Onueke | General Hospital Abudu |
| General Hospital Ahoada | General Hospital Ajeromi, Lagos | General Hospital Akamkpa |
| General Hospital Alkaleri, Bauchi | General Hospital Amaku, Awka | General Hospital Amanawa |

| | | |
|---|---|---|
| General Hospital Ankpa | General Hospital Apapa | General Hospital Awe |
| General Hospital Awo-omama | General Hospital Azare | General Hospital Babbar Ruga |
| General Hospital Badagry, Lagos | General Hospital Bakura | General Hospital Billiri |
| General Hospital Birnin Gwari | General Hospital Birnin-Magaji | General Hospital Bokkos |
| General Hospital Bwari | General Hospital Calabar | General Hospital Danbatta, Kano |
| General Hospital Dass, Bauchi State | General Hospital Daura | General Hospital Dogon-Daji |
| General Hospital Dukku | General Hospital Dutsinma | General Hospital Ekwulobia, Anambra |
| General Hospital Enugwe Ukwu | General Hospital Epe, Lagos | General Hospital Erema |
| General Hospital Funtua | General Hospital Gamawa, Bauchi State | General Hospital Gbagada, Lagos |
| General Hospital Gboko | General Hospital Gembu | General Hospital Gumel, Jigawa State |
| General Hospital Gwarzo, Kano | General Hospital Gwoza | General Hospital Iboko |
| General Hospital Igarra | General Hospital Ikara | General Hospital Ikorodu, Lagos |
| General Hospital Ikot Abasi | General Hospital Ikpe Annang | General Hospital Illela |
| General Hospital Iruekpen | General Hospital Isolo, Lagos | General Hospital Kachia |
| General Hospital Katsina | General Hospital Katsina-Ala | General Hospital Kauran Namoda |
| General Hospital Keana | General Hospital Konduga | General Hospital Kontagora |
| General Hospital Kubwa | General Hospital Kuje | General Hospital Kumo |
| General Hospital Kura, Kano | General Hospital Kwali | General Hospital Lagos |
| General Hospital Langtang | General Hospital Maradun | General Hospital Minna |
| General Hospital Misau, Bauchi State | General Hospital Monguno | General Hospital Mubi |
| General Hospital Nassarawa | General Hospital Ningi, Bauchi State | General Hospital Numan |
| General Hospital Nyanya | General Hospital Oban | General Hospital Obi |
| General Hospital Obubra | General Hospital Oju | General Hospital Okigwe |
| General Hospital Onitsha | General Hospital Oron | General Hospital Owerri |
| General Hospital Potiskum | General Hospital Sagbama | General Hospital Shinkafi |
| General Hospital Suleja | General Hospital Talatan Mafara | General Hospital Tambawal |
| General Hospital Tureta | General Hospital Uromi | General Hospital Wukari |

| | | |
|---|---|---|
| General Hospital Wuse | General Hospital Yabo | General Hospital Yauri |
| General Hospital Zango Kataf | General Hospital Zauro | General Hospital Zing |
| General Hospital, Akpet | General Hospital, Bali | General Hospital, Bama |
| General Hospital, Biu | General Hospital, Ekpan | General Hospital, Mararaba |
| General Hospital, Obanliku | General Hospital, Oji River | General Hospital, Ugep, Yakurr L.G.A |
| General Hospital, Umuokanne | General Hospital, Warri | German Leprosy and TB Relief Association |
| Girls' Power Initiative | Hasiya Bayero Pediatric Hospital | Holy Family Catholic Hospital Ikom |
| Howard University | Immaculate Heart Hospital and Maternity Nkpor | Immunel General Hospital, Eket |
| Infectious Disease Hospital, Bayara | Infectious Diseases Hospital | Initiative for Peoples Good Health (People Arise!) |
| International Centre for Advocacy on Rights to Health, Nigeria (ICARH) (Formerly Alliance Rights Nigeria) | Iyi Enu Hospital | Kachia HAST Local Government |
| Lagos Island General Hospital | Lagos Mainland General Hospital, Lagos | Lagos State AIDS Control Agency |
| Life Link Organization | Lutheran Hospital Yahe, Yala | Maitama District Hospital |
| Mambilla Baptist Hospital, Gembu | Martha Bamaiyi Hospital Zuru | Massey St. Children's Hospital, Lagos |
| Model Primary Health Care Center, Odakpu | Murtala Mohammed Specialist Hospital | Nassarawa HAST Local Government |
| National Union of Road Transport Workers FCT | National Union of Road Transport Workers Lagos | National Union of Road Transport Workers, Nigeria |
| Niger Delta University | Nigeria Customs Medical Center Karu | Nka Iban Uko |
| Nuhu Bamalli Hospital | Oko Community Hospital | Orhionmwon LGA Edo State |
| Oriade Primary Health Centre | Orile Agege General Hospital | Planned Parenthood Federation of Nigeria |
| Presbyterian Tuberculosis and Leprosy Hospital Mbembe | Primary Health Center Bateriko | Primary Health Center Efraya, Etung |

| | | |
|---|---|---|
| Primary Health Center Ikot Okpora, Biase | Primary Health Center Obudu Ranch, Obaniku | Primary Health Center Utanga, Obanliku |
| Primary Health Centre, Ikot Omin | Primary Health Centre, Ofatura | Redeemed AIDS Program Action Committee (RAPAC) |
| Regina Caeli Maternity Hospital Awka | Regina Mundi Catholic Hospital, Mushin | Sabo Bakin Zuwo Hospital |
| Sancta Maria Catholic Hospital | Sani Abacha Specialist Hospital Damaturu | Save the Child Initiative |
| Sheikh Mohammed Jidda Hospital | Shell Petroleum Cottage Hospital | Sir Mohammed Sanusi Hospital |
| Sir Yahya Memorial Hospital Birnin Kebbi | Society Against the Spread of AIDS | Specialist Hospital Sokoto |
| Specialist Hospital Yola | St. Benedict Tuberculosis and Leprosy Hospital Moniaya-Ogoja | St. Charles Borromeo |
| St. Mary's Catholic Hosp. Gwagwalada | State Hospital Ikole | State Hospital Sokenu, Abeokuta, Ogun State |
| State Hospital, Asubiaro | State Hospital, Otta | State Hospital, Oyo |
| State Hospital, Saki | Surulere General Hospital | SWAAN Anambra |
| SWAAN Kano | The Armed forces Program for AIDS Control Airforce Hospital | The Armed Forces Rreproductive Health Program Navy Hospital |
| The Independent Project (TIP) Mens Health Project | Tiga General Hospital | Udi LGA Enugu State |
| Umaru Shehu Ultramodern Hospital Maiduguri | University of Calabar Medical Centre | Wamakko L.G. Council |
| Wudil General Hospital | Yakurr LGA Cross River | |

## Overview Narrative

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Construction/Renovation | REDACTED |
| Economic Strengthening | 510,448 |
| Education | 510,448 |
| Food and Nutrition: Commodities | 510,448 |

| | |
|---|---|
| Food and Nutrition: Policy, Tools, and Service Delivery | 510,448 |
| Gender: Reducing Violence and Coercion | 510,448 |
| Human Resources for Health | 1,020,895 |
| Water | 510,448 |

## Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
Military Population
Mobile Population
Safe Motherhood
TB
Family Planning

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **10029** |
| **Mechanism Name:** | **USAID Track 2.0 GHAIN** |
| **Prime Partner Name:** | **Family Health International** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HBHC | 7,529,300 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HKID | 2,273,906 | |

| Narrative: | | | |
|---|---|---|---|
| None | | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Care | HTXS | 17,738,775 | |
| **Narrative:** | | | |
| None | | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Care | HVCT | 177,350 | |
| **Narrative:** | | | |
| None | | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Care | PDCS | 1,000,000 | |
| **Narrative:** | | | |
| None | | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Care | PDTX | 1,626,350 | |
| **Narrative:** | | | |
| None | | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Other | HVSI | 2,459,945 | |
| **Narrative:** | | | |
| None | | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Prevention | HMBL | 60,000 | |
| **Narrative:** | | | |
| None | | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |

| | | | |
|---|---|---|---|
| Prevention | HMIN | 175,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVAB | 446,011 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVOP | 2,005,795 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | MTCT | 5,378,846 | |

**Narrative:**

ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS:

In COP10, GHAIN will continue supporting activities to prevent mother-to-child HIV transmission (PMTCT) in the existing 168 GHAIN supported sites. Through these sites, an approximately 120,000 pregnant women will be tested, counseled and informed of their HIV status as possible. GHAIN staff will continue to train and mentor the facility staff to enable them deliver PMTCT services according to the national guideline, to reduce the risk of mother-to-child-transmission. In addition, GHAIN will continue intensive PMTCT mobilization and awareness in all 16 LGAs of Taraba state aimed at not only saturating the state with PMTCT services, but also to create demand and increase the access to early infant diagnosis (EID) services utilizing the recently commissioned EID laboratory at Jalingo Federal Medical Center. Through these strategies, facilities will be supported to reach approximately 4,000 HIV-positive pregnant women in the COP year.

To increase access and uptake of PMTCT services, GHAIN will continue to support integration of PMTCT services into maternal and child health services commencing at antenatal care (ANC) at the primary health care (PHC) level which serves as an entry point to HIV/AIDS prevention, care and support services for mothers, their infants, family members and the community, This is in line with the minimum package stipulated by the GON and the USG strategy to provide PMTCT service coverage at the LGA

level; initially in states with high prevalence and in facilities with a high volume of ANC clients.

To address gender issues and generate greater male involvement in PMTCT services, couple counseling will continue to be included in the PMTCT/RH/MIP integrated trainings. This will lead to improved service uptake, and adherence to interventions. The continuation of this new strategy will further address the challenges of partner disclosure and the negative consequences (domestic violence, divorce and abandonment) that have occasionally been noted in discordant couples or when women take unilateral decisions to enroll for HIV services.

Using a family centered approach, PMTCT service providers will promote partner testing as well as testing for any other children in the family. In addition, families with HIV positive children will be encouraged to enroll all them into ART, if eligible or the facility-based care and support programs. GHAIN will also continue to support various strategic initiatives such as provider-initiated testing and counseling in ANC and labor/delivery wards and community outreach activities to cluster ANC and delivery facilities so as to increase the number of pregnant women who know their HIV status and thus triggering enrollment for PMTCT services. GHAIN will continue promoting and educating women on infant feeding options (exclusive breast-feeding for six months or breast milk substitute if affordable, feasible, acceptable, safe and sustainable - AFASS) and addressing misconceptions, stigma and retrogressive social norms that impede uptake of PMTCT services in different parts of the country. Comprehensive services will be encouraged through integration with MCH services which includes counseling and linkages to services such as family planning, infant feeding and immunisation in line with the national IMNCH strategic plan.

To ensure effective coverage at the LGA level, the experience and lessons learnt from piloting the HAST (HIV/AIDS, Sexually transmitted infections/reproductive health and TB) model of providing integrated services at the LGA level in various states will be utilized. Community volunteers identified by CBOs and NGOs will be trained using a specially modified national PMTCT incorporating RH modules to render minimum PMTCT services (linkages and referrals, awareness and demand creation for PMTCT) appropriate to their level of care. Referral from the PHC level to secondary facility will be done when the need arises for higher quality care and treatment.

During the year, GHAIN will give more focus to enhancing service quality and strengthening measures for sustainability using performance indicators of the PMTCT service cascade. The skills of health care providers in the supported facilities will be strengthened through additional training and mentoring to cover all modules in the national PMTCT training curriculum and through the integration of RH and malaria services using other funding sources. Family planning services integrated with HIV services will be offered in a number of select facilities to address and strengthen the second prong of core PMTCT

which aims at preventing unwanted pregnancies amongst women/couples that are HIV infected and in a bid to reduce the number of children exposed to the virus. MIP services will be strengthened through mentoring of trained staff and advocacy to facilitate access to preventive therapy and insecticide treated nets. Additional emphasis will be put on strengthening the link of ANC – Maternity – Under-5 services in order to improve a continuum of prevention, treatment, care and support for mothers and children. Linkages to the national Integrated Maternal Newborn and Child Health (IMNCH) will be strengthened and collaborations with other partners working in this area established.

GHAIN will continue to ensure that supported sites provide quality PMTCT service in line with national and international standards and evidence-based best practices. Project activities will be tailored towards improving quality and build in sustainable take over capacity by ensuring that health care workers have up to date PMTCT knowledge and skills; enforcing adherence to SOPs; ensuring that all point of service have the necessary tools, materials and logistics; ensuring that CT with 'opt out' option is offered to all women presenting in ANC, in labor & delivery wards, and post-natal in the family planning units; while encouraging male involvement; instituting effective intra and inter-facility referral mechanisms; and ensuring that antiretroviral (ARV) drugs are offered to HIV + pregnant women. PMTCT prophylaxis will be provided,(zidovudine starting at 28 weeks, zidovudine and lamivudine if starting at 34 weeks until delivery and single dose nevirapine at the onset of labour), or ARV treatment (CD4 count less than 350) according to the national guidelines for their own health. Post-partum interventions for exposed infants including single dose nevirapine within 72 hours of birth and zidovudine syrup for 6 weeks)., CTX prophylaxis is commenced from six weeks after birth, until their status is determined, utilizing the national guideline as basis for treatment decisions.

All clients who are tested will receive results on the same day as feasible. HIV testing of all partners of pregnant women will be actively encouraged and women/couples counseled and linked to FP services as needed. This will be ensured through linkages with the scaled up GHAIN supported RH-HIV integrated services. Those who test negative to HIV will receive post-test counseling on how to remain negative. Positive and discordant couples will be given prevention for positive package and provided information to address their future fertility desires (family planning services). GHAIN will utilize lessons learnt and best practices from other programs in ensuring that positive mothers delivering outside health facilities have access to single dose nevirapine in labor.

Mothers' support groups will also be used to track and support mother-infant pairs and other family members in the communities and link them to care. In addition, strengthening of SBC activities in the facility and community will be continued as a strategy to improve awareness on the need for mothers to deliver in the facilities and to return for care and support for themselves, their babies and for their family. In addition, the family will be encouraged to enroll all their children into the facility based care and support

program.

GHAIN will continue to train lay counselors to provide counseling services to pregnant mothers, thus, reducing workload and burnout of regular counselors. Other activities will include encouraging male involvement by using trained community gate-keepers to sensitize the community with special focus on men; encouraging men to accompany their wives to the clinics and ensuring that holistic services are offered to HIV+ pregnant women and their families. Positive pregnant women identified at PHC level, will have their CD4 done at the linked secondary facility through sample referral. Identified positive women will subsequently be followed up at an HIV comprehensive care centre to ensure continuity of care. CD4 test will be prioritized for pregnant women to identify and refer those who require ART for their own health. PMTCT services will also be geared towards ensuring that in labor & delivery rooms, safe obstetrical practices and universal precautions are implemented.

Funding will address capacity building of health care workers on counseling (HIV, FP, IFC amongst others), strengthening linkages with EID services and support to families on infant feeding options in accordance with the mother's choice and, the national guideline on infant feeding. GHAIN will train and re-train pharmacists on pharmaceutical care, pharmacy best practices and adherence counseling in PMTCT sites while collaborating with the community pharmacists to expand the reach and quality of services at LGA and community level.

Joint GON/USG/GHAIN supportive supervision will be carried out to all the sites on a quarterly basis, in addition to regular onsite mentoring and support of the sites by FHI/GHAIN technical team. Appropriate tools for program monitoring including National PMTCT registers will be provided to all the sites while monthly DQA will be carried out in collaboration with the relevant state and national bodies. Feedback will be provided to the facilities and stakeholders through the monthly M&E meetings hosted at SACA offices. The quality of services will be assured through facilitative supervision, M&E, QA/QI analysis and QA checks using standardized national tools developed for this purpose. In line with the '3 ones', GHAIN will disseminate information through regular reporting to the GoN via NACA and NASCP.

As part of its strategy to enhance the sustainability of PMTCT programs, in COP 10, GHAIN will rededicate its efforts towards ensuring that technical and institutional capacities of its PMTCT implementing agencies (IAs) are strengthened to effectively plan, implement, monitor, maintain and evaluate PMTCT programs. During the period, GHAIN will transition activities to the respective federal, state, local governments departments responsible for PMTCT, as well as FBOs and NGOs currently supporting PMTCT programs. To actualize this strategy, GHAIN will support the responsible government departments and agencies to prioritize developing and retaining health care workers; strengthening health systems; building their capacities to plan, implement, monitor and evaluate PMTCT activities; and

to have a solid understanding of financing and costing information to inform planning and decision making concerning PMTCT programs.

Additionally, GHAIN will ensure that in addition to technical skills oriented training, HAST LGA based IAs (CSOs) receive training in organizational development with emphasis on such topics as governance, program design, monitoring and evaluation, resource mobilization and financial management. Also, during COP 10, GHAIN will focus on providing TA and oversight leaving IAs to assume more implementation responsibilities. Additionally, GHAIN will ensure proper documentation and dissemination of SOPs, national policies, guidelines and standards to IAs to enable them continue implementing quality and effective PMTCT interventions after GHAIN. GHAIN will support IAs to ensure that by the end of the 3rd quarter, they all have developed clear and measurable transition and sustainability action plans.

Further, to enhance local and national ownership, GHAIN will continue empowering federal, state and LGA governments to plan, monitor and evaluate PMTCT programs in line with the national HIV/AIDS policy and PMTCT guideline. Through training and advocacy, national and local governments will be empowered to assume full responsibility for creating demand for accurate information and services on PMTCT including creating demand for HIV testing and counseling as well as linking PMTCT efforts with prevention and treatment.

In COP10, under 'PEPFAR Nigeria's accelerated PMTCT plan', GHAIN, will strengthen its support to PMTCT service delivery by implementing activities that further improve the coverage and quality of PMTCT services. These activities will be directed towards increasing utilization of PMTCT services at existing service outlets through demand creation in collaboration with community resources and ensuring the upgrade of existing supported PHCs offering stand alone HIV counseling and testing to render at least minimal package of PMTCT services. In order to leverage resources, priority will be given to PHCs located in the selected focal states with presence of other donor agencies and in local government areas already earmarked for HSS support through GFATM. Where new sites are envisioned, those that are used for national ANC sero-sentinel surveys but yet to commence PMTCT services as well as PHCs located in communities with high HIV prevalence rates above the National average will be given priority.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HLAB | 6,600,200 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Treatment | HTXD | 3,423,284 | |
| **Narrative:** | | | |
| None | | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Treatment | HVTB | 1,950,000 | |
| **Narrative:** | | | |
| None | | | |

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 10031** | **Mechanism Name: USAID LMS ProAct** |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Leadership Management Sustainability, Prevention Organizational Systems AIDS Care and Treatment Project (LMS ProACT) | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 10,678,536** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 10,678,536 |

## Sub Partner Name(s)

| | | |
|---|---|---|
| Axios Partnerships in Tanzania | | |

## Overview Narrative

The Leadership Management Sustainability Prevention organisational system AIDS Care and Treatment LMS ProACT project is designed to develop the leadership and management capacity of health managers and their teams in health care organizations and programs to improve organizational management and operational systems and to strengthen the capacity of health workers, teams, and organizations to deliver

quality HIV/AIDS care and support services. Since 2007, the LMS ProACT project has rapidly and systematically scaled up the availability and accessibility of HIV/AIDS services in 53 sites across six states (Kogi, Niger, Kebbi, Taraba, Adamawa, Kwara) in Nigeria through a process of partnership and capacity building with indigenous public institutions providing health services at primary and secondary health facilities. In COP10 LMS ProACT will work to strengthen the capacity of state and local governments to carry out evidence based strategic and operational planning/budgeting, and advocate for resources needed to sustain their programs. Through this activity, the state and local governments will be able to coordinate wider stakeholder involvement in planning, implementing, monitoring and evaluating HIV/AIDS and TB control efforts. This should lead to improved resource mobilization, deployment and accountability which are critical elements in the initial steps towards government ownership and sustainability. LMS ProACT will support the establishment of TWGs, state supervisory teams, quality assurance and will assist the state and local government to use strategic information to develop plans that will guide the buy in of Implementing Partners and other donor agencies.

In COP10 LMS ProACT project will use a modified Leadership Development Program to develop the capacity of state ministries of health, agencies for the control of AIDS, and two health facility multi disciplinary teams in each of the six states to lead and manage HIV/AIDS prevention and control programs .Training will also emphasize the need to address gender disparities in access to and use of health and HIV/AIDS Services. Additional trainings in HCT, integrated MCH/FP/PMTCT services, Adult and Pediatric ART, basic palliative care, TB/HIV care, laboratory services, M&E and Supply Chain Management Systems and quality assurance will also be conducted. The project will implement a series of tasks to assure high quality services and will liaise with HIVQUAL working group to adapt the quality indicators to the project's M&E system. Continuous quality improvement will be the focus of ongoing professional development efforts and one of the major issues discussed at the quarterly project meetings with the state and local governments.

LMS ProACT will continue to support a minimum of 21 CCT sites in six states to provide the full spectrum of prevention, care and treatment services. HCT activities will focus on strengthening Provider Initiated Testing and Counselling services in all hospital units, PMTCT will be integrated into MCH/FP programs and will focus on providing prophylaxis and HAART for eligible clients. TB/HIV will focus on strengthening linkages between the TB and HIV programs at facility and LGA level, adult and pediatric care and treatment will be provided according to National guidelines, laboratory services will include capacity for CD4 evaluation and patient monitoring. Drugs for Opportunistic Infections, ARVs and other medical supplies procured will be distributed regularly to sites using the "Pull System" which uses site utilization data to forecast the needs for the next quarter. Essential wrap around services particularly nutrition and income generating activities (IGA) will be leveraged through networking and collaboration with other IPs

and organizations that provide these services.

LMS ProACT will work to increase the capacity of local governments to decentralize HIV/AIDS service delivery to at least two selected primary health care (PHC) facilities in each LGA. Decentralization will increase identification of persons who are HIV positive, enhance adherence to care, closer observation and minimize the burden of transportation. To address human resource gaps, LMS ProACT will continue to advocate for task shifting with local authorities and hospital directors while providing the needed mentoring, support supervision and monitoring of implementation activities. Health facilities will be assisted to use task shifting as one mechanism for rationalizing the deployment of available human resources, based on the realities at each facility.

Through fixed small grants, LMS ProACT project will develop the capacity of 12 grass root civil society organisations in six states to deliver community based HIV/AIDS/TB services linked with health facilities. The grants will provide CBOs in six states with technical assistance and funds to address one of the three categories of services: home based care for PLAs (including community-facility-community referrals) OVC care and support, and HIV prevention programs. LMS ProACT prevention strategy involves both primary prevention-Abstinence, Be faithful (AB) and other prevention programs (OPP) and secondary prevention (PwP). Prevention programs will be strengthened to promote low risk among in school and out of school youths and most at risk populations (MARPS). A gender analysis will also be conducted to determine gender disparities that need to be addressed in the prevention programs. Other focus areas include population awareness campaigns, community outreach, peer education models and workplace programs. LMS ProACT COP10 activities are targeted at State and Local governments, health providers, facility managers, CBOs and other individuals in the community in LMS supported states that are involved in the state's HIV response.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Construction/Renovation | REDACTED |
| Education | 299,951 |
| Food and Nutrition: Commodities | 149,976 |
| Food and Nutrition: Policy, Tools, and Service Delivery | 224,963 |
| Gender: Reducing Violence and Coercion | 449,927 |
| Human Resources for Health | 899,854 |
| Water | 149,976 |

## Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
Military Population
Safe Motherhood
TB
Workplace Programs
Family Planning

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **10031** |
| **Mechanism Name:** | **USAID LMS ProAct** |
| **Prime Partner Name:** | **Leadership Management Sustainability, Prevention Organizational Systems AIDS Care and Treatment Project (LMS ProACT)** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HBHC | 933,040 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HKID | 932,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HTXS | 1,482,750 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HVCT | 95,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | PDCS | 137,500 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | PDTX | 75,625 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Other | HVSI | 60,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVAB | 1,236,670 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVOP | 1,135,598 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | MTCT | 2,272,532 | |

**Narrative:**

Activity modified in the following ways: EID services is reported under pediatric treatment and care

Using the revised National PMTCT Guidelines, 12,000 pregnant women will be counseled, tested and receive their results and 552 HIV positive pregnant women will receive ARV prophylaxis. LMS will train 70 health care workers (in addition to the 220 trained in COP09) to work in ANC clinics and delivery wards. In COP10 LMS- will continue the activities initiated in the 36 project-supported PMTCT sites in Kogi, Niger, Adamawa, Taraba, Kebbi and Kwara States during COP 09. PMTCT services will be initiated at 7 additional PHC health facilities in these existing states. This makes a total of 43 PMTCT sites in COP10. In COP09 the project focused on building the capacities of facility based multi disciplinary teams to increase testing and counseling, treatment and prophylaxis for pregnant women and their infants, provide them and their families the appropriate protection and care to reduce the risk of HIV infection or mitigate transmission and negative health effect and in partnership with CBOs facilitated the referral of pregnant positive clients and their families to community based resources. In COP10 LMS ProACT will use a modified Leadership Development Program (LDP) to develop the capacity of state ministries of health, LGA, agencies for the control of AIDS, and two health facility multi disciplinary teams in each of the six states to better plan, lead and manage PMTCT programs .Training will also emphasize the need to address gender disparities in access to and use of health and HIV/AIDS Services. In COP09 the project supported the hosting of the quarterly PMTCT TWG meeting in Niger State to ensure better coordination and mobilization of resources for state level PMTCT interventions. To ensure universal access, the project also supported the mapping of PMTCT services availability in all Local Government Areas in this state. In COP 10, LMS ProACT in collaboration with four State ministries of health and other donor agencies will support the setting up of PMTCT TWG which will serve as a coordination platform for PMTCT activities in the states.

LMS-Pro-ACT will continue to focus on the scale-up of integrated MCH/FP/HIV services to health facilities in 4 states in order to bring about a reduction in the number of unwanted pregnancies in HIV positive women as well as an improvement in maternal and child health outcomes. This will result in a total of 6 states that have been supported to integrate MCH/FP into HIV services. One health facility will be selected per state to pilot the integration process. The capacity of health facilities to carry out integrated MCH/FP/HIV services at all service delivery points will be strengthened. Health workers from selected health facilities will be trained on integrated MCH/FP/HIV services. The state ministries of health will be involved in every step of the integration process and advocacy to leverage family planning commodities and other resources from partner organizations like Society for Family Health, PPFN, UNICEF and UNFPA will be strengthened and sustained.

Activities to improve male involvement in PMTCT will continue in COP10. LMS-Pro-ACT will strengthen

community engagement activities that address maternal and child health issues that result in improved collective health outcomes. The project will support the state ministries of health in the organization and implementation of community town hall meetings with male peer groups and traditional leaders where issues around maternal and child health and HIV stigma and discrimination will be discussed.

Strengthening and quality improvement activities aimed at providing quality PMTCT services to clients in supported health facilities will continue in COP10. The project will continue to train health care workers in provider-initiated testing and counseling (PITC) to be offered during ANC, labor and the immediate post-delivery period. Lay counselors will be trained and facilitated to carry out PMTCT counseling and support newly recruited PMTCT parents to adhere to prophylaxis and infant feeding practices. This will reduce workload on the health care providers. The project will offer same-day HIV counselling, testing and results to clients. Spouse/Partner and family testing will be encouraged so that PMTCT becomes the entry point to family-centered HIV care, support and treatment (PMTCT plus). CD4 testing will be done on every positive pregnant woman. Those with CD4 count >350 will be referred for ART-HAART for their disease while those with CD4 count of 350 and above will receive Zidovudine (AZT) from 28 weeks or (AZT/3TC) Combivir from 34 weeks. In labour, all positive pregnant women, except those on HAART, will receive sdNVP + Combivir with a 7-day Combivir tail. All HIV positive pregnant women will be given sdNVP tablet to take home on their first ante-natal visit, with instructions to swallow the tablet when labour begins and before they report to hospital for delivery. Women who receive no antenatal care during their pregnancy or who have had only limited antenatal care but presented to the facility with unknown HIV status will receive C&T during labor and if positive, will receive sdNVP and 7-day Combivir tail according to national guidelines. The project will ensure the mother's CD4 count results are available the same day to guide commencement of HAART if >350 or PMTCT prophylaxis if 350 and above. Pregnant women will be counseled on infant feeding options and supported to adhere to chosen option. Expectant positive mothers will be encouraged to disclose their HIV sero status and the PMTCT services they are receiving to their spouses and to request the spouses to come with them to the clinic at the next visit for family counselling and testing. Food and nutritional supplements will be leveraged from non-Pepfar implementing partners to supply malnourished pregnant and lactating positive women. Infants of HIV positive women will receive NVP syrup at birth and AZT for six weeks. All HIV–exposed infants will be followed up in the post-natal period and provided with cotrimoxazole prophylaxis from 6 weeks of age until their HIV status is confirmed negative and are no longer exposed to risk of HIV infection through breast milk. Cotrimoxazole prophylaxis will be continued if the children are confirmed HIV positive. All HIV-exposed infants will be referred for EID at 6 weeks and followed up with care and treatment depending on their HIV result. EID activities started in COP09 will be enhanced in COP10 to cover most of the PMTCT clinics supported by the LMS Associate project.

All HIV positive mothers receiving project-supported PMTCT services will be encouraged to exclusively

breast feed their infants for six months as this strategy will reduce mother to child transmission of HIV while not stigmatizing HIV positive mothers. HIV positive mothers who meet the AFASS criteria will be supported and guided on safe infant feeding. Health workers will be taught that recent research has demonstrated far better outcomes for exclusively breastfed infants of HIV positive mothers even in more affluent situations. Replacement feeding is often associated with an increase in morbidity and mortality from malnutrition, diarrheal diseases and respiratory infections among HIV exposed infants. In addition to receiving PMTCT services, each mother-baby pair will be registered with the health facility referral coordinator for linkage and access to community HIV/AIDS services like follow-up and support of mother-baby pairs, OVC services, on-going adherence counselling, HBC and others. This will enable the Home Based Care Volunteers to give psychosocial support, nutrition education and leveraging nutritional foods, and child growth monitoring.

LMS-Pro-ACT in COP10 will continue to train and support clients who had accessed PMTCT services as Peer Support Coordinators in antenatal care (ANC) settings helping newly recruited PMTCT families to understand and appreciate the benefits of PMTCT services and to adhere to the counselling and prophylaxis information given to them. The peer support coordinators will be positive role models to reduce stigma and act as champions for HIV positive pregnant women to ensure that they are not discriminated against during their antenatal and maternity care. The peer support coordinators will share their own experience with newly diagnosed pregnant HIV positive mothers and how they are coping. This will support new pregnant HIV positive mothers to come to terms with their own HIV status and reduce "self-stigma". Through the work of peer support groups, TBAs and engagement of spiritual leaders, the project will reduce drop-outs from PMTCT services and increase adherence to ARV prophylaxis and safer infant feeding choices. The Nigerian-adapted curriculum for training TBAs will be used to equip TBAs with knowledge and skills to support PMTCT services in the community. Because many pregnant women will attend ANC but deliver at a different facility or more likely deliver at home in the community, introducing mechanisms for use of ARVs particularly Nevirapine in the community, if this is possible, will also greatly increase the accessibility of PMTCT. Every pregnant HIV positive mother at first antenatal visit will be given a tablet of Nevirapine to take home but will be educated on the importance of skilled delivery.

CONTRIBUTIONS TO OVERALL PROGRAM AREA:
Activities in this area will strengthen the capacity of the states and health facilities to provide integrated MCH/FP/HIV services. The capacity of health facilities as well as health workers to provide ARV prophylaxis, counseling and support for improved maternal nutrition and safe infant feeding, and additional HCT and support as included in PMTCT plus activities will be strengthened. This area will also improve male involvement in PMTCT services as well as contribute to improved health outcomes of

children and families directly affected by HIV/AIDS.

LINKS TO OTHER ACTIVITIES:
This activity relates to the HVCT where every effort will be made to counsel and test every pregnant woman that visits the project-supported health facilities through the PITC approach and if positive enrolled into care to utilize the PMTCT services provided (15645.08). Adult Care and Support will be provided in terms of basic investigation like CD4 count for women that are positive, diagnosis and treatment of OIs, malaria, Urinary tract infection and provision of ITN and water guard (15642.08), and ARV drugs for prophylaxis (12414.08).

POPULATIONS BEING TARGETED
This activity focuses on pregnant women and their families from the communities served by project supported sites (19 in COP09)

EMPHASIS AREAS
This activity addresses gender concerns related to the specific HIV/AIDS-related care and treatment needs of pregnant women. Many gender issues have been reported in relation to PMTCT services ranging from rejection by spouses and families to Gender Based Violence. The project will train health workers to appreciate gender issues and ways they can be mitigated. The activity emphasizes developing the capacity of a wide range of persons (health personnel, mothers' peer support groups, PLWHA and TBAs) to increase testing, counseling and treatment and prophylaxis for pregnant women and their infants, to provide them and their families the appropriate protection and care to reduce the risk of HIV infection or mitigate transmission and negative health effects.

This activity will address the need to counsel and test pregnant women in order to prevent future HIV infections, to the mother, child or spouse/partner. Male involvement will be encouraged through various strategies including partners testing together and sensitizing men through the fora that are appropriate to them. Pregnant women accessing PMTCT services will be counseled on FP to enable them make informed decisions on future pregnancy. HIV-exposed infants will be followed up in young children clinics where they will receive routine immunizations, nutritional counselling and growth monitoring. Malnourished mothers and their children will receive nutritional supplementation leveraged from the Clinton Foundation and the community-food basket to be established through the peer support coordinators.

In COP10, under 'PEPFAR Nigeria's accelerated PMTCT plan', LMS ProAct, will strengthen its support to PMTCT service delivery by implementing activities that further improve the coverage and quality of PMTCT services. These activities will be directed towards increasing utilization of PMTCT services at

existing service outlets through demand creation in collaboration with community resources and ensuring the upgrade of existing supported PHCs offering stand alone HIV counseling and testing to render at least minimal package of PMTCT services. In order to leverage resources, priority will be given to PHCs located in the selected focal states with presence of other donor agencies and in local government areas already earmarked for HSS support through GFATM. Where new sites are envisioned, those that are used for national ANC sero-sentinel surveys but yet to commence PMTCT services as well as PHCs located in communities with high HIV prevalence rates above the National average will be given priority.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HLAB | 1,805,200 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HTXD | 352,621 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HVTB | 160,000 | |

**Narrative:**

None

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 10032** | **Mechanism Name: USAID Track 2.0 NELA** |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Cooperative Agreement |
| Prime Partner Name: NELA | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| Total Funding: 603,064 | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 603,064 |

## Sub Partner Name(s)

| | | |
|---|---|---|
| Adamawa Development Association | Al-Umar Community Service Organisation, Kebbi | Community Life Advancement Program |
| Community Reach Association, Adamawa | Ecclysiyar Yanuwa a'Nigeria | Family Health Care Foundation |
| Federation of Muslim Women Association in Nigeria, Adamawa | Federation of Muslim Women Association in Nigeria, Kebbi | First Step Foundation |
| FOMWAN National | Girls' Power Initiative | Health E |
| Inna Care Initiative, Jigawa | Koyenum Immalar Foundation | Lapo Development Foundation, Edo |
| Methodist Care Organization | Muslim Sisters Organisation | Mustard Seed Support Network, Osun |
| Safe Motherhood Ladies Association | Soc. for Com. Health Awareness & Mob. Jigawa | SWAAN Borno |
| SWAAN National & CiSHAN North Central | SWAAN Osun | The Hope Initiative, Borno |
| Volunteers for Change in Africa, Ebonyi | Women, Children's Health & Com. Dev. Initiative, Ebonyi | |

## Overview Narrative

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Economic Strengthening | 216,218 |
| Education | 144,145 |
| Food and Nutrition: Commodities | 147,624 |
| Human Resources for Health | 29,988 |

| | |
|---|---|
| Water | 602 |

## Key Issues

Addressing male norms and behaviors

Increasing gender equity in HIV/AIDS activities and services

Increasing women's access to income and productive resources

Malaria (PMI)

Child Survival Activities

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **10032** |
| **Mechanism Name:** | **USAID Track 2.0 NELA** |
| **Prime Partner Name:** | **NELA** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HBHC | 149,800 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HKID | 360,264 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | PDCS | 23,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVAB | 70,000 | |

| Narrative: |
| --- |
| None |

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| Mechanism ID: 10033 | Mechanism Name: USAID Track 2.0 Measure III |
| --- | --- |
| Funding Agency: U.S. Agency for International Development | Procurement Type: Cooperative Agreement |
| Prime Partner Name: University of North Carolina | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| Total Funding: 2,410,000 | |
| --- | --- |
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 2,410,000 |

## Sub Partner Name(s)

| | | |
| --- | --- | --- |
| Futures Group, South Africa | John Snow, Inc. | Management Sciences for Health |

## Overview Narrative

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## Key Issues

(No data provided.)

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **10033** |
| **Mechanism Name:** | **USAID Track 2.0 Measure III** |
| **Prime Partner Name:** | **University of North Carolina** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HKID | 300,000 | |
| **Narrative:** | | | |
| None | | | |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Other | HVSI | 2,110,000 | |
| **Narrative:** | | | |
| None | | | |

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| | |
|---|---|
| **Mechanism ID: 10034** | **Mechanism Name: USAID Track 2.0 FS C-Change** |
| Funding Agency: U.S. Agency for International Development | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Academy for Educational Development | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 2,225,013** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 2,225,013 |

## Sub Partner Name(s)

| | | |
|---|---|---|
| Consortium for Social Change | Internews | Ohio University |

| | | |
|---|---|---|
| Straight Talk Foundation, Uganda | | |

## Overview Narrative

Communication for Change (C-Change) is a cross-bureau mechanism designed to improve the effectiveness and sustainability of communication in social and behavior change interventions across a range of program areas: health, environment, economic growth and poverty alleviation, democracy and governance, social transition, and education. C-Change is a partnership led by the Academy for Educational Development (AED). It works with global, regional and local partners to support more effective use of communication as a catalyst for changing behaviors and social norms. In Nigeria, C-Change's partners include Internews, Ohio University, Straight Talk Foundation and the Consortium for Social Change Communication. In Africa, the C-Change partnership currently supports country efforts in Swaziland, Kenya, Namibia, Lesotho, Madagascar, Ethiopia and the Democratic Republic of the Congo. The goal of C-Change's support in Nigeria is to improve the effectiveness and sustainability of country-driven communication for social and behavior change for HIV prevention. Key elements of C-Change's strategy include:

? reliance on research for determining intervention focus, design and effectiveness
? focus on social contexts as important determinants of individual behaviors
? mobilizing communities to facilitate changes in group norms and individual behavior
? streamlining communication tools and methodologies for rapid results
? engaging a range of mass media to catalyze change
? building systems to harmonize communication efforts across multiple response agencies
? working with existing structures to facilitate indigenous ownership and sustainability for long term change

C-Change works through NACA's BCC Technical Working Group and two SACAs in Cross River and Kogi states to facilitate operationalization of a common framework for BCC programming aligned to the newly adopted National BCC Strategy. C-Change assesses current SBCC effort in country through detailed capacity assessments of USG-supported Implementing Partners (IPs) and other NGOs and CBOs in the two states within the South South (SS) and North Central (NC) regions targeted. Through Internews, C-Change will also assess the capacity of print and broadcast media to provide meaningful support to HIV prevention goals.

Together, the C-Change partnership will provide training, mentoring and technical assistance to address the gaps identified by these assessments and support alignment of response agencies' programs with the national prevention priorities and BCC Strategy. Internews works with journalists, media personalities and gatekeepers to improve and expand coverage, scale and intensity of HIV prevention. All training will integrate activities for building competencies in gender analysis and gender equity promotion, essential

elements mainstreamed in the C-Change approach. C-Change will work with the national BCC TWG and the two SACAs to facilitate leadership and coordination of SBCC for improved HIV prevention. It will strengthen systems and processes for coordination at national level and within two states of Cross River in the SS region and Kogi in the NC. These states were chosen based on:
? HIV prevalence
? USG IP presence
? concentration of nascent community response organizations
? potential for improved performance in print and broadcast media
? ease of access to state from C-Change's central operations in Abuja
? cost of access to states
? disposition of NACA and SACAs
? safety &security
? consultations with key stakeholders

Support for strengthening SBCC capacity will focus on USG implementing partners, national NGOs and CBOs, health workers, journalists and media gatekeepers in Cross River (SS) and Kogi (NC). C-Change will seek to create structures for sustaining improved SBCC performance in those states selected and at national level. These include the introduction of training courses, basic tools and linkages between established expertise and new efforts in the field. Ohio University (OU), a global C-Change partner, will support introduction of a facilitator-assisted, on-line, certificate course in SBCC. At the state level, OU will attempt to work with cognate departments within the state university or polytechnic to develop and offer courses for social and behavior change communication. Each of these activities paves the way for sustained capacity building in social and behavior communication for HIV prevention.

Finally, C-Change will support a multi-channeled mass media campaign aimed at reducing HIV risk behaviors among Nigeria's youth. C-Change, will implement campaigns, linking communication efforts at state level with community based-responses and national campaigns already underway. Internews (IN) will work with print and broadcast journalists; media personalities; and gatekeepers within media houses in these same states to improve the quality and scope of media support for HIV prevention, shaping the environment, strengthening constituencies for action and eroding barriers to change. Internews will also work with USG IPs, and NGOs/CBOs to expand partnerships with mass media for more effective HIV prevention.

C-Change Objectives in the Federal Capital Teritory (FCT), Crosss River and Kogi States seeks to achieve improved effectiveness and sustainability of country-driven communication for social and behavior change efforts through the following objectives:
Objective 1

To enhance coordination of social and behavior change communication efforts so that SBCC interventions are aligned to the priorities for prevention outlined in the National HIV and AIDS Prevention Plan 2007-2009 and the National BCC Strategy 2009-2014.
Objective 2
To improve technical capacity of USG partners, NGOs/CBOs and health workers to design and implement evidence-based, community-informed SBCC so that prevention interventions engage in the program development processes and work towards the prevention priorities outlined in the National BCC Strategy.
Objective 3
To expand utilization of mass media channels by SBCC implementing agencies and improve mass media's support of HIV prevention priorities outlined in the National BCC Strategy and Prevention Plan.

The Project's M&E approach is grounded in the principles of responsiveness, state-of-the-art approaches, and connection to programs and decision-making. The main tenet of this approach is capacity development of implementing partners in M&E for BCC programming. Our approach is responsive to PEPFAR concerns for accurate data and regular results reporting. M&E guidelines will provide a standard format to compile, track and report and will provide discrete ways in which data will be analyzed for enhanced project management.

The M&E team will develop standardized frameworks for data collection and analysis and promulgate these through guidelines and technical materials, as well as on-the-job training and M&E training workshops for IPs, as needed. C Change will work with NACA to ensure the incorporation of essential BCC indicators into the NNRIMS. A focus on capacity-building will support the use of data for enhanced project management. Our M&E approaches will yield programmatic data in a participatory and capacity-building manner that will bear on enhanced program management, and that will broaden the base of knowledge on how to implement communication program interventions efficiently and effectively. M&E systems will be harmonized with NACA systems in support of the Three Ones.

M&E Approaches and Techniques

The M&E system will include program monitoring and HMIS data, performance monitoring measures, omnibus surveys to capture reach and recall of mass media campaigns, household surveys in specified communities to measure the result of integrated BCC approaches at the local level, case studies of the reach and effect of radio journals and interviews and qualitative inquiry data to describe the development of campus radio.

Monitoring and Evaluation Capacity Building

C-Change will take a leadership role in promoting techniques and approaches to M&E by developing frameworks for data collection and analysis that can be easily adopted by other organizations; by disseminating experiences and results; and by encouraging the adoption of general recommendations and conclusions that emerge from these approaches. To facilitate the skills development of IPs, C Change will develop M&E training courses focusing on new communication indicators for HIV and AIDS programming and harmonization of M&E approaches across implementing agencies and partners.

For purpose of innovations and knowledge transfers, C-Change will engage partners and collaborating institutions and will work with existing teams (such as NACA subcommittees on M&E, USAID Mission-led reporting initiatives, etc.), to share information about:

• The process of BCC data collection
• The interpretation and presentation of BCC results
• New BCC indicators and the interpretation of data
• Tools that can be used for streamlined data collection and results reporting

Data analysis and interpretation workshops will enable program and evaluation staff to work together to write up program results and to identify program modifications.

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## Key Issues

(No data provided.)

## Budget Code Information

| | | | |
|---|---|---|---|
| **Mechanism ID:** | **10034** | | |
| **Mechanism Name:** | **USAID Track 2.0 FS C-Change** | | |
| **Prime Partner Name:** | **Academy for Educational Development** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Other | OHSS | 481,600 | |
| **Narrative:** | | | |
| | | | |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVAB | 981,203 | |

**Narrative:**

The 2008 national HIV/AIDS BCC response identified lack of effective coordination and technical direction in the BCC activities carried out by the USG IPs and other partners.
In COP 09, C-Change therefore focused on strengthening the National Agency for the control of AIDS (NACA) and State Agency for the control of AIDS (SACAs) capacity to effectively coordinate and with support of the national and state Technical Working Groups (TWGs) provide technical direction to the national HIV/AIDS BCC response. At the national level, C-Change worked with NACA's BCC Technical Working Group to facilitate operationalization of a common framework for BCC programming aligned to the newly adopted National BCC Strategy. At a state-wide level, C-change strengthened SACA in two states, Cross River and Kogi, in the area of effective coordination of the State BCC response through training and technical assistance to SACA personnel. This was to ensure that the state BCC response is in line with national prevention strategies; is evidence-based and community driven; and processes, outputs and outcomes are documented and shared among all stakeholders for the purpose of learning and replicating best practices. C-Change also assessed current SBCC efforts in- country through detailed capacity assessments of USG-supported implementing partners (IPs) and other NGOs and CBOs. C-Change will continue to work in COP 10, with NACA and other USIPs to develop tools for national BCC response coordination as well as streamline indicators to effectively capture outputs and outcomes from the national BCC response.

In COP 10, C-CHANGE will build capacity of IPs to implement BCC programs using strategies that respect and respond to local customs, social and community norms, programming will support delay of sexual debut; develop skills in unmarried individuals for practicing abstinence and negotiation for safe sex while transiting from abstinence; address coerced sexual activity and transactional sex; emphasize the importance of faithfulness in reducing the transmission of HIV. This will entail development of the 'Abstinence and Be faithful' messaging component of sexual prevention activities of IPs to target young people (10 -15) using mass media, print, religious and community gatherings including counseling service provision. C-Change will train 30 individuals from USIPs and NGOs'as master trainers for youth peer education. The 30 individuals will in turn train a total of 200 in school youths as peer educators/AB advocates. It is expected that the peer educators will reach out to 10,000 individuals with messages and materials that promote abstinence and be faithful and that encourage HIV counseling and testing according to the minimum package of prevention. C-Change will assist IPs in targeting community and traditional leaders and organizations by focusing on messages to be promoted during planned advocacy visits and community intervention programs. Messages will also promote linkages to other program areas including counseling testing, STI treatment and other facility based services. Messages addressing

skills for personal risk assessment and delayed sexual debut will also be developed and disseminated. Working with SACA, C-Change will identify at least 10 NGOs, CBOs/FBOs, engage them and build their capacity in the area of evidence-based, theory-guided social and behavioural change communications program design and development. To complement the multi-media campaign, C-Change will develop a comprehensive interpersonal communication program through the establishment of an efficient peer education system including the training of peer educators/community HIV prevention advocates, the use of entertainment education approaches including community theater and community action dialogue meetings. At the community level, C-Change will work with NGOs, CSOs, CBOs, media houses and traditional institutions to design and implement a multi-media social and behavioral change campaign that will address individual risky sexual behaviours among youths as well as group and collective social norms that predispose young people to HIV infections.

C Change will assist IPs to address the mobilization of communities to address norms and behaviors on cross generational and transactional sex, promote increased male involvement in prevention activities and improved health seeking behaviors. Issues of stigma and discrimination will also be addressed in the intervention. C Change will adhere to recommendations made in the National Prevention Plan and National Behavior Change Communication Strategy and utilize a balanced ABC approach in its interventions. C-CHANGE will further collaborate with the media to ensure sustainability and support of NACA BCC efforts, provide TA to the BCC committee of the National Prevention TWG (NPTWG) and support BCC activities in the wider public health programming. Based on findings from assessments conducted in COP 09, C-Change will facilitate the participatory design of state-wide behaviour change strategies that will inform the multi-media campaign. These campaigns will be evidence-based and community driven, drawing from insights gained through the assessments of the previous year. Care will be taken to make sure strategies respond directly to the epidemic drivers identified during the assessments. This campaign will contain the following approaches among others:
- Multi media campaign to include radio/television programs (implemented in collaboration with media houses and advertising/media production agencies as well as development of other communication materials that would include posters and leaflets. C Change will ensure that other USG IPs are involved in the adaptation/development of the multi media approach for uniformity of messages and materials for appropriate target audience.
- Interpersonal Communications (Formation of community coalitions, training of peer educators and community advocates, training of service providers on interpersonal communications for sexual prevention of HIV transmission) in collaboration with NGOs, CBOs and FBOs. C-Change will identify CSOs involved in HIV prevention activities to work with in the two states. The capacities of these CSOs will be built through training to ensure that BCC programming is evidence-based, community driven and aligns with state/national prevention priorities.

C Change will ensure data quality and continuous quality improvement of activities by encouraging IPs program reports through the design and development of peer education activity monitoring forms which will capture the essentials of the minimum prevention package of programming, capacity building in monitoring and evaluation of communication programs for IP program staff and conduct periodic site visits to verify planned implementation as well as to provide technical assistance that will ensure continued quality data collection

CONTRIBUTIONS TO OVERALL PROGRAM AREA
C-Change's contribution to the overall Abstinence and Be faithful (AB) activities will be by building technical capacities of partners to review and develop strategies for working with different target audiences including in school youths and other segments of the general population. C-Change, in building the capacity of these partners will contribute to generating demands for counseling and testing (CT) and prevention of mother to child transmission (PMTCT) services that are entry points for other HIV and AIDS services.

LINKS TO OTHER ACTIVITIES
These activities will be linked to community program development, HCT, PMTCT, Blood Safety, Injection Safety, TB HIV, treatment, care and SI.

POPULATIONS BEING TARGETED
Population targeted for this activity are young people, educational institutions and other faith based organisations including media organizations.

EMPHASIS AREAS
This activity will emphasize Behaviour Change Communication with focus on strategy and message development directed at AB programming to emphasizes local organization capacity building, human capacity development and efforts to increase gender equity in HIV/AIDS programs to ensure access to information and services. Through AB activities, major emphasis is on community mobilization and participation, as an element of outreach for prevention efforts and also reinforce information, education and communication for high-risk populations.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVOP | 762,210 | |

**Narrative:**

None

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 10036** | **Mechanism Name: USAID Track 2.0 SBFAF** |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Safe Blood for Africa Foundation | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 2,670,000** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 2,670,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

New Activity

In C0P 10 the Safe Blood For Africa Foundation (SBFAF) Youth Expansion Program will establish 16 Club 25 chapters in 16 local government areas (LGAs), recruit at least 320 new club 25 members, train 192 young people and provide sexual prevention services, which include Abstinence, Be faithful, and Condom use (AB & C) to 20, 160 youth in line with the National Prevention Plan (NPP), and PEPFAR Guidelines. A combination of intervention strategies will be employed in SBFAF programming in COP10. Every individual within the target groups will be reached with a minimum of three interventions, addressing the individual at personal, community and socio-cultural levels. Also within the period, it is expected that 50% of this target audience will become regular voluntary donors. We can therefore estimate that 10,080 units of blood will be collected within COP 10. This will require an extended technical assistance programme for the NBTS from SBFAF.

In order to achieve the targets stated above and also contribute to the overall goal of developing a sustainable network of risk- free volunteer repeat blood donors among youth, SBFAF will reinforce safe

life style messages to old members and introduce the safe lifestyle program to new members to help them address the challenges of the risk of HIV/AIDS, deal with peer pressure and also feel empowered to support their peers. This program will utilize Abstinence and Be Faithful messages as a key part of the Club 25 message. Club 25 abstinence and be faithful program (safe lifestyle) will focus on strategies that will include peer education (age peers), focus group discussions (FGDs) and non curricula based approach (drama and HIV) as part of the minimum package. The Youth Project will equip young people drawn from all project locations with peer education and FGD skills. The peer education will prepare selected volunteers to provide their peers with correct and complete information on HIV/AIDS prevention while the FGDs and Club 25 will serve as avenues for message reinforcement and sensitization activities using the "enter-educate" approach. This will be supported by targeted audio and print educational materials and community outreaches and reinforced by mass media campaigns.

SBFAF's abstinence/be faithful (A/B) program will focus on community mobilization and outreach activities that promote abstinence, fidelity, delay of sexual activity, partner-reduction messages and related social and community norms primarily in the project locations in Imo and Kaduna with the aim of reaching 14,112 (70% of the target audience) individuals with A/B Messages and 6,048 (30%) with "A" only messages.

Through community mobilization and dialogue this activity will particularly address norms affecting the behavior of women/girls and men/boys and inequalities between male and female that increase vulnerability to and the impact of HIV/AIDS. SBFAF will also mobilize communities to address norms/behaviors on cross generational and transactional sex. Community mobilization will equally promote increased male involvement in prevention activities, timely health seeking behaviors and address issues of stigma and discrimination.

An important partner in supporting the community at large, and youth in particular, to adopt and sustain abstinence/ be faithful behaviors is undoubtedly the faith community, leaders and organizations. Targeted and on-going advocacy will be conducted to ensure the religious leaders reinforce correct and consistent messages regarding HIV/AIDS prevention, stigma and discrimination as well as to promote health seeking behaviors and address social norms and inequalities that increase vulnerability to HIV/AIDS. Religious leaders will be mobilized to include messages regarding HIV/AIDS in their weekly sermons in churches and mosques.

In addition, influential individuals in the community will be strengthened to provide age and context appropriate information in an aim to create an enabling environment for sustained behavior change. This will be implemented through advocacy and on- going mentoring.

Balanced AB messages will be provided during all community mobilization activities, with appropriate linkages and referrals made to other behavioral risk prevention programs for people in need of correct and accurate information about condom use. Referrals and linkages will be strengthened with other services, including Umbrella care, Preventive care, Clinical care and Support care as well as TB to benefit from the demand creation activities of the community mobilization in pursuance of the goals.

The activities will be implemented with technical support particularly from SBFAF national Prevention and Behavior Change communication units to intensify and expand community mobilization and capacity building activities.

SBFAF's secondary sexual prevention strategy will involve the utilization of multi-media to support the primary activities. This will entail the development and execution of, multi-media campaigns, development and distribution of SBC materials in addition to advocacy, capacity building, referrals, monitoring and evaluation of activities as well as provide mentoring to Implementing Agencies.

COP 10 SBFAF activities will be guided by the PEPFAR Guideline, the National Prevention Plan and the National Behavior Change Communication Strategy.

SBFAF will put in place appropriate monitoring, evaluation and impact assessment mechanisms to ensure that key lessons, success stories, and impact of the pilot project are effectively documented and shared.

SBFAF set up the Club 25 program in Nigeria in 2004 with only eight members. Club 25 membership is now made up of approximately 1,200 active and inactive members. The club consists of young donors aged 18-25 who are encouraged to live risk-free lifestyles and donate blood regularly. This age group represents a significant amount in the number of donors donating blood voluntarily in all the existing NBTS centers. Out of the 16,987 units collected in the year 2007, 8,428 were between the ages of 18-25. This represents half of the donor pool (an average of 49.6%) and demonstrates the criticality of a community based youth donor program.

Currently, Club 25 key program outputs are donor recruitment, peer education on the importance of blood safety and voluntary non-remunerated blood donation in senior secondary and tertiary institutions, media awareness, campaign activities and community outreach programs such as hospital and orphanage visits.

The blood safety message will be delivered alongside the abstinence/be faithful messages and it is expected that 50% of this target audience for the abstinence/be faithful messages will become regular voluntary donors. A key activity in blood safety messages is donor recruitment. We can therefore estimate that 10,080 units of blood will be collected within COP 10.

CONTRIBUTIONS TO OVERALL PROGRAM AREA

SBFAF will contribute to the overall United States Government's (USG) strategic plan to combat HIV/AIDS by generating a critical mass of individuals within each project community to carry out sexual and other behavioral risk prevention activities with youth. SBFAF will focus on equipping these young people with appropriate skills to effectively carry out sustainable HIV prevention activities, including development and dissemination of strategic behavior communication (SBC) materials, community mobilization, condom use programs, peer education activities, counseling services, referrals and linkages among others. The Youth project activities will in turn contribute to generating demands for testing and counseling (T&C) and prevention of mother to child transmission (PMTCT) services which serve as entry points for other services such as ART and palliative care.

LINKS TO OTHER ACTIVITIES

Youth project activities will continue to be linked to other relevant services available in the community. SBFAF will liaise with other IPs to facilitate access to other related services. Also, there will be linkages with community based blood banks.

POPULATIONS BEING TARGETED

Low risk population aged 12 – 25 (in accordance with the new National Prevention guidelines) will form the target population to receive the Abstinence and Be Faithful, Blood Safety messages.

KEY LEGISLATIVE ISSUES ADDRESSED

All Youth project activities will take into consideration gender issues related to HIV/AIDS programs through providing equal quality prevention services without discrimination against sex, nationality, religion, creed, etc. as well as a concerted effort to increase male involvement in HIV/AIDS activities. Though young people below the age of 18 will be targeted with prevention and blood safety messages, the project will ensure that under aged are not recruited as donors.

EMPHASIS AREAS

The youth club is the platform for the message. The club will be made to be appealing and attractive to youth. The "enter-educate" principle will be adopted in delivering the prevention and blood safety messages. The core of the program will remain the same, linking youth club activities, (e.g. sports, skill training, group recognition) with social participation and empowerment. The education and counseling in HIV prevention comes as a requirement to donate blood. Repeat donors are recognized with awards and public notice. This is a positive incentive and peer recognition that overcomes the social or cultural pressures to have sex.

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## Key Issues

(No data provided.)

## Budget Code Information

| | | | |
|---|---|---|---|
| **Mechanism ID:** | **10036** | | |
| **Mechanism Name:** | **USAID Track 2.0 SBFAF** | | |
| **Prime Partner Name:** | **Safe Blood for Africa Foundation** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Prevention | HMBL | 1,537,512 | |

**Narrative:**

In C0P 10 the Safe Blood For Africa Foundation (SBFAF) Youth Expansion Program will establish 16 Club 25 chapters in 16 local government areas (LGAs), recruit at least 320 new club 25 members, train 192 young people and provide sexual prevention services, which include Abstinence, Be faithful, and Condom use (AB & C) to 20, 160 youth in line with the National Prevention Plan (NPP), and PEPFAR Guidelines. A combination of intervention strategies will be employed in SBFAF programming in COP10. Every individual within the target groups will be reached with a minimum of three interventions, addressing the individual at personal, community and socio-cultural levels. Also within the period, it is expected that 50% of this target audience will become regular voluntary donors. We can therefore estimate that 10,080 units of blood will be collected within COP 10.

In order to achieve the targets stated above and also contribute to the overall goal of developing a sustainable network of risk- free volunteer repeat blood donors among youth, SBFAF will reinforce safe life style messages to old members and introduce the safe lifestyle program to new members to help them address the challenges of the risk of HIV/AIDS, deal with peer pressure and also feel empowered to support their peers. This program will utilize Abstinence and Be Faithful messages as a key part of the Club 25 message. Club 25 abstinence and be faithful program (safe lifestyle) will focus on strategies that

will include peer education (age peers), focus group discussions (FGDs) and non curricula based approach (drama and HIV) as part of the minimum package. The Youth Project will equip young people drawn from all project locations with peer education and FGD skills. The peer education will prepare selected volunteers to provide their peers with correct and complete information on HIV/AIDS prevention while the FGDs and Club 25 will serve as avenues for message reinforcement and sensitization activities using the "enter-educate" approach. This will be supported by targeted audio and print educational materials and community outreaches and reinforced by mass media campaigns.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVAB | 1,132,488 | |

**Narrative:**

New Activity

In C0P 10 the Safe Blood For Africa Foundation (SBFAF) Youth Expansion Program will establish 16 Club 25 chapters in 16 local government areas (LGAs), recruit at least 320 new club 25 members, train 386 young people and provide sexual prevention services, which include Abstinence, Be faithful, and Condom use (AB & C) to 20, 160 youth in line with the National Prevention Plan (NPP), and PEPFAR Guidelines. A combination of intervention strategies will be employed in SBFAF programming in COP10. Every individual within the target groups will be reached with a minimum of three interventions, addressing the individual at personal, community and socio-cultural levels. Also within the period, it is expected that 50% of this target audience will become regular voluntary donors. We can therefore estimate that 15,120 units of blood will be collected within COP 10.

In order to achieve the targets stated above and also contribute to the overall goal of developing a sustainable network of risk- free volunteer repeat blood donors among youth, SBFAF will reinforce safe life style messages to old members and introduce the safe lifestyle program to new members to help them address the challenges of the risk of HIV/AIDS, deal with peer pressure and also feel empowered to support their peers. This program will utilize Abstinence and Be Faithful messages as a key part of the Club 25 message. Club 25 abstinence and be faithful program (safe lifestyle) will focus on strategies that will include peer education (age peers), focus group discussions (FGDs) and non curricula based approach (drama and HIV) as part of the minimum package. The Youth Project will equip young people drawn from all project locations with peer education and FGD skills. The peer education will prepare selected volunteers to provide their peers with correct and complete information on HIV/AIDS prevention while the FGDs and Club 25 will serve as avenues for message reinforcement and sensitization activities

using the "enter-educate" approach. This will be supported by targeted audio and print educational materials and community outreaches and reinforced by mass media campaigns.

SBFAF's abstinence/be faithful (A/B) program will focus on community mobilization and outreach activities that promote abstinence, fidelity, delay of sexual activity, partner-reduction messages and related social and community norms primarily in the project locations in Imo and Kaduna with the aim of reaching 30,240 (70% of the target audience) individuals with A/B Messages and 6,048 (30%) with "A" only messages.

Through community mobilization and dialogue this activity will particularly address norms affecting the behavior of women/girls and men/boys and inequalities between male and female that increase vulnerability to and the impact of HIV/AIDS. SBFAF will also mobilize communities to address norms/behaviors on cross generational and transactional sex. Community mobilization will equally promote increased male involvement in prevention activities, timely health seeking behaviors and address issues of stigma and discrimination.

An important partner in supporting the community at large, and youth in particular, to adopt and sustain abstinence/ be faithful behaviors is undoubtedly the faith community, leaders and organizations. Targeted and on-going advocacy will be conducted to ensure the religious leaders reinforce correct and consistent messages regarding HIV/AIDS prevention, stigma and discrimination as well as to promote health seeking behaviors and address social norms and inequalities that increase vulnerability to HIV/AIDS. Religious leaders will be mobilized to include messages regarding HIV/AIDS in their weekly sermons in churches and mosques.

In addition, influential individuals in the community will be strengthened to provide age and context appropriate information in an aim to create an enabling environment for sustained behavior change. This will be implemented through advocacy and on- going mentoring.

Balanced AB messages will be provided during all community mobilization activities, with appropriate linkages and referrals made to other behavioral risk prevention programs for people in need of correct and accurate information about condom use. Referrals and linkages will be strengthened with other services, including Umbrella care, Preventive care, Clinical care and Support care as well as TB to benefit from the demand creation activities of the community mobilization in pursuance of the goals.

The activities will be implemented with technical support particularly from SBFAF national Prevention and Behavior Change communication units to intensify and expand community mobilization and capacity building activities.

SBFAF's secondary sexual prevention strategy will involve the utilization of multi-media to support the primary activities. This will entail the development and execution of, multi-media campaigns, development and distribution of SBC materials in addition to advocacy, capacity building, referrals, monitoring and evaluation of activities as well as provide mentoring to Implementing Agencies.

COP 10 SBFAF activities will be guided by the PEPFAR Guideline, the National Prevention Plan and the National Behavior Change Communication Strategy.

SBFAF will put in place appropriate monitoring, evaluation and impact assessment mechanisms to ensure that key lessons, success stories, and impact of the pilot project are effectively documented and shared.

SBFAF set up the Club 25 program in Nigeria in 2004 with only eight members. Club 25 membership is now made up of approximately 1,200 active and inactive members. The club consists of young donors aged 18-25 who are encouraged to live risk-free lifestyles and donate blood regularly. This age group represents a significant amount in the number of donors donating blood voluntarily in all the existing NBTS centers. Out of the 16,987 units collected in the year 2007, 8,428 were between the ages of 18-25. This represents half of the donor pool (an average of 49.6%) and demonstrates the criticality of a community based youth donor program.

Currently, Club 25 key program outputs are donor recruitment, peer education on the importance of blood safety and voluntary non-remunerated blood donation in senior secondary and tertiary institutions, media awareness, campaign activities and community outreach programs such as hospital and orphanage visits.

The blood safety message will be delivered alongside the abstinence/be faithful messages and it is expected that 50% of this target audience for the abstinence/be faithful messages will become regular voluntary donors. A key activity in blood safety messages is donor recruitment. We can therefore estimate that 10,080 units of blood will be collected within COP 10.

CONTRIBUTIONS TO OVERALL PROGRAM AREA
SBFAF will contribute to the overall United States Government's (USG) strategic plan to combat HIV/AIDS by generating a critical mass of individuals within each project community to carry out sexual and other behavioral risk prevention activities with youth. SBFAF will focus on equipping these young people with appropriate skills to effectively carry out sustainable HIV prevention activities, including

development and dissemination of strategic behavior communication (SBC) materials, community mobilization, condom use programs, peer education activities, counseling services, referrals and linkages among others. The Youth project activities will in turn contribute to generating demands for testing and counseling (T&C) and prevention of mother to child transmission (PMTCT) services which serve as entry points for other services such as ART and palliative care.

LINKS TO OTHER ACTIVITIES
Youth project activities will continue to be linked to other relevant services available in the community. SBFAF will liaise with other IPs to facilitate access to other related services. Also, there will be linkages with community based blood banks.

POPULATIONS BEING TARGETED
Low risk population aged 12 – 25 (in accordance with the new National Prevention guidelines) will form the target population to receive the Abstinence and Be Faithful, Blood Safety messages.

KEY LEGISLATIVE ISSUES ADDRESSED
All Youth project activities will take into consideration gender issues related to HIV/AIDS programs through providing equal quality prevention services without discrimination against sex, nationality, religion, creed, etc. as well as a concerted effort to increase male involvement in HIV/AIDS activities. Though young people below the age of 18 will be targeted with prevention and blood safety messages, the project will ensure that under aged are not recruited as donors.

EMPHASIS AREAS
The youth club is the platform for the message. The club will be made to be appealing and attractive to youth. The "enter-educate" principle will be adopted in delivering the prevention and blood safety messages. The core of the program will remain the same, linking youth club activities, (e.g. sports, skill training, group recognition) with social participation and empowerment. The education and counseling in HIV prevention comes as a requirement to donate blood. Repeat donors are recognized with awards and public notice. This is a positive incentive and peer recognition that overcomes the social or cultural pressures to have sex.

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| Mechanism ID: 10096 | Mechanism Name: HHS/HRSA Track 2.0 Harvard |
|---|---|

| | |
|---|---|
| | **SPH** |
| Funding Agency: U.S. Department of Health and Human Services/Health Resources and Services Administration | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Harvard University School of Public Health | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 27,681,758** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| Central GHCS (State) | 12,410,577 |
| GHCS (State) | 15,271,181 |

## Sub Partner Name(s)

| | | |
|---|---|---|
| Abnira Medical Centre | Adeoyo Maternity Hospital | Ahmadu Bello University, Zaria |
| AIDS AllianceAIDS Alliance Nigeria | Association for Reproductive and Family Health | COCIN PHC Kurgwi |
| Community Health Clinic Zamko | Cottage Hospital Wase | Cottage Hospital, Kwalla |
| FCE Clinic | Federal Medical Center, Nguru | General Hospital Dengi-Kanam |
| General Hospital Ogbomoso | HaltAIDS VCT | Jos University Teaching Hospital, Plateau |
| Makurdi Federal Medical Center | Mashiah Foundation | May Clinic |
| National Military Hospital "Creek" | Nigerian Army Reference Hospital, Lagos | Nursing Home Maiduguri, Maiduguri |
| Our Lady of Apostles, Jos | Pankshin General Hospital | Primary Health Center, Amo Katako |
| Primary Health Center, Amper | Primary Health Center, Angware | Primary Health Center, Bashar |
| Primary Health Center, Chugwi | Primary Health Center, Dengi | Primary Health Center, Dorowa Babuje |
| Primary Health Center, Gindiri | Primary Health Center, Jarmi | Primary Health Center, Kabwir |
| Primary Health Center, Kerang | Primary Health Center, Kwa | Primary Health Center, Kwande |
| Primary Health Center, Mabudi | Primary Health Center, Maijuju | Primary Health Center, Maikatako |

| | | |
|---|---|---|
| Primary Health Center, Mangu | Primary Health Center, Sabon Fobur | Primary Health Center, Wase |
| Primary Health Center, Zabolo | Primary Health Center, Zomo | Solat Women Hospital |
| State Specialist Hospital, Maiduguri | University College Hospital, Ibandan | University of Maiduguri Teaching Hospital |
| University of Nigeria Teaching Hospital, Enugu | Vom Christian Hospital | Widowcare, Abakaliki, Ebonyin |

## Overview Narrative

During COP10, Harvard will provide PMTCT services to 65,500 pregnant women at 64 sites, ART services to 57,200 patients at 24 sites, HIV-related basic care and support services to 79,675 patients, and additional care services to 2,500 orphans and vulnerable children. We aim to enroll 7,900 new patients on ART. In addition, we will provide HIV counseling and testing services to 8,500 individuals, and prevention services focused on abstinence and/or be faithful (AB) messaging for 4,355 individuals and on messaging focused on behavior change beyond AB for an additional 35,000. Program activities will take place in 10 target states of Nigeria.

Health system strengthening is a crucial element of our program. REDACTED. Furthermore, we have implemented a network of care model, which links primary healthcare centers (PHCs) and secondary level hospitals to tertiary care institutions, facilitates long-term sustainability of services, multi-level capacity development, and strong community linkages to ensure access to care at the community level.

The foundation for our efforts in the area of health system strengthening are comprehensive training programs for physicians, nurses, lab personnel, pharmacists, counselors, community health workers, data management personnel and others who work with HIV patients. During COP10, nearly 1,200 personnel will be trained in the provision of ART services, 363 personnel on the National PMTCT Training curriculum, 985 in the provision of clinical prophylaxis and treatment of HIV/TB co-infected individuals, 384 in SI in order to build capacity and the sustainability of both site-based and national M&E systems, 324 personnel in prevention activities, 280 in safe injection practices, 140 in blood safety and 650 in laboratory services. To build the capacity of our sites in pharmacy and logistics management and pharmaceutical expertise, we will conduct a variety of on-site training workshops as well as centralized workshops in Abuja throughout COP10.

To further strengthen the overall health system, Harvard has worked with in-country staff to develop standardized protocols for clinical management, laboratory testing and pharmacy handling which conform to an optimized standard of care. We have established an ART supply chain and logistics management system and a central warehouse and distribution system. During COP08, we established a local NGO,

APIN Ltd./Gte. (APIN), which subsequently received direct funding for the management of two former Harvard sites (PHC Iru and Sacred Heart Lantoro) and support for 40 TB-DOT centers in Oyo State. At the beginning of COP09, 4 additional Harvard sites (NIMR, LUTH, Onikan, and Mushin) were also transferred to APIN.

Through each one of our program areas, we target a number of cross-cutting issues. REDACTED. We address the area of food and nutrition through HBHC, PDCS, OVC and PMTCT. More specifically, in our pediatric and adult programs, we monitor anthropometric measurements and dietary issues to support our clinical management of HIV disease. All patients are provided with nutritional counseling and supplements, including multivitamins. In the PMTCT program, all mothers are counseled on safe feeding practices and provided follow-up care to ensure safe motherhood. For patients that are unable to come to the clinics, HBC teams assist them on a variety of issues, including nutritional support. Through our HBHC, PDCS and OVC activities, we also address the area of economic strengthening through facilitating access to economic empowerment and education. In addition, through our care and support activities, we also address the area of safe water by providing water vessels and Water Guard in our basic care kits. We address the area of gender by streamlining access to services for women and the issue of gender-based violence through our system of referrals as well as provision of PEP to victims of rape. The key issue of TB is addressed through HBHC, PDCS and TB-HIV through the screening, treatment and monitoring of co-infected patients.

During COP09 and continuing into COP10, we have been employing various strategies to achieve improved economies in procurement. In line with OGAC's recommendations, we will continue to work with SCMS for purchasing of first-line ARV regimens for our program sites. In order to reduce costs on procurement of laboratory supplies, Harvard has established contracts with local vendors and will work with APIN through COP10 to ensure a smooth system of purchasing. In the past, each site had separately established maintenance contracts for major laboratory equipment and during COP10, Harvard and APIN will leverage bargaining power to work towards negotiating a single contract covering all program sites at a more economical rate.

During the first year of our program, a database system containing all information required in the course of care and treatment was developed. This system is used at all clinical sites, and is updated as needed to ensure that it supports the provision of high quality clinical care and is responsive to GON indicators. The Harvard electronic record system facilitates access to pharmacy pick-up data, lab results, and other clinical information. During COP10, information from these databases will be used for site and program-specific evaluation of services provided in each of our program areas, including evaluations of CD4 counts, loss to follow-up and viral suppression. Through our work at 68 Military Hospital, we will also conduct a focused analysis on military populations. In addition, Harvard will support APIN in their

collaboration with the National M&E working group and their participation in experience sharing. Our goal is to develop the capacity for an integrated M&E system that is responsive to stakeholders and supports the sustainability of Nigeria's ART program.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Construction/Renovation | REDACTED |
| Economic Strengthening | 396,420 |
| Education | 72,686 |
| Food and Nutrition: Commodities | 280,043 |
| Food and Nutrition: Policy, Tools, and Service Delivery | 460,744 |
| Gender: Reducing Violence and Coercion | 162,572 |
| Human Resources for Health | 2,988,829 |

## Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Malaria (PMI)
Child Survival Activities
Military Population
Safe Motherhood
TB
Workplace Programs
Family Planning

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **10096** |
| **Mechanism Name:** | **HHS/HRSA Track 2.0 Harvard SPH** |
| **Prime Partner Name:** | **Harvard University School of Public Health** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Care | HBHC | 4,420,057 | |
| **Narrative:** | | | |
| None | | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Care | HKID | 433,758 | |
| **Narrative:** | | | |
| None | | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Care | HTXS | 11,245,829 | |
| **Narrative:** | | | |
| None | | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Care | HVCT | 75,500 | |
| **Narrative:** | | | |
| None | | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Care | PDCS | 520,022 | |
| **Narrative:** | | | |
| None | | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Care | PDTX | 529,023 | |
| **Narrative:** | | | |
| None | | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Other | HVSI | 862,853 | |
| **Narrative:** | | | |
| None | | | |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HMBL | 40,913 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HMIN | 80,806 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVAB | 141,913 | |

**Narrative:**

ALTHOUGH THE SEXUAL PREVENTION NARRATIVE FROM COP09 HAS BEEN SPLIT INTO SEPARATE NARRATIVES (HVAB AND HVOP) FOR COP2010, THIS ACTIVITY IS UNCHANGED FROM FY2009.

NARRATIVE:
In COP10, Harvard will continue to provide sexual prevention programming activities in line with the overall PEPFAR Nigeria goal of providing a comprehensive package of prevention services to individuals reached, thereby improving the effectiveness of this messaging, through a balanced portfolio of prevention activities including abstinence and be faithful messaging (HVAB) along with condoms and other prevention (HVOP). By the end of COP09, Harvard was conducting HVAB activities in 9 states, including Benue, Borno, Enugu, Kaduna, Lagos, Oyo, Ogun, Plateau and Yobe. Through its other program areas, Harvard has a large population of HIV-positive adults, adolescents and children to which it is already providing services; this group forms part of the core target population for age-appropriate HVAB messaging that is provided by Harvard through its prevention with positives (PwP) activities, including STI screening and management, sexual risk reduction, disclosure, adherence, reduction of alcohol consumption, and testing of sex partners and children in the HIV clinic setting. In addition, Harvard will target activities to HIV-negative persons in its catchment areas in order to minimize their risk behaviors and contribute to an overall reduction in HIV prevalence.

In COP10, Harvard will implement HVAB activities at both the facility and community levels utilizing the minimum prevention package strategy as contained in the National Prevention Plan. This package includes: 1) community outreach campaigns; 2) peer education; 3) infection control activities; and, 4) STI

management/treatment. The goal of the program is to focus on targeted communities and to saturate those communities with messages conveyed in multiple forums. Utilizing such a methodology, a large number of people will be reached with HVAB messages.

HVAB activities conducted at the local level by Harvard will be reinforced through national level mass media campaigns by other USG partners, such as the successful Zip-Up campaign. HVAB messages promoting abstinence, mutual fidelity and addressing issues of concurrent and multiple sexual partnerships will be balanced with concurrent condoms and other prevention messaging where appropriate and will be integrated with treatment and care services at 66 sites and be implemented by 2 stand-alone HCT providers.

A key age group for HVAB activities is youth/young adults aged 15-24 years as this encompasses the highest prevalence age group. The 2005 ANC survey in Nigeria indicated that the 20-29 year old age group has the highest HIV prevalence (4.9% compared to a national prevalence of 4.4%). In addition, the 2005 National HIV/AIDS and Reproductive Health Survey (NARHS) demonstrated a low risk perception (28%) among the general population and significant reports of transactional sex (11%) among young women aged 15-29 years. This age cohort for both men and women represents the working age group in Nigeria; it is expected that a combination of prevention messaging approaches will ensure they are reached with prevention interventions. Harvard will reach beneficiaries through community awareness campaign, peer education models and peer education plus activities within the year.

A community awareness strategy will also be employed to serve the catchment areas of the hospital facilities, which will be linked with community mobilization efforts promoting HCT. During static and mobile HCT services, counselors will be disseminating HVAB messages to recipient communities and clients through focused group discussions and interpersonal communication. With an HCT target of 14,000 clients getting CTR, a minimum of this many clients will receive HVAB messaging through this approach. The key messages that will be conveyed are delay in sexual debut, secondary abstinence, mutual fidelity, prompt and complete treatment of all STIs and promotion of need to ascertain HIV serostatus through HCT.

Harvard will also use the peer education model to target job peers who are healthcare workers. Healthcare workers at each site will be trained using established National peer education curricula and each will be requested to form peer groups of approximately 10 members from the healthcare worker community for dissemination of HVAB messaging. It is anticipated that these healthcare workers will continually serve as conduits for age-appropriate prevention messaging not only for their work peers, but also for their social peers and all clients with whom they come in contact.

The target for the AB messaging campaign is 4,355 individuals. Additional staffing and training of counselors will also be provided by this funding, including a dedicated fulltime staff person. This activity will provide support for training of 366 individuals in AB messaging.

EMPHASIS AREAS
ABC programming emphasizes local organization capacity building, human capacity development and efforts to increase gender equity in HIV/AIDS programs. These activities also promote a rights-based approach to prevention among positives and other vulnerable members of society and equal access to information and services. Reduction of stigma and discrimination are also key to the program. Through ABC activities, we place major emphasis on community mobilization and participation, as an element of outreach for prevention efforts. Additionally, we place major emphasis on training, infrastructure and human resources in order to build the capacity of counselors and providers in a full range of prevention strategies. We also place emphasis on IEC as an essential element of outreach to high-risk populations, and on developing networks for linking these activities to HCT, PMTCT, and other ART activities to serve as a source of prevention information. Emphasis areas also include military populations, through support for ABC activities at 68 Military Hospital and Military Hospital Ikoyi, Lagos.

These activities address gender equity issues by providing equitable access to prevention services for men and women. In some cases, our activities seek to target men who may be at high risk for HIV in order to promote condom use as a means of prevention and access to services for their sexual partners. Male targeted counseling seeks to address male norms and behaviors in order to encourage safer sexual practices. Strong prevention programs that accommodate the array of societal and cultural norms can also help reduce stigma and discrimination. Providing services at the community level will serve as an important platform from which general HIV/AIDS information can be provided and risk reduction strategies discussed.

POPULATIONS TARGETED:
Key populations targeted are the healthcare community in treatment facilities, PLWHA, youths and adults accessing HCT services at either static or mobile within catchment areas of the treatment sites, support group members and immediate families of PLWHA. Other target populations include religious leaders. Targeting these populations is important to encourage HCT and use of prevention measures. Health care workers will also be targeted for training on the most effective prevention measures for various risk groups.

CONTRIBUTION TO OVERALL PROGRAM AREA
These prevention activities are consistent with PEPFAR's goals for Nigeria, which aim to support a number of prevention strategies as a comprehensive prevention package. In order to be maximally

effective, the prevention messages developed at different sites will be tightly targeted to various risk groups that they serve. Furthermore, these activities are consistent with the PEPFAR 5-year strategy, which seeks to scale-up prevention services, build capacity for long-term prevention programs, and encourage testing and targeted outreach to high-risk populations. The establishment of networks and referral systems from prevention efforts at the community level to PMTCT and HIV care and treatment will help facilitate the scale-up of the overall program. Additionally, as part of our sustainability building efforts, Harvard will provide technical assistance and support for APIN to assume program management responsibility for all ABC activities. This will include the implementation of a plan to transition site oversight, management and training over to APIN. The goal of such efforts is to provide for greater assumption of responsibility for management and implementation of PEPFAR programming by Nigerian nationals through an indigenous organization.

LINKS TO OTHER ACTIVITIES:
HVAB activities relate to HVOP. They relate to HCT (HVCT) by increasing awareness of HIV. They also relate to Adult Care and Treatment (HTXS and HBHC) and Pediatric Care and Treatment (PDTX and PDCS) activities through dissemination of information by home-based care providers and ultimately by decreasing demand on care services through decreased prevalence. Linkages also exist to OVC programming (HKID) by targeting OVC. These activities are also linked to TB-HIV activities in that prevention messaging will be disseminated to individuals who are provided with HCT in a TB setting. Through training of personnel, these activities also link to Health Systems Strengthening (OHSS). As certain activities focus on gender-related issues, this program area also links to the cross-cutting area of Gender.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVOP | 1,220,874 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | MTCT | 2,254,915 | |

**Narrative:**

ACTIVITY UNCHANGED FROM FY2009.

NARRATIVE:
COP10 funding will support a comprehensive PMTCT program in line with the revised National PMTCT Guidelines (2007), at 64 service outlets in 9 states (Benue, Borno, Ebonyi Enugu, Kaduna, Lagos, Oyo,

Plateau, and Yobe). This consists of 10 tertiary, 21 secondary and 33 primary sites. "Opt-out" testing and counseling with same-day test results will be provided to all pregnant women presenting at antenatal care (ANC) or labor and delivery (L&D). The current level of PMTCT testing and counseling uptake from women presenting for ANC or L&D is 90%. All women are provided post-test counseling services on prevention of HIV infection, including the risks of MTCT. They are encouraged to bring partners and family members for on-site HCT. The program has a target of providing C&T results to 65,500 women. PMTCT prophylaxis will be provided to approximately 3,275 women in line with the national guidelines. Infant follow-up care linked with PMTCT activities includes nutritional counseling and support, growth monitoring, co-trimoxazole prophylaxis, HIV testing, and other preventative care services. It is estimated that of the infants tested for HIV infection, 131 will be HIV-positive; these infants will be referred to the pediatric basic care and support program. EID will be carried out using whole blood at the tertiary and DBS at the secondary and primary level in line with the national EID scale up plan.

Through this program area, Harvard will provide linkages to other prevention, care and treatment services. All ART-ineligible women will be placed on zidovudine from 28 weeks and or zidovudine and lamivudine from 34 weeks until delivery and will be enrolled into palliative care services (HBHC) at the time they access MTCT services Following delivery, mothers will be monitored in the HBHC program, where services include on-site enrollment or referrals for family planning and other reproductive health services. In addition, PMTCT services are integrated into a system of maternal and child health services designed to promote maternal and child health for all women. All ART-eligible pregnant women will be provided with ART through the adult treatment (HTXS) program area in line with the PMTCT guidelines. Children who become HIV-infected during the time they are being monitored as part of the MTCT program area will be linked to the pediatric treatment (PDTX) and care and support programs (PDCS). Those HIV-exposed children placed on single dose nevirapine at birth and zidovudine for 6 weeks that remain uninfected at 18-months following the completion of ARV prophylaxis will be linked to the OVC program (HKID) for continued care services.

Counseling on infant feeding options will be conducted during the antenatal period, at L&D and/or at infant follow-up visits using the National PMTCT and Infant Feeding Guidelines. Infant feeding counseling will be performed in an unbiased manner and women will be supported in their choice of method. Clients will also be counseled on the beneficial effect of couple/partner HCT/disclosure on adherence to infant feeding choice. A follow-up team consisting of counselors and a home-based care (HBC) support group of PLWHAs will assist in home and community tracking of positive mothers to provide nutritional support and ascertain infant diagnosis. This funding will support the ANC, labs, ARV prophylaxis intervention to mothers and babies (not ART), and personnel involved in PMTCT.

A regular training program will be established at all sites to train and retrain 363 health personnel

involved in the PMTCT program using the National PMTCT Guidelines. Non-laboratory personnel will also be trained in HIV testing. Indirect targets include training traditional birth attendants (TBAs) using an adapted curriculum in local areas near sites in PMTCT counseling, training PMTCT counselors in the National PMTCT Program, providing technical assistance for the development of the National Infant Feeding Counseling Manual, and providing a zonal training of trainers with this manual. This training supports PMTCT efforts at all national PMTCT centers; Harvard proposes that all pregnant women tested and receiving results at national PMTCT sites are indirect targets.

During COP08-COP09, Harvard piloted a clinical quality assessment (QA) for PMTCT activities at a number of our sites. During COP10, Harvard will continue to conduct QA activities to improve quality of care in our PMTCT programs. The program will also continue to monitor and utilize electronic data captured through SI activities to measure the quality of services provided as well as the associated patient outcomes and transmission rates.

Harvard has partnered with other implementing partners (IPs) in the implementation of the PEPFAR-Nigeria local government area (LGA) coverage strategy in the program areas of PMTCT, OVC and TB/HIV, designed to ensure the provision of PMTCT and TB/HIV services in at least one health facility in every LGA of 6 identified states. Per patient costs reflect the expansion to at least 33 new sites and scale up as a part of this LGA coverage strategy in Plateau State. Under the coverage strategy, these facilities are all linked with primary health facilities, which provide HCT and referrals for PMTCT services for HIV-infected mothers. Harvard will leverage FMOH, UNICEF and other IP support in capacity building/training in identifying new PMTCT sites in its scale-up plans. Harvard will strengthen the Benue state PMTCT committee as part of the LGA coverage strategy. Harvard will support one quarterly PMTCT task team meetings as part of the support to the GON.

EMPHASIS AREAS

This activity will place major emphasis on the development of networks through expansion into more local areas through a network of secondary or primary PMTCT clinics, with rural outreach to community healthcare workers and TBAs involved in home delivery; all community workers and TBAs with whom we work are linked to tertiary health care facilities. In addition, major emphasis will be placed on building organizational capacity in order to work towards sustainability of PMTCT centers and further expansion of the Nigeria PMTCT program in conjunction with the FMOH and USG. These system strengthening activities are led by local investigators at current PMTCT sites who participate in new site assessments, overseeing QA/QI, capacity development and training for new PMTCT centers. Minor emphasis is placed on performing targeted evaluations of PMTCT interventions, to estimate the rate of transmission with each of the ARV prophylaxis regimen used. Emphasis areas also include military populations, through support for PMTCT activities staff at 68 Military Hospital and Military Hospital Ikoyi, Lagos.

POPULATIONS BEING TARGETED

In addition to providing PMTCT services for pregnant women that know their HIV infection status, this program also targets women who may not know their HIV status and may be at greater risk for MTCT. Furthermore, it seeks to target infants, who are most at risk of becoming infected from an HIV-positive mother during the antepartum, intrapartum and postpartum periods. Through the HCT program area, Harvard seeks to target a broader group of adults by encouraging women to bring their partners and family members in for HCT. Furthermore, training activities will train public and private health care workers on the implementation of PMTCT protocols and HIV-related laboratory testing.

CONTRIBUTIONS TO OVERALL PROGRAM AREA

Through the PMTCT program, Harvard will provide HCT with test results to 65,500 pregnant women. Additionally, treatment and prophylaxis will be provided to 3,275 pregnant women. Implementation of the National PMTCT Guidelines in 64 sites (new and continuing) contributes to the PEPFAR goal of expanding ART and PMTCT services. We have increased the numbers of sites by adding secondary and primary level sites in the radius of Harvard tertiary care institutions; the tertiary centers will continue building the network capacity and coverage in of target states. Counseling will encourage mothers to bring their partners and family members for testing to reach discordant couples and expand the reach of HCT, based on the new PEPFAR 5-year strategy. This program is implemented in geographically networked sites to optimize training efforts and provide collaborative clinic/lab services as needed. Harvard will train and retrain 363 health care personnel from the PMTCT sites, including doctors, nurses, pharmacists and counselors. Training will build capacity at local sites to implement PMTCT programs and provide essential treatment support to pregnant women with HIV/AIDS. Capacity building efforts are aimed at future expansions of PMTCT programs. QA/QI will be carried out through personnel training, data collection from sites for monitoring and evaluation and supervisory visits from key program management staff, which may include representatives from the USG and GON.

The program will increase gender equity by specifically targeting pregnant females for HCT and PMTCT prophylaxis and their male partners for HCT. Data collection on PMTCT regimens provides a basis for developing strategies to ensure that all pregnant women have access to needed and optimally effective PMTCT services. This program addresses stigma and male norms and behaviors through the encouragement of partner notification and bringing other family members in for HCT. Infant feeding counseling, including on the appropriate use of exclusive breastfeeding or exclusive use of breast milk substitute (BMS) where AFASS is available, will be in line with the National PMTCT Guidelines. Referrals to income generating activities (IGAs) will also be provided to women as a part of palliative care and counseling activities.

Additionally, as part of our sustainability building efforts, Harvard will provide technical assistance and support for APIN to assume program management responsibility for our PMTCT activities. This will include the implementation of a plan to transition site oversight, management and training over to APIN. The goal of such efforts is to provide for greater assumption of responsibility for management and implementation of PEPFAR programming by Nigerian nationals through an indigenous organization.

LINKS TO OTHER ACTIVITIES
This activity is also linked to counseling and testing (HVCT), OVC (HKID), adult treatment (HTXS), pediatric treatment (PDTX), adult care and support (HBHC), sexual prevention (HVAB, HVOP), biomedical prevention (HMBL, HMIN), SI (HVSI), health capacity development (HCD), health systems strengthening (OHSS), and gender. Pregnant women who present for HCT services will be provided with information about the PMTCT program and referred to the PMTCT program if they are eligible for these services. ART services for HIV-infected infants and mothers will be provided through adult and pediatric treatment services. Basic pediatric care and support, including support for chosen feeding option and TB care, is provided for all infants and children through our OVC activities; all exposed infants identified through PMTCT services will be linked to these OVC services. Pregnant women are at high risk for requiring blood transfusion. Personnel involved in patient care will be trained in universal precautions as a part of injection safety activities. Additionally, these activities are linked to SI, which provides support for monitoring and evaluation of the PMTCT activities and QA/QI initiatives.

In COP10, under 'PEPFAR Nigeria's accelerated PMTCT plan', Harvard, will strengthen its support to PMTCT service delivery by implementing activities that further improve the coverage and quality of PMTCT services. These activities will be directed towards increasing utilization of PMTCT services at existing service outlets through demand creation in collaboration with community resources and ensuring the upgrade of existing supported PHCs offering stand alone HIV counseling and testing to render at least minimal package of PMTCT services. In order to leverage resources, priority will be given to PHCs located in the selected focal states with presence of other donor agencies and in local government areas already earmarked for HSS support through GFATM. Where new sites are envisioned, those that are used for national ANC sero-sentinel surveys but yet to commence PMTCT services as well as PHCs located in communities with high HIV prevalence rates above the National average will be given priority.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HLAB | 3,535,823 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Treatment | HTXD | 1,148,852 | |
| **Narrative:** | | | |
| None | | | |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HVTB | 1,170,621 | |
| **Narrative:** | | | |
| None | | | |

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 10098** | **Mechanism Name: HHS/CDC Track 2.0 Univ Maryland** |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: UMD-IHVN-ACTION | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 52,006,707** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 52,006,707 |

## Sub Partner Name(s)

| | | |
|---|---|---|
| Amino Kano Teaching Hospital | ANAWIM Home, Gwagwalada, Abuja | Axios Foundation |
| Bauchi Specialist Hospital | Central Hospital, Agbor | Church of Christ in Nigeria |
| Federa Medical Centre Asaba | Federal Medical Center, Azare | Federal Medical Centre, Gombe, Gombe State |

| | | |
|---|---|---|
| General Hospital Tafawa Balewa, Bauchi State | General Hospital, Garki | General Hospital, Kafin Mdaki |
| General Hospital, Otukpo | General Hospital, Shirayana | IDA Foundation (Drug Procurement) |
| Imo state University Teaching Hospital Orlu | Lagos University Teaching Hospital, Lagos | National Hospital Abuja |
| National TB and Leprosy Training Cenre, Zaria | Nigerian Institute of Pharmaceutical Research & Development | Nmamdi Azikiwe Teaching Hospital |
| State Specialist Hospital, Ikere-Ekiti | University of Abuja | University of Ado-Ekiti Teaching Hospital |
| University of Calabar Teaching Hospital | Uyo Universtiy Teaching Hospital, UYO | |

## Overview Narrative

During COP 10 the AIDS Care and Treatment in Nigeria (ACTION) Project of UMD/IHVN addresses significant challenges in quality of care and treatment by strengthening linkages between institutional programs and community-based services at 139 sites in 23 states where it has activated comprehensive HIV/AIDS services. This linkage targets strengthening retention of adult patients in treatment and care, improving uptake of services for women engaged in the PMTCT cascade, strengthening post natal follow up of HIV exposed children to provide timely HIV diagnosis and treatment for the pediatric age group, and upgrading linkages between TB services and HIV treatment and care in close alignment with the framework of the Nigerian National Strategic Plan. The path to securing a sustainable Nigerian response that ensures a lasting legacy impact of the PEPFAR investment requires that UMD/IHVN continue to be an agent for change by stressing evidence-based quality improvement. Vital to this is strengthening of systems for accessing reliable patient level and more sophisticated program indicator data through site-based strategic information collection approaches that are aligned with PEPFAR and GON framework. The UMD/IHVN COP 10 paradigm focuses on strengthening capacity at existing sites rather than continued expansion to new sites by drilling down with in the hub and spoke model to integrate primary health care centers and community-based service delivery into the network. Meeting the human resource challenge requires an increased emphasis on task shifting and the application of quality indicators to guide training to remediate deficiencies in knowledge that adversely effect quality. The hub and spoke model employs local centers of excellence linked to IHV-N's regional offices to guide dissemination of quality services at all levels of the health care delivery system. Vital to the success of this model is the ongoing investment in strengthening laboratory services at sites through rigorous quality assessment and improvement. The ACTION program is anchored at 5 Regional Offices staffed by a highly trained

multidisciplinary Nigerian team based in the following geopolicial zones: North-West (Kano), North-Central/North-East (Jos), South-East/South-South (Benin), Federal Capital Territory (FCT - Abuja) and South-West region (Lagos) that is coordinated by the IHV-N Central Administrative Office in Abuja. The services are located in 23 states and in each of these states, there are Project Offices integrated within the facilities and administration of the sites being supported.

Care and Treatment ACTION targets clinical service to 115,326 HIV+ adults and support services to an additional 214,273 persons affected by AIDS (PABAs) and ARV services to 74,037 adults and 7257 children utilizing the Hub and Spoke model. In COP10 ACTION stresses strengthening of spoke, particularly community-based venues employing hub sites as centers of excellence to promote decentralization. Novel strategies such as strengthening care team accountability for patient retention, augmenting community linkages between hub and spoke sites, promoting patient down load of stable patients from overpopulated sites to convenient community-based venues, and promotion of mobile services.. In COP10 ACTION will provide care for 14,000 Orphans and Vulnerable Children within 32 Network Communities. While Care and Support will be carried out at 139 sites, with 70 of them offering pediatric care. OVC services will be consistent with the National OVC Standard of Practice and OVC National Plan of Action. ACTION has focused its OVC services on linkage between medical points of care and community based OVC providers, providing three core services with emphasis on education, nutrition, and improving quality of care in collaboration with over 25 CBOs/NGOs/FBOs. through an institutional and a community based service that includes provision of LLITN, Water Guard and a scale up of therapeutic nutritional supplement ACTION Meal developed in COP09. Using expert staff from established POS as resource persons, site staff participate in central or regional trainings on ARV care, adherence counseling, and/or pharmacy SOPs and QIP in Adult and Pediatric ART Programs. The special challenges of pediatric management are being addressed through enhanced didactic and experiential training. An additional challenge is the emergence of a growing number of patients with drug resistance who are in need of second line therapy. The training plan for COP10 to support training of 30 Master Trainers from established ARV sites who will work with ACTION. ACTION will monitor and evaluate the services to ensure quality by expanding the modified HIVQUAL tools used in a pilot by the GON . In COP09 HIVQUAL was implemented in 20 sites. In COP10, all Care and Treatment sites will be involved in a biannual HIVQUAL exercise. The Gwagwalada Clinical Training Center established in COP09 serves as a model for demonstrating best practices to trainees from local sites employing an observational and experiential approach coupled to didactic training including specialized training in the management of treatment failure. ACTION will continue to participate actively in National Care and Treatment Guideline Committees. All sites are supported to employ treatment support specialists, who are PLWHA.

ARV Drugs In COP10 ARV drugs will be procured in line with USG Guidance whereby all First Line ARVs will be procured centrally for all IPs so that ARV treatment can be provided to adults and children under treatment. To transition to self sufficiency challenges of supply chain management must be met by

empowering capacity for forecasting and procurement of ARV drugs a process to be jointly carried out by ACTION and SCMS in concert with site-based staff. Training of site pharmacists and pharmacist technicians on pharmaceutical care and pharmacovigilance will be carried out by ACTION. ACTION will pilot the involvement of Community pharmacies as patient drug counseling and pick up sites in the mobile care strategy network in COP 10 to strengthen the GON ART decentralization policy..

Laboratory Services ACTION laboratory services support ARV, Basic Care and Support (BC&S), OVC, TB/HIV, PMTCT, and HCT programs by building lab infrastructure and training staff to accurately diagnose, stage and monitor patients. ACTION monitors laboratories through its QA/QC activities to ensure high quality results while working with the USG/GON to ensure 84 labs within its network are accredited both locally and internationally in COP10. ACTION will continue to be at the forefront of supporting the FMOH Early Infant Diagnosis (EID) scale up by ensuring national coverage of viral load testing for adults and children through its 11 regional Virology Labs. Specialized laboratory infrastructures such as the BSL3 TB Culture Lab in the NTBLTC Zaria and the HIV Genotype Facility in Asokoro require ongoing engagement as the technology transfer of such facilities is a complex process that depends upon the expertise of IHV technical advisors working closely with CDC and GON staff. ACTION will continue to support the FMOH EID QA activity through its support to the Plateau State Virology Research Center PLASVIREC as a Reference Lab. ACTION has developed PCR capability at the NTBLTC and has piloted the PCR based HAINS Assay to support in country capacity for monitoring TB drug resistance. ACTION will continue to coordinate with GON through Global Fund supported initiatives in the roll out of improved TB detection and culture capacity.

Strategic Information ACTION will strengthen Strategic Information (SI) under the "One M&E Framework" component of the National Strategic Framework. In COP10 it is expected that ACTION will continue to support SI activities in 139 sites in 23 states,. A key goal of this activity is to strengthen the capacity to capture patient level data that requires improved data collection and quality control at the site level. ACTION is integrating such data collection as part of the care team process at sites. ACTION is engaged in providing TA to the State ACTION Committees on AIDS (SACAs) and State Ministries of Health (SMOH) in the implementation of the Nigerian National M&E System (NNRIMS). Capacity at LACA will also be strengthened through trainings and TA. State level data for the NNRIMS is reported by the SACA to the National Agency for the Control of AIDS (NACA). ACTION is working in collaboration with the USG/GON in the implementation and piloting of the Logistics and Health Program Management Information Portal (LHPMIP) – this uses VOXIVA technology. The SI team will continue to be active participants on the SI working group established and coordinated by USG-Nigeria.

Prevention: ACTION in COP10 contributes to the PEPFAR goal of preventing new infections in alignment with the NSP through dissemination of HIV counseling and testing (HCT) targeting most at risk populations and pregnant women in the context of PMTCT, prevention messaging and services targeting sexual transmission and biomedical strategies targeting the blood supply and occupational safety. The COP 10 scale back of HCT, a tool vital to effective prevention through informing the client of their HIV

status, challenges program effectiveness and requires alignment with GON-sponsored HCT programs where possible.

PMTCT – 139 sites are supported to provide PMTCT services with a target of reaching 142,000 pregnant women of whom 5822 HIV positive women and their babies will access ARV prophylaxis. HCT is delivered using the opt out approach that encourages partner testing. To address the large fall off in accessing ART prophylaxis, infant feeding counseling and follow up mother-child pair linkage to services, ACTION applies a "Family-Centered" approach for strengthening linkages to existing community health programs for family planning/reproductive health services and well baby/immunization clinic programs. This model derives from a demonstration project carried out by IHVN that determined the preference of women for selecting a community over facility-based venue for delivery of their baby. To accommodate this preference ACTION has piloted a modified version of the PMTCT National Curriculum for traditional birth attendants (TBA), which focuses on HCT and referral of HIV-positive women. To reduce barriers to facility-based treatment access, mobile clinic outreach is integrated at the community level to bring PMTCT services to women. Manpower shortfalls are addressed by engaging PLWHA who successfully engaged in all PMTCT services to anchor a "Mothers to Mothers" peer education and retention support strategy in each site. Ten regional laboratory centers for DNA PCR, established by ACTION as part of the National network of EID Testing Centers apply dry blood spot testing to determine infection status.

Sexual Prevention - ACTION COP 10 sexual prevention activities target services to 10,310 youth and young adults through Abstinence/Be Faithful (AB) activities and 46,364 individuals through condoms and other prevention (C&OP) activities. Sexual prevention activities targets youth/young adults aged 15-24 years with particular emphasis on young women between 15 and 18 based on data from IHV-N that documents high rates of new infections among this target population. Thus the AB comprehensive package, extended to focused communities in six states (Plateau, FCT, Benue, Kaduna, Kano and Edo) targets faith-based and school-aged populations who are less likely to have experienced sexual debut. This intervention continues partnership with the Federal Ministry of Education, and the International Institute of Christian Studies (IICS), an NGO that has worked with the Nigerian Federal Ministry of Education and has implemented effective AB services in secondary schools in Nigeria. C&OP more suitably targets most-at-risk persons (MARPs; 23,182 males and 23,182 Females) by support of 60 community based condom outlets in locations frequented by MARPs, such as bars, brothels and truck stops. C&OP services are provided in hospital based outlets co-located at HCT/ART clinics with special focus on discordant family relationship, a strategy that complements prevention with positives (PwP) services supported under basic care and support programming. ACTION employs mobile services in five regional offices to reach MARPs in high risk venues where transactional and intergenerational sex are common in collaboration with 12 CBOs.

Biomedical - ACTION contributes to the 3.12.12 goals of PEPFAR in the area of prevention of new infections in collaboration with JSI by supporting prevention activities of Infection Control Committees at all sites targeting safe injection and appropriate waste disposal. Extension to the network of care involves

step down and refresher trainings at network sites and sustainability by empowerment of sites to "own" commodity logisitics. In the area of Blood Safety, in alignment with a nationally coordinated program to ensure a safe and adequate blood supply ACTION supports hospital blood banks at 32 of its implementation sites to utilize screened blood from NBTS Zonal Centers for their transfusion needs facilitated through the provision of laboratory consumables and supplies, supportive supervision, and on-site refresher training including QA/QC will be supported.. With a scale-back in HCT targets in COP10, testing services are to be co-located with Condoms and Other Prevention sites to focus on MARPs by targeting 13,500 persons at 12 points of services in 9 states. To strengthen HIV TB linkages ACTION collaborates with indigenous NGOs to extend HCT at an additional 110 TB DOTS POS reaching 25,000 persons under the TB/HIV program area.
Health System Strengthening ACTION will support the efforts of the Nigerian FMOH and nursing and midwifery educational sectors in strengthening the skills of nurses and midwives for the national response to the HIV/AIDS epidemic in line with the Health Sector National Strategic Framework for HIV/AIDS. Continuous Capacity Building will be a feature of all Program Areas so that sufficient capacity is built to ensure sustainability in the coming years.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Construction/Renovation | REDACTED |
| Economic Strengthening | 118,917 |
| Education | 118,917 |
| Food and Nutrition: Commodities | 1,074,382 |
| Food and Nutrition: Policy, Tools, and Service Delivery | 71,625 |
| Gender: Reducing Violence and Coercion | 57,854 |
| Human Resources for Health | 100,000 |
| Water | 71,625 |

## Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources

Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
Mobile Population
Safe Motherhood
TB
Workplace Programs

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **10098** |
| **Mechanism Name:** | **HHS/CDC Track 2.0 Univ Maryland** |
| **Prime Partner Name:** | **UMD-IHVN-ACTION** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HBHC | 7,871,900 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HKID | 2,378,348 | |

**Narrative:**

In addition to 11,406 HIV infected or exposed children served in the Pediatric Care and Support program area, ACTION will reach 14,000 HIV-infected and/or affected children under OVC. IHVN will train 600 providers/caregivers in COP2010.and strengthen the State Ministry of Women Affairs OVC units in facilitative supervision of OVC services

ACTIVITY DESCRIPTION:
ACTION has previously focused its OVC services on linkage between medical points of care and community based OVC providers, providing three core services to over 10,000 HIV-infected, exposed, and affected children. In COP09 ACTION scaled up its services across the country at the community level providing more than three core services to 14,000 OVC with a renewed emphasis on education and nutrition service components and improving quality of care. . In COP10, ACTION will utilize OVC funding to focus on consolidation of quality OVC services across the country and at the community level, ensuring comprehensiveness. ACTION will provide OVC services to 14,000 HIV infected and affected

children including adolescents in 23 states (Akwa Ibom, Anambra, Bauchi, Benue, Cross Rivers, Delta, Edo, FCT, Gombe, Imo, Jigawa, Kaduna, Kano, Katsina, Kogi, Kwara, Lagos, Nasarawa, Niger, Ogun, Osun, Plateau, Sokoto). ACTION supports Pediatric HIV care and support in 30 networks at 90 medical points of service. ACTION will continue its collaboration with the State Ministry of Women Affairs (SMOWA) in the 23 states to build capacity of its focal person especially in advocacy for OVC services in each state. Through OVC programming, ACTION will will continue to support and engage an OVC network coordinator in each of the 30 networks to ensure that at least three core services are provided to all OVC in the network as well as linkage of all OVC to services not provided directly by ACTION ensuring comprehensive quality services. The focus of this OVC scale up will be to address the most vulnerable children living without adequate adult support, living outside of family care, or living in a situation where they are marginalized, stigmatized, or discriminated against.

The OVC Network Coordinator in each network will work in consultation with the State Ministry of Women Affairs OVC units to identify children in need of OVC services through contact with families at points of medical service and community mobile services. The Coordinator will ensure that OVC are linked to needed medical care and services including health assessments, treatment of common childhood diseases like malaria, diarrhea, respiratory track infections, etc; provision of LLITNs, water guard, water cans, laboratory supports and multivitamin supplementation. The Coordinator will link medically vulnerable children to community OVC providers and ensure that at least two additional needed core services are provided. The Coordinator will also identify HIV affected children who are vulnerable due to inadequate adult support, family care, or are marginalized/stigmatized, and link these children to community OVC providers which will be supported in each of the 30 care networks by ACTION and ensure that needed services in at least 3 core areas are provided.

ACTION will work with Faith Based organizations to build their capacity to identify and care for OVCs within the 30 Networks. These Faith Based Centers will create a sustainable mechanism for community care where there are no orphanages and so become a vehicle for transition of street based children into family care.

OVC providers will ensure that food and nutrition services are available to all OVC regardless of HIV status. Leveraging support from the Clinton Foundation, ACTION will continue to provide comprehensive nutritional support for OVC through the provision of fortified cereals, Kwashi-pap and PlumpyNut, targeting any child meeting the definition of acute malnutrition. All children will receive nutritional assessment and caregivers counseled at intake and periodically. Those meeting the definition of acute malnutrition will receive food by prescription (either Plumpy Nut or the ACTION meal soy based Kwashi-pap formulations, both vitamin fortified ready to mix nutritional supplements approved by NAFDAC) provided by ACTION under an existing clinical care protocol for short term nutritional support. In the

provision of nutritional supplements, ACTION will build the capacity of caregivers by providing raw materials and instructions so that affordable food supplements can be prepared by them at home. This caregiver instruction will be provided by medical points of service and community OVC providers using a training manual and demonstration materials provided by ACTION. For OVC with ongoing food insecurity, ACTION will prioritize partnering with USG-supported wraparound services in states where it is co-located with these activities to meet these needs through referral. ACTION will also leverage resources on improving the capacity of care givers on income generating activities (IGAs).

The 30 care networks supported by ACTION will continue to provide educational assistance through support of school fees, uniforms and educational supplies for OVC. The community OVC providers will provide residential shelter and care, and protection for OVC who cannot be placed in family care and are at risk of physical or psychological abuse. Community OVC providers will be trained in psychosocial support through training focused on developmentally appropriate adherence counseling and support of children. The curriculum has been expanded to include the establishment of kids and Adolescents clubs.

Community home-based care (HBC) for children will be available in each of the 30 networks and is implemented by a supervising community HBC nurse, health extension workers and volunteers. This activity will be linked to primary prevention and HCT programs emphasizing the home-based approach to ensure that family members at risk including other children in the household are tested and counseled. This strategy supports family engagement in HBC and identifies family members in need of HIV care. In addition, home based care staffs support parents with ART adherence for children in the home setting through education and addressing adherence barriers. They also focus on linkages to services, ensuring that clients in need of hospital care are able to access this care and linking family members to PMTCT, community immunization, family planning, and TB DOTS services. ACTION will continue to utilize different models depending upon the site preference. Extension workers will be preferentially recruited from the PLWHA support group membership. HBC will be linked to the child's medical care source, as the supervising community home based care nurse/PHC extension worker will work under the medical direction of the site physician/clinical associate. Integrated approach will be adopted in the provision of HBC and OVC services including linkages to ACTION treatment and prevention programs.

Training of Community OVC providers will continue to be conducted at site and Community level to ensure maximum coverage in the most cost effective manner. There will be 1 Central and 5 Regional 2 day Stakeholders meetings to be coordinated by the FMOWA and SMOWA supported technically by ACTION to create awareness and sensitization of the public on community responsibilities for OVCs. 30 site-based trainings of 20 staff each will be conducted for a total training target of 600. Training in the issues of HIV for NGOs engaged in OVC services and for social workers will target improved understanding of the issues including stigma surrounding HIV positive children and the need to integrate

healthy HIV positive children into mainstream social and school settings without fear due to lack of understanding of risks surrounding HIV transmission in school-aged children.

CONTRIBUTIONS TO OVERALL PROGRAM AREA:
This activity provides services which are a high priority for the 3-12- 12 Emergency Program strategy by providing core OVC services to all HIV affected children. The services are consistent with the National OVC Standard of Practice and OVC National Plan of Action. Capacity development at the site level and consistency with national guidelines will ensure sustainability. Capacity development will be achieved through regional training and skills development.

LINKS TO OTHER ACTIVITIES:
This activity is linked to HCT , ARV services , TB/HIV , AB , lab , and SI . HCT services will be available to HIV affected family members (PABAs) in need of HIV testing including in-home HCT through HBC services. Home based care programs will be implemented by a number of indigenous NGOs, CBOs and FBOs. Sub-agreements will be coordinated with other PEPFAR IPs to ensure non-overlap of funding and services. Some services are co-located with TB DOTS centers and ACTION staff work with sites to ensure coordination systems are in place. High quality laboratory services supported by an ACTION facilitated laboratory QA program are available at sites. This will include EID available in all catchment areas (see lab narrative).

POPULATIONS BEING TARGETED:
OVC services are offered to infants and children in HIV/AIDS infected and or affected families, children orphaned by HIV, and caregivers of OVC. Doctors, nurses, social workers, care givers, teachers, family members and other health workers in the public and private sector are targeted for training. Community groups including CBOs, NGOs and FBOs will be targeted for training and system strengthening, linkages and identifying OVC.

EMPHASIS AREAS:
Emphasis is placed on training and human resources as capacity development for sustainability is a key focus and much of the community linkages are through partners. In addition, community mobilization and infrastructure development of CBOs/FBOs is critical for the identification and care of OVC. Integrated approach to programming will also be emphasized.

This activity addresses the area of wraparounds as activities that will strengthen/develop linkages between HIV/AIDS services and other sectors for food resources including IGAs. The activity also addresses the key area of stigma and discrimination as training of health care workers and community volunteers will reduce stigma.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HTXS | 16,567,770 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HVCT | 135,012 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | PDCS | 1,377,126 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | PDTX | 1,137,150 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Other | HVSI | 1,800,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Other | OHSS | 100,000 | |

**Narrative:**

ACTIVITY DESCRIPTION:
ACTION will continue to support the efforts of the Nigerian FMOH, Nursing, Midwifery and Community Health Practitioners educational sectors in strengthening the skills of nurses, midwives and community health practitioners for the national response to the HIV/AIDS epidemic in the country in line with the Health Sector National Strategic Framework for HIV/AIDS. Nurses, Midwives and Community Health

Practitioners constitute the highest number of health care workers in Nigeria at urban and rural settings and spend the highest number of hours with patients.

In the past couple years; some efforts have been made through HSS to address the weak nursing knowledge in HIV care that exists country wide. As the number of patients accessing ART services continues to increase especially in tertiary and secondary sites, doctors are overworked and patient access to care is sub-optimal. The increasing need to decentralize ART services to rural areas through PHCs and introduce task shifting roles for ART refills and follow up have placed additional demand to rapidly ensure these frontline HCWs provided the skills and knowledge necessary to triage, assess, monitor and follow up patients on ART while maintaining quality of care. If adequately trained and empowered to utilize learned skills, nurses, midwives and CHO could render more appropriate care for PLWHAs and contribute meaningfully to mitigating the impact of HIV/AIDS, improve patient access, as well as help sustain efforts supported by the Emergency Plan.

This activity is aimed at continuing to support a HIV care nurse and community training program at the practice and education levels to address the weaknesses that exist in the skill levels of nursing professionals in Nigeria in a sustainable manner. This training will be tied in with an integrated care strategy being implemented at the model HIV Clinical Training Center at University of Abuja Teaching Hospital at Gwagwalada. The care model employs a care team strategy that upgrades the role of the nurse in care provision and case management and nurse refill of ART & follow up for stable patients. This frees the physician to address patient management challenges rather than focusing on onerous paper work. A care team consisting of a physician, several nurses, adherence counselors, PLWHA treatment support specialists and pharmacy staff work together to facilitate efficiency and quality of patient care. A community liaison links the team and the patient to community-based services targeting improved treatment access, adherence, nutrition, safe water, linkage to other services and home-base care. This team will actively participate in practicum and preceptor roles during the training. Evaluation of this model and expanded training of other sites in an evidence-defined care model will help shape policy to operationalize the IMAI/IMC concept.

The standardized curriculum developed and piloted in COP07 & COP08 was crafted to focus on comprehensive but specific skills sets and knowledge needs identified by the Nursing and Midwifery Council of Nigeria and Nigerian nursing educators. The curriculum incorporates the FMOH/NACA adopted IMAI/IMCI approach to HIV/AIDS care with emphasis on such nursing skills as: aseptic technique, injection safety/universal precautions, nursing assessment & triage, follow up of stable ARV patients with prescription re-authorization, monitoring for ARV adverse effects and treatment efficacy, adherence/general counseling, and linkages with community care and other services. In addition, HIV

palliative care at facility and community levels, treatment of minor ailments (such as thrush, malaria, and diarrhea) using standing orders developed and approved by supervising physicians. Through the training, nursing skills are enhanced to provide counseling for prevention, HCT, disclosure/partner notification and other support services.
Also in COP07 & 08, ACTION together with MSH trained 55 Nurse-leaders. ACTION also rolled out TOT using this standardized nursing curriculum training a total number of 48 master trainers/continuing education nurses from state MOH, NPHCDA, tertiary and secondary and primary health facilities to enhance HIV training and retraining. A total of 34 nursing, midwifery and community health practitioner tutors were also trained as trainers. The HIV/AIDS nursing training curriculum was adapted by the Council for incorporation into standard education of nursing & midwifery students country-wide. ACTION produced copies of the curriculum for these trainings and dissemination. In addition, nursing school administrators were encouraged to incorporate clinical rotations at ACTION and other IP supported hospital and community based sites into their curriculum to enhance hands on experience for students.

Under COP09, ACTION focused on continuing to strengthen the capacity of nursing, midwifery community health practitioner schools countrywide to improve the knowledge base of future graduating nurses and midwives in the area of HIV prevention and comprehensive care of PLWHAs and PABAs. ACTION supported 2 regional step down trainings for a total of 60 educators from a least 5 schools of nursing/midwifery & CHOs who were identified by the respective licensing organizations at 2 nursing schools in ACTION regions utilizing the master trainers from COP08. ACTION also provided TA to AIDSRelief and conducted similar TOT for 14 program nurses and 13 nursing & midwifery tutors from faith based institutions. Training Department will continue to assess, monitor quality and follow up of these trainees
In COP10, ACTION will support USG & GON strategies to increase the number of HCW graduating from pre service education systems. ACTION will support 3 regional step-down trainings for 90 educators to be identified by the registration boards. ACTION will additionally provide mentoring for schools with the aim to saturate all nursing, midwifery and community health practitioner schools. ACTION will intensify advocacy and engagement of Medical & Dental Council, Nursing & Midwifery Council, Community Health Practitioner and Pharmacy Boards to take ownership for ongoing curriculum oversight & updates as well as rapidly inculcate strategies into pre-service education that will support task shifting, quality HIV care including pharmaco-vigilance, team process, leadership skills etc. ACTION will continue to provide TA and mentoring to FMOH, SMOH & NPHCDA, Implementing Partners and local service/labour organizations to ensure ongoing use and dissemination of the standardized curriculum and use expert Trainers for continuing education in practice/post service settings.

ACTION in COP08/09 has initiated discussions with the National Post Graduate Medical College for the development of a Masters Degree in HIV Medicine for doctors. In COP10 ACTION will organize a

stakeholders 5 day meeting utilizing its in-house and external facilitator to conclude the development of the curriculum. This will then be piloted using one of ACTION affiliated universities.

ACTION currently supports ARV services at a total of 139 sites structured under a hub and spoke network model. Hub sites are affiliated with smaller secondary hospital sites and additional primary health center ARV sites so that routine care of stable patients can be available at the community level. These primary health center sites already have established referral relationships with existing ARV sites at the secondary or tertiary level and will be strengthened under COP10 to provide ARV in a more accessible location. Most of these sites are staffed by nurses. ACTION anticipates that at least 16 of the primary health centers will be developed as "nurse managed" ART sites with oversight from the affiliated hubs. These are ideal settings for student rotations. ACTION support for nurse HIV and AIDS training will not be limited to ACTION supported sites or states, as the program is designed to provide supports across PEPFAR and beyond.

Sites were selected in line with the National ARV Scale-Up Plan with the goal of universal access. They include: Akwa Ibom, Anambra, Bauchi, Benue, Cross Rivers, Delta, Edo, FCT, Gombe, Imo, Jigawa, Kaduna, Kano, Katsina, Kogi, Kwara, Lagos, Nasarawa, Niger, Ogun, Osun, Plateau, Sokoto.

CONTRIBUTIONS TO OVERALL PROGRAM AREA:
Curriculum development and implementation will lead to capacity development at the site level and nursing schools. This is consistent with national guidelines to ensure sustainability. ACTION staff will ensure that there is a step down training with trainees from various hospitals using the Training Centers in Benin, Kano, Jos and Abuja. The GON and other IPs will also utilize the curriculum and other trainers developed to further step down the trainings with development of a cohort of trainers across the country.

EMPHASIS AREAS:
This activity focuses on training, as capacity development for sustainability is a key focus. This activity also focuses on training curriculum and module development, provision of additional training resources for trainers and trainees for step down training in hospitals, and human resources, as manpower shortfalls to address HIV care needs will be addressed.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HMBL | 70,516 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HMIN | 145,082 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVAB | 443,279 | |

**Narrative:**

ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS:
AB targets have been adjusted per notional targets for 2010. Increased activities of AB will target younger girls in High Schools through Faith Based Institutions. .

ACTION COP 10 sexual prevention activities will continue to provide prevention services to 10,310 youth and young adults (4,074 males and 6,236 females) through Abstinence/Be Faithful (AB) activities. AB programming activities will be implemented by ACTION in line with the overall PEPFAR Nigeria goal of providing a comprehensive package of prevention services to individuals through a balanced portfolio of AB prevention activities. In order for ACTION as a partner in her PEPFAR Nigeria services, AB services will be extended to focused communities in six states (Plateau, FCT, Benue, Kaduna, Kano and Edo). In COP09, ACTION reached over 10,000 individuals using a combination of abstinence and/or being faithful prevention messaging approaches. Targeted intervention of AB activities will be provided to youth/young adults aged 15-24 years, as this is the highest prevalence age group. In COP10, ACTION will additionally target young girls aged 10 -17 in Faith Based organizations like the Girls Brigade (GB) and Jamaatu Nasril Islam (JNI) with religiously appropriate AB messages.. Many young adults are in tertiary educational institutions where they can be reached with appropriate AB messages. The other ACTION program activities will reach a large population of HIV-positive adults, adolescents and children through care and treatment services. In addition Prevention with Positive (PwP) services will be provided to HIV-affected partners and family members of these clients.

The focused AB activities at tertiary educational institutions (polytechnic schools and universities) are located in cities where individuals are reached with AB messages and those who voluntarily visit a TCH center and test positive will be referred or linked to care and treatment facilities, as necessary. ACTION will work principally at educational institutions but will also provide services at the community through a combination of multiple strategies in line with the Government of Nigeria/U.S. Government (GON/USG) minimum care package. These will include: community awareness campaigns specifically focusing on small group discussions (SGD) organized within departments; a school based approach that will leverage

existing curricula developed jointly by the Federal Ministry of Education and the Society for Family Health; and peer education plus activities focusing on drama groups. Peer education plus activity dance drama groups will perform in the targeted institutions. These dramas will have culturally and age group relevant scripts written by a professional consultant using input from the SGD. In COP09 content was piloted and was found to be acceptable and accurate for AB messages. ACTION will continue to collaborate with the International Institute of Christian Studies (IICS), an NGO that has worked with the Nigerian Federal Ministry of Education and has implemented effective AB services in secondary schools in Nigeria. ACTION will also partner with the Girls Brigade and JNI to leverage the existing development goals entrenced in these FBOs.

AB program activities conducted at the local level by ACTION will be reinforced through national mass media campaigns by other USG partners, such as the successful Zip-Up campaign. Where appropriate both AB and condoms and other prevention messaging will be balanced and integrated with other PEPFAR program area services in proximal areas. The goal of AB interventions is to saturate targeted communities with messages conveyed using different strategies. Utilizing such a methodology, a large number of people will be reached with messages received via one method or another, but the target group reached will be those individuals that will have received AB messaging on a regular basis and via the three strategies ACTION will employ (community awareness campaigns, school based programming and peer education plus activities). Using these strategies ACTION will reach 10,310 individuals with intensive messaging campaign. A total of 500 persons made up of teachers, guidance counselors, school health care workers, FBO Officers and peer educators will be trained to provide effective prevention interventions inclusive of AB messaging from 166 outlets. In COP10, ACTION will strengthen the linkages between appropriately balanced ABC services, condoms and other prevention activities, HIV counseling and testing, and HIV treatment activities. Since lecturers have access to this age group on a regular basis, they will incorporate HIV AB messages in order to institutionalize the AB services. In addition, prevention activities will be incorporated into points of health care service in each institution, including family planning counseling, sexually transmitted infection management and counseling, and risk-reduction counseling.

CONTRIBUTIONS TO OVERALL PROGRAM AREA:
This program will contribute to the global HIV/AIDS strategy by reaching 10,310 people with AB messaging and 5,740 people with abstinence only messaging in a comprehensive approach. As high risk and "bridge" populations contribute to HIV transmission, C&OP activities will support the Nigerian Federal Ministry of Health (FMOH), and emergency plan goal of reducing new infections and thus decreasing the overall disease burden of HIV in Nigeria by enhancing HCT with targeted prevention messages and interventions. Integration of AB activities with prevention , treatment and care services will be

emphasized. Use of the community awareness campaigns, school based programs, and peer education plus activities (community drama, dance events, etc.) allows dissemination of AB messaging, including integration with condom messaging, from socially-credible sources of information (educators, healthcare workers and related populations of PLWHA).. Targeted efforts to promote correct and consistent condom use and STI management for MARPs can reduce the risk of HIV infection. The activities will also address issues of stigma and discrimination through the education of individuals and communities.

LINKS TO OTHER ACTIVITIES:
The populations being targeted often do not access services via traditional treatment venues. AB and C&OP activities relate to HCT, basic care and support (through dissemination of information by home based care providers), OVC programming (through specific targeting), and SI. A challenge of this program is to successfully link identified HIV-positive individuals with services.. The program will create a means to strengthen linkages and will identify through the hub and spoke model innovative strategies for creating access to treatment in convenient venues. Targeting MARPs will help to identify persons who need referral into care, ARV services and prevention for positives counseling, which will be an important component of post-test counseling of HIV-positive persons as part of HCT services and the basic package of care. Combination prevention messages targeting behavior change will complement HCT for all, irrespective of HIV status. OVCs will be taught family life and sexual initiation delay/abstinence negotiation skills.

POPULATIONS TARGETED:
AB will be targeted at youth (particularly university and polytechnic students), teachers, and adults accessing HCT services, The other major focus is school-based youth and young girls in FBOs.

EMPHASIS AREAS:
Emphasis will be on human capacity development for AB and equal access to information and services. Reduction of stigma and discrimination are also key features of the program. Community development through strengthening of structures for information dissemination to youth groups are also emphasize

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVOP | 1,635,963 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | MTCT | 5,687,075 | |

**Narrative:**

ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS: Early infant diagnosis (EID) is referenced and reader is referred to Pediatric Care and Treatment narrative. Increased focus on Community Based Interventions to improve coverage

ACTIVITY DESCRIPTION:
Utilizing a network model with PMTCT care centers linked to secondary and tertiary "hub sites" that provide more complex PMTCT care and lab testing, in COP10 125,000 pregnant women will receive PMTCT counseling & testing and receive their results. A total of 139 PMTCT sites established by the end of COP09 will be maintained in COP10. Sites are located in 23 states: Akwa Ibom, Anambra, Bauchi, Benue, Cross Rivers, Delta, Edo, FCT, Gombe, Imo, Jigawa, Kaduna, Kano, Katsina, Kogi, Kwara, Lagos, Nasarawa, Niger, Ogun, Osun, Plateau, and Sokoto. In COP09, ACTION paid particular attention in Nasarawa state as the Lead IP to support the development and implementation of the PMTCT LGA (local government area) coverage strategy that ensures there is at least one PMTCT point of service in each LGA. In COP10 ACTION-supported PMTCT services will be focused at quality improvement in ANC sentinel sites including the primary health center level and will increase coverage through the establishment of community-based PMTCT interventions, within the networks of ACTION care& treatment services.

In this networks, PMTCT stand alone points are linked to adult and pediatric ARV care through utilization of a PMTCT consultant coordinator in each network based at the hub site, network referral standard operating procedures (SOPs), monthly PMTCT network meetings, and incorporation of team approaches to care in all training and site monitoring. Through this SOP, HIV-positive pregnant women who require HAART are linked to an ARV point of service. Particular emphasis is placed on the involvement of community health workers who are the primary source of care for women in the pre and post-partum period and are integral to a program that seeks to engage women where they seek care. This program will work closely with the care and support team to maximally engage community based PMTCT model of care and ARV linkages. In addition to receiving PMTCT services, each HIV-positive pregnant woman will be referred to OVC services in order to facilitate care for all of her affected children. ACTION has worked with sites in COP09 to identify and train site staff with full responsibility for Network Coordination. These staff will be provided with Technical support by ACTION to ensure care is linked and to reduce to the barest minimum loss of clients along the PMTCT Cacade

Opt-out testing and counseling with same day test results will be provided to all women presenting for ANC and untested women presenting for labor and delivery. The same approach will be adopted for mobile PMTCT services to women in hard to reach communities. All women are provided pre-test counseling services on prevention of HIV infection including the risks of MTCT. Partner testing is offered

as part of PMTCT services or through referral to on-site HCT centers where available. A step down training of couple counseling and prevention with positives (PwP) package (combination prevention package) will be utilized in all sites. This will provide an opportunity to interrupt heterosexual transmission, especially in discordant couples and will facilitate partner involvement in care, treatment and support. Master trainers for HCT will train labor and delivery staff in the use of HIV rapid tests for women who present at delivery without antenatal care.

An anticipated 5,822 HIV-positive pregnant women will be identified and provided with a complete course of ARV prophylaxis (based on ACTION's current program prevalence of 4.5% and loss to follow up). HIV-positive women will have access to lab services including CD4 counts without charge. This will be available on-site or within the network through specimen transport. Women requiring HAART for their own health care are linked to a network ARV center. For the anticipated 2/3 of women not requiring HAART, the current Nigerian PMTCT guidelines recommended short course ARV option will be provided which includes ZDV from 28 weeks or ZDV/3TC from 34/36wks, intra-partum NVP, and a 7-day ZDV/3TC post-partum tail. Women presenting in labor will receive SDNVP and a 7-day ZDV/3TC post-partum tail. All HIV-positive women will be linked post-partum to an HIV/ART point of service, which will utilize a family centered care delivery model whenever feasible, co-locating adult and pediatric care and providing a linkage to family planning services. Women frequently face barriers to facility-based treatment access as a result of demands on them for childcare and to contribute to the family economic capacity. To address this, mobile clinic outreach as described in the adult care and treatment narrative will be integrated at the community level to bring PMTCT services to women who otherwise will opt-out of care and treatment.

HIV-positive women will be counseled pre- and post-natally regarding exclusive breast feeding with early cessation or exclusive breast milk substitute (BMS) if AFASS using the WHO UNICEF curriculum adapted for Nigeria. Couples counseling or family member disclosure will be utilized to facilitate support for infant feeding choices. Consistent with national policies on importation of infant formula and recent concerns regarding appropriate use of BMS, ACTION will not utilize EP funds to purchase BMS. As part of OVC programming ACTION will provide safe nutritional supplements including safe weaning for exposed infants as well as water guard, bed nets and other home based care items. HIV-positive women will be linked to support groups in the facility and their communities, which will provide both education and ongoing support around infant feeding choices, early infant diagnosis (EID), ART, adherence and PwP. PLWHA are currently employed at ACTION-supported ARV points of service as treatment support specialists. In COP09, the use of dedicated treatment support specialists (mentor mothers) for PMTCT in the clinic was implemented based upon the successful "Mothers to Mothers" model in Southern and East Africa. This model will be expanded to all PMTCT sites. This will ensure that HIV-positive women remain in care throughout pregnancy and receive appropriate services for herself and her infant. This concept

was used in the establishment of community-based PMTCT programs in COP09.

In accordance with Nigerian National PMTCT guidelines, Infant prophylaxis will consist of single dose NVP with ZDV for 6 weeks. Cotrimoxazole suspension will be provided to all exposed infants pending a negative virologic diagnosis. Ten regional laboratory centers for DNA PCR have been established by ACTION. Testing of infants will be carried out using dried blood spot (DBS) specimen collection. In COP09, ACTION actively participated in the national early infant diagnosis initiative by providing DNA PCR testing of dried blood spots (DBS) at ACTION-supported labs. The source of DBS samples will include ACTION and non-ACTION supported PMTCT sites. A systematic coordinated approach to program linkages will be operationalized at the site level and program level including linkages to adult and pediatric ART services, OVC services and basic care and support. Quality monitoring will be undertaken through site visits using an existing assessment tool and routine monitoring and evaluation indicators. As part of ensuring sustainability of PMTCT in Nigeria, ACTION will continue to provide Technical Support to Federal, State and Local Government personnel in appropriate support supervision so that the National scale up will have the appropriate ownership and funding by the various levels of government. In each state ACTION will carry out its activities along with responsible Officers in the state.

ACTION will re-train HCWs from each of the PMTCT sites in COP10 including community-based health workers in the provision of PMTCT services and infant feeding counseling. The revised and updated national PMTCT training curriculum and the infant feeding curriculum will be utilized. Under COP08, ACTION has adapted and piloted a modified version of the PMTCT National Curriculum for traditional birth attendants (TBA), which focuses on HCT and referral of HIV-positive women. ACTION piloted this with 20 TBA in COP07 , 50 in COP08 and additional 100 in COP09, targeting TBAs based on a community needs assessment that has been carried out in COP08 identifying points of deliveries for women in the community. Site-based step down trainings will be carried out in conjunction with the Ministry of Health (MOH) utilizing Master Trainers that were trained on infant feeding in COP08. There will be a minimum of 10 trainees per site for a total of 300. Thus, the total direct training target is 400. ACTION will continue to collaborate with the government of Nigeria (GON) and the Clinton Foundation to increasing access to early diagnostic services for infants. This activity is described under Pediatric Care and Treatment.

In addition to routine monitoring and evaluation activities, ACTION will contribute to a Multicountry PHE that will evaluate best practices and document best program models for increasing the number of HIV-positive pregnant women who receive HAART. The aim is to identify which models of ART service delivery to pregnant women result in the best uptake for PMTCT and maternal treatment interventions.

CONTRIBUTIONS TO OVERALL PROGRAM AREA:

This activity will provide counseling & testing services to 125,000 pregnant women, and provide ARV prophylaxis to 5,822 mother and infants pairs. This will contribute to Nigeria's goal of increasing PMTCT coverage by 80% by 2010 and the EP goal of supporting this effort.

LINKS TO OTHER ACTIVITIES:
This activity is linked to adult and pediatric care and treatment, OVC, laboratory infrastructure, condoms & other prevention, AB, and SI where ACTION will continue to provide TA for the National PMTCT MIS. PwP messages will be integrated within PMTCT care for HIV-positive women. The basic package of care provided to all HIV-positive patients will be available to HIV-positive pregnant women. ACTION lab staff will ensure that HIV testing provided within the PMTCT context is of high quality by incorporating PMTCT sites into the laboratory QA program. ACTION will collaborate with UNICEF and other implementing partners in the support of PMTCT services at some sites & states, leveraging resources without duplication and creating a more sustainable service support structure.

POPULATIONS BEING TARGETED:
This activity targets pregnant women who will be offered HCT, HIV-positive pregnant women for ARV prophylaxis, infant feeding counseling and family planning. The exposed infants will be offered prophylaxis and early infant diagnosis services. Family members will have access to prevention, care and support services.

EMPHASIS AREAS
The key emphasis area is training and quality care, as most supported personnel are technical experts. A secondary emphasis area is commodity procurement as ARVs for prophylaxis and laboratory reagents for infant diagnosis will be procured. Another secondary emphasis area is the establishment of community-based PMTCT with network/ referral systems as networks of care will be supported, which are critical to ensuring quality of care at the PHC level, identifying women in need of HAART, and ensuring access to HAART within the network. In addition, partners and PABAs will be identified for linkage to care and support services. This activity also addresses gender since treatment will be provided to women and will focus on family centric issues including male involvement in PMTCT programming.

In COP10, under 'PEPFAR Nigeria's accelerated PMTCT plan', IHVN, will strengthen its support to PMTCT service delivery by implementing activities that further improve the coverage and quality of PMTCT services. These activities will be directed towards increasing utilization of PMTCT services at existing service outlets through demand creation in collaboration with community resources and ensuring the upgrade of existing supported PHCs offering stand alone HIV counseling and testing to render at least minimal package of PMTCT services. In order to leverage resources, priority will be given to PHCs located in the selected focal states with presence of other donor agencies and in local government areas

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| already earmarked for HSS support through GFATM. Where new sites are envisioned, those that are used for national ANC sero-sentinel surveys but yet to commence PMTCT services as well as PHCs located in communities with high HIV prevalence rates above the National average will be given priority. |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HLAB | 7,170,976 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HTXD | 3,754,999 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HVTB | 1,731,511 | |

**Narrative:**

None

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 10100** | **Mechanism Name: HHS/HRSA Track 2.0 CRS AIDSRelief** |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Health Resources and Services Administration | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Catholic Relief Services | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 23,045,535** | |
|---|---|
| **Funding Source** | **Funding Amount** |

| | |
|---|---|
| Central GHCS (State) | 1,920,422 |
| GHCS (State) | 21,125,113 |

## Sub Partner Name(s)

| | | |
|---|---|---|
| Adoka Maternity, Adoka | Ahmadiyyah Hospital, Kano City | Al Noury Hospital, Kano |
| Annunciation Specialist Hospital, Emene, Enugu | Bishop Murray Medical Center, Makurdi | Bishop's House Oturkpo |
| Christian Hospital, Onicha Ngwa | Community Support and Development Initiative | Comprehensive Health Center Ugba Logo |
| Daughters of Divine Love Hospital, Ehaluma | Ebonyi State University Teaching Hospital, Abakaliki | ECWA Evangel Community outreach centre,Kagoro |
| ECWA Evangel Hospital, Jos | ECWA Hospital Kagoro | Enugu State University Teaching Hospital |
| Evangelic Reform Church of Christ Alushi, Nasarrawa | Faith Alive Foundation Hospital Jos | Faith Mediplex, Benin City |
| GEECHAN, Gembu | General Hospital Bambur | General Hospital Igueben |
| General Hospital Tse-Agbragba | General Hospital Tudun Wada Kano | Grimard Catholic Hospital, Ayingba |
| Health Center Obollo Affor | Health Center Osisioma Abia | Holy Name Clinic, Ugbokolo |
| Holy Rosary Hospital Abo Mbaise | Holy Rosary Hospital, Emekuku | Holy Rosary Hospital, Onitsha |
| Immaculate Heart Hospital, Nnewi | Immaculate Heart, Aguieri | Itim Ukwu General Hospital, Afikpo |
| Joint Hospital Ozubulu, Ekwusigo | Mater Misericordiae Hospital, Afikpo | Medical Mission of Mary, Ondo |
| Mile 4 Catholic Hospital, Abakaliki | Mother of Christ Hospital Specialist, Enugu | Nsukka Health Center, Nsukka |
| Our Lady of Apostles, Akwanga | Our Lady of Lourdes, Ihiala | Plateau State Specialist Hospital, Jos |
| Primary Health Care | Primary health Center Filinbo | Primary Health Center, Dogon Kurumi Kaduna |
| Primary Health Center, Isa Kaduna | Rural Health Center Owukpa | Saint Vincent Hospital, Kubwa |
| Santa Maria Catholic Hospital | Shuwa Health Center and | St. Anthony Catholic Hospital, |

| | | |
|---|---|---|
| Uzairue | Maternity | Zaki-biam |
| St. Camillus Hospital, Uromi | St. Catherine, Ondo | St. Francis Jambutu Hospital, Yola |
| St. Gerard's Hospital, Kaduna | St. Johns;s Catholic Hospital, Kabba | St. Joseph Hospital |
| St. Joseph Hospital Adazi | St. Joseph Ogobia | St. Louis Hospital Owo |
| St. Louis Hospital, Zonkwa | St. Martins Ugwuagba, Obosi, Anambra | St. Marys Joint Hospital, Amaigbo |
| St. Mary's Okpoga, Otupo | St. Monica Hospital, Adikpo | St. Thomas Hospital, Ihugh |
| St. Vincent's Hospital, Aliade | Sudan Mission Hospital Onuenyim | TB and Leprosy Referral hospital Uzuakoli |
| TB clinic , Abagana | TB/Leprosy Hospital, Yadakunya | TBL Clinic Akwa, Akwa South |
| Thomas Clinic and Maternity Kipwe Lissam | | |

## Overview Narrative

I. PROGRAM DESCRIPTION

The overall goal of the AIDSRelief program is to ensure that PLHIV have access to ART and high quality medical care. By the end of COP09, AR will have 35,860 people on treatment and 50,000 in care. Treatment success is measured by durable therapeutic outcomes and quality of life indicators. An analysis of Patient Level Outcomes in 2009 found a viral load suppression rate of 84% among sample patients.

Aids Relief operates in the 16 states of Abia, Adamawa, Anambra, Benue, Ebonyi, Edo, Enugu, FCT, Imo, Kaduna, Kano, Kogi, Nasarawa, Ondo, Plateau, and Taraba. Patients are those presenting at Local Partner Treatment Facilities (LPTF's) for Opportunistic Infections (OI's) or those referred from C+T, TB, and PMTCT programs. Patients are generally prioritized for treatment by CD4 count under 350; 88% of the 2009 PLO sample had a CD4 count under 350.

The grant document outlines program objectives:

Objective 1: Existing ART service providers rapidly scale up delivery of quality ART.

a) AidsRelief works to prevent the spread of HIV/AIDS in the following areas: PMTCT, Abstinence and Behaviour Change, Blood and Injection Safety, and

Counselling and Testing.

b) AidsRelief provides treatment for those infected by working in the following areas:

Adult and Pediatric Treatment, TB/HIV, ARV Drugs, Lab Infrastructure. Because of the quality of these services, AidsRelief has high retention rates: 90% in a 2009 sample and 85% for the population at large. Given resource constraints, only replacement patients will be enrolled and total enrolment will remain at 35,860.

Objective 2: The number of health care facilities providing quality ART is increased and capacity at sites… is increased to allow initiation of ART. Given resource constraints, no additional LPTF's are being added.
Objective 3: Expand community-level services providing quality ART to vulnerable and low-income HIV-infected people. At the community level, AidsRelief works in the following areas: Adult and Pediatric Care and Support, and
OVC.
Objective 4: Create and strengthen health care treatment networks to support capacity building within countries and communities.
AidsRelief currently works through 34 comprehensive health facilities, 9 PMTCT centers, and 33 TB/DOTS satellites. Of the 34 comprehensive sites, 3 are public hospitals and 1 is a local NGO. The balance is made up of a network of faith-based institutions including those representing the Catholic (24), Protestant (4), and Islamic (2) traditions. PTMTC have mixed ownership and TB/DOTS sites belong to the government. The PEPFAR grant has increased the capacity of these institutions to implement HIV/AIDS and other health services.
Meanwhile, given a Congressional mandate to transition activity to a local organization by 2012, AidsRelief is working to sustainably indigenize the program as quickly as possible. By the end of COP09, AidsRelief will have identified (an) organization(s) capable of and willing to assume AidsRelief's role in the future. COP10 activities will include carrying out capacity building activities that will enhance the ability of the named Local Partner(s) to eventually manage the program independently.
This network of faith-based organizations (FBO's) supplements HIV/AIDS work by national and state governments. This is acknowledged in the 2005-9 National Strategic Framework which calls for increased collaboration with "civil societies" and in discussions on the new framework now being developed. In addition to capacity building in the faith-based network, AidsRelief also supports capacity improvements in the public institutions, especially in the technical areas of clinical care and strategic information.
II. MONITORING AND EVALUATION
AidsRelief's monitoring system covers both patient management and monitoring (PMM) and indicators necessary for program managers to track progress against PEPFAR and national plan indicators. Monthly collection of this information will continue at all sites in COP10. The emphasis in the monitoring system has been on creating a culture of Data Demand and Information Use, with the objective of making information useful to grant decision makers at all levels. As part of its "Continuous Quality Improvement" program, AidsRelief also conducts periodic "Patient Level Outcome" studies (PLO) and one will be conducted in 2010. These analyses are used to make systematic changes to the clinical management of the program where these are appropriate.
III. COST EFFICIENCIES/RESOURCE MOBILIZATION
AidsRelief recognizes that global resources for HIV/AIDS are constrained and in COP10 will contribute to the drive to greater cost efficiency in four ways:

a) AidsRelief has benefitted, and will continue to benefit, from cost reductions from the conversion of proprietary to generic drugs. Reserving a portion of the drug budget for local use allows for unforeseen circumstances that lead to stock-outs. However, the program plans that centralized procurement will constitute up to 80% of new ARV purchases.
b) Training, technical assistance, and equipment cost reductions will come with conversion of the program from "scale-up" to "maintenance" mode. Although AidsRelief will continue to address staff turnover and equipment obsolescence at the LPTF level, investments in new capacity building at that level will be reduced.
c) Various initiatives will be undertaken with a view to improving program quality at lower cost. These will include, among others, a Performance Based Funding pilot to analyze costs and test relationships with partners that are based on quality output rather than resources paid. AidsRelief is also exploring a pilot effort to extend Level of Effort analysis of LPTF staff by providing information on per unit outpurs. Marginal costs of these pilots are minimal.
d) In the short term, the plan to transition the program to grant management by Local Partner(s) will require resources for travel and capacity building (training, equipping, technical assistance). However, ultimately transition to local partners will reduce travel and overhead costs.
In parallel with the effort to be more cost efficient, AidsRelief will emphasize resource mobilization next year. Part of that emphasis will lie in enhanced relations with the MOH and an exploration of resource sharing. Collaboration with other donors, including the Global Fund and bilateral donors, will be explored.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 1,681,425 |

## Key Issues

Increasing gender equity in HIV/AIDS activities and services
Safe Motherhood
TB

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **10100** |
| **Mechanism Name:** | **HHS/HRSA Track 2.0 CRS AIDSRelief** |

| Prime Partner Name: | Catholic Relief Services | | |
|---|---|---|---|
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Care | HBHC | 3,889,084 | |
| **Narrative:** | | | |
| None | | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Care | HKID | 600,000 | |
| **Narrative:** | | | |
| None | | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Care | HTXS | 8,275,725 | |
| **Narrative:** | | | |
| None | | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Care | HVCT | 115,000 | |
| **Narrative:** | | | |

ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS:

AIDSRelief (AR) provided support in COP09 for counseling and testing (HCT) services to a total of 84 sites. This comprised the current 34 Local Partner Treatment Facilities (LPTFs), 19 ART/PMTCT satellites and 31 TB/DOT sites in 16 states (Abia, Adamawa, Anambra, Benue, Ebonyi, Edo, Enugu, FCT, Imo, Kaduna, Kano, Kogi, Nasarrawa, Ondo, Plateau, and Taraba). AR will continue to build the capacity at LPTFs to enable them integrate HCT services within care and treatment systems. AR will continue to emphasize support for decentralization clinics and testing of family members of in-care clients. AR will target the provision of HCT services mainly to PABAs - especially children, as well as to STI patients and TB DOT clients at the LPTFs and satellite clinics. At rural satellite clinics, AR will also target women of reproductive age with combined HCT and STI screening. AR also will provide HCT services as a routine component of blood transfusion services. All HCT clients will be linked to prevention services, as well as treatment, care and support services where applicable. 7,500 (specialized categories for TB cases, pediatrics, index case family members, provider initiative for sick patients) persons will benefit from HCT and receive their results.

All HCT service outlets will continue to be branded with the "Heart to Heart" logo. AR will continue to encourage Provider Initiated Testing and Counseling (PITC) in all supported healthcare facilities. This approach to HCT will be actualized by AR technical and programmatic staff through onsite mentoring of providers and the engagement of leadership at AR-supported facilities. AR also will scale-up couples counseling and testing in all supported sites through organized training, family-centered testing and on-site mentorship.

AR will promote HCT as a necessary and important arm of HIV prevention in terms of averting new infections and providing treatment for those in need, and post-test counseling will be strengthened to lay emphasis on prevention for positives. Post test counseling will include full and accurate information on all prevention strategies. Referrals to outlets that provide other prevention services not available at AR-supported facilities will be provided. All HCT sites will provide same day results and will use the current National serial testing algorithm. For infants and children less than 18-months Early Infant Diagnosis (EID) will be available at PMTCT sites according to the national scale up plan; lab testing for EID will be done in conjunction with other IPs.

The USG will provide AR with rapid HIV test kits and AR will be responsible for their warehousing, storage and distribution to LPTFs. Sites will be actively linked to the Government of Nigeria and other donor agencies to access extra kits and supplies needed, and supported to maintain their regular usage and feedback through the above mentioned strategies. This will help increase uptake of HCT services in all points of service in the facilities. Newly identified HIV positive patients will be actively linked to care and treatment in facilities with capacity to enroll new patients. Sites will be supported and retrained on forecasting and stock control using bin cards and will maintain a three month buffer stock. LPTFs will report on inventory and forecasting to the AR central office on a monthly basis.

AR will provide refresher training for 90 LPTF staff on counseling and testing using the GON HCT training curriculum. Counselor training will include couples counseling to strengthen this aspect of the program. This will ensure the availability of a pool of trained counselors to promote continuity. In addition, providers will be sensitized on the adoption of PITC and point of service testing in their facilities. Non-laboratorians will be used at multiple points of service for facility based HCT where appropriate and when allowed by national policy. To this effect AR will continue to train HCW (counselors, nurses and outreach workers) that will be supervised by onsite laboratorians to assure quality. To expand HCT services within the network of faith based organizations and increase rural access to HCT, AR community based HCT will continue to advocate for greater use of non-laboratory staff to conduct testing in the community setting as well.

AR will carry out quarterly monitoring visits which focus on quality assurance and onsite mentoring. There will be evaluations of counseling techniques, HCT testing algorithms, the utilization of the National CT Register, proper medical record keeping, referral coordination, patient flow, and use of National HCT tools. On-site TA with more frequent follow-up monitoring visits will be provided to address weaknesses when identified during routine monitoring visits. Semi-annual partner meetings will provide an additional forum for sharing of new information between sites and communities.

AIDSRelief will continue to collaborate with faith-based and community-based organizations, in particular the 7-Dioceses program of Catholic Relief Services, in carrying out community based and mobile HCT services. AR will also continue to collaborate with state and local government HCT programs by carrying out joint trainings, monitoring visits and leveraging resources to test those who may require testing outside the USG supported numbers.

CONTRIBUTIONS TO OVERALL PROGRAM AREA:
AIDSRelief will continue to support HCT services at 84 sites at the primary, secondary and tertiary levels in rural and previously underserved communities to provide services to 7,500 clients including 4,000 children thus contributing to the PEPFAR and GON targets for increasing access to HIV counseling and testing. HCT services will enable the identification of HIV positive individuals in a timely manner and will direct them into care and treatment services. HCT will add to the prevention strategies of averting new infections through efficient and effective posttest counseling and patient education. HCT will further contribute to the national goal of universal access to HIV/AIDS services. By continuing to support the building of LPTF capacity, AR will continue to contribute to the sustainability of HCT activities at these sites and in Nigeria.

LINKS TO OTHER ACTIVITIES:
This activity relates to activities in ARV services, ARV drugs, laboratory, care and support, PMTCT, OVC, AB, TB/HIV and SI. Linkage of HCT to treatment, care and support services will continue to be strengthened within and across programs and between other implementing partners using standard referral tools. AR will continue to support referral linkages with National TB DOTs centers to ensure that TB patients are routinely screened for HIV and those testing HIV+ are referred to AR LPTFs for HIV/AIDS care and treatment. The LPTFs will ensure integration of the AR-supported HCT program with other departments to provide routine HCT services to all patients and to ensure that those testing HIV+ are referred for appropriate care.

POPULATIONS BEING TARGETED:
This activity targets the general population and in particular PABAs (especially children), STI patients,

and TB suspects/patients.

EMPHASIS AREAS
This activity has emphasis on training including supportive supervision and quality assurance/quality improvement. REDACTED

The expansion of free HCT services will ensure gender equity in access to HCT services in rural and previously underserved communities. It will also ensure that HIV-positive people are identified and linked to timely life-saving ART services and HIV-negative clients are educated on the importance of avoiding risky behaviors.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | PDCS | 625,000 | |

**Narrative:**

ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS:

In COP09 AIDSRelief (AR) provided pediatric care and support services in 34 Local Partner Treatment Facilities (LPTFs) and 19 satellite sites in 16 states (Abia, Adamawa, Anambra, Benue, Ebonyi, Edo, Enugu, FCT, Imo, Kaduna, Kano, Kogi, Nasarawa, Ondo, Plateau, and Taraba). In setting and achieving COP10 targets, consideration has been given to consolidating on AR's COP09 accomplishments in order to maintain continuous quality improvement

Key to increasing pediatric enrollment into care and support will be to strengthen linkages among all service components in AR's LPTF as well as to expand community outreach. This activity will require sustaining staff training/retraining and strengthening referral linkages., AR will consolidate on its multi-pronged approach to increase the number of children enrolled into care and support: organization of services to provide family centered care and treatment, PITC (provider initiated testing and counseling) and community mobilization. AR will pilot the use of less invasive and less technical methods (OrasureR) for increasing access to pediatric HIV testing in communities where children and caregivers are clustered. All exposed infants delivered in the LPTF or identified through the family centered approach will be enrolled into the HIV Comprehensive Care clinic and linked to community based OVC programs for care and support.

The package of care services provided to each HIV positive or exposed child includes a minimum of clinical service with basic care kit and two supportive services in the domain of psychological, spiritual, and PwP delivered at the facility, community, and household (home based care) levels in accordance

with the PEPFAR and Government of Nigeria (GON) national care and support policies and guidelines. The basic care package for HIV positive child/care givers in AR's partner sites include Basic Care Kit (ORS, LLITN, water guard, water vessel, soap, IEC materials, and gloves); Home-Based Care (client and caregiver training and education in self-care and other HBC services); Clinical Care (basic nursing care, pain management, OI and STIs prophylaxis and treatment, nutritional assessment- weight, height, BMI, micronutrient counseling and supplementation and referrals, Laboratory Services (which will include baseline tests: CD4 counts, hematology, chemistry, malarial parasite, OI and STI diagnostics when indicated); Psychological Care (adherence counseling, bereavement counseling, depression assessment and counseling with referral to appropriate services); Spiritual Care (access to spiritual care); Social Care (support groups' facilitation, referrals, and transportation) and Prevention Care (Prevention with Positives). All HIV positive or exposed children's nutritional status will be assessed at contact and on follow-up visits, micronutrients will be provided as necessary, and those diagnosed as severely malnourished will be placed on a therapeutic feeding program. This will be done through wraparound services as well as direct funding. AR will procure basic care kits through a central mechanism and OI drugs will be procured through mechanisms that ensure only NAFDAC approved drugs are utilized. Cotrimoxazole prophylaxis will be provided for exposed and infected children according to the national guidelines.

All LPTFs will be strengthened in their capacity to provide comprehensive quality care and support services through a variety of models of care delivery. This includes quality management of OIs, a safe, reliable and secure pharmaceutical supply chain, technologically appropriate lab diagnostics, treatment preparation for patients, their families and supporters and community based support for adherence. This technical and programmatic assistance utilizes on-site mentoring and preceptorship. It also supports the development of site specific work plans and ensures that systems are in place for financial accountability.

AR will continue to build and strengthen the community components by using nurses and counselors to link health institutions to communities. AR Community Based Treatment Services (CBTS) specialists will continue to support extension of support services to the home and community level. The CBTS Specialists will develop a community volunteer structure in collaboration with the Volunteer Services Organization (VSO) in COP10 to ensure sustainability of services at LPTFs to include mental health support (psychotherapeutic, psychosocial, depression and substance abuse management) and home based care. New and refresher training will be provided for LPTF staff in adherence monitoring. Each LPTF will appoint a specific staff member to coordinate the linkages of patients to all services. This will also build the capacity of LPTFs for better patient tracking, referral coordination, and linkages to appropriate services. All children in care and support will be served with home visits to assess need for intervention. Psychosocial support will continually be enhanced for all infected children by linkages with support group activities and provision of age specific educational/recreational kits. AR will support

expansion of kid support groups to all LPTFs and expand their activities to include periodic social/recreational and educational activities to address issues of stigma and discrimination. AR will support LPTFs to provide step down trainings onsite in this regard.

Efforts will be made to strengthen adolescent friendly services for infected and affected children including linkages to reproductive health.

Non-ART eligible children will be enrolled into care for periodic follow-up, including laboratory analysis at least every 6 months, to identify changes in ART eligibility status. All enrolled children will be linked to the AR OVC program to access an array of services including nutritional support, preventive care package (water sanitation/treatment education, ITN) and psychosocial support. Educational support and food supplements will be leveraged from other partners particularly the CRS SUN program and Catholic Secretariat of Nigeria USG funded SUCCOUR program.

In COP10 AR will train and retrain an additional 68 health service providers according to the National Pediatric HIV Training curriculum. Training will maximize use of all available human resources including a focus on community nursing and community adherence to ensure care is decentralized to the home level. AR will establish sustainable structures and models for training health care providers. This will include consolidating support for tertiary institutions within the AR network and supporting specialty clinics to manage salvage and complex pediatric cases as part of support for AR's transition sustainability plan for capacity building. These institutions will provide for various cadres of health care workers, hands-on training and case conferences in the management of pediatric HIV.

AR will collaborate with the GoN and other stakeholders to implement and scale up task shifting strategies to enable nurses and community health officers provide Pediatric ART. AR will strengthen existing nurse refill services at 3 LPTFs and scale up to 10 additional LPTFs in accordance with AR decentralization and decongestion strategies. AR nurse educators will continue to support the integration of community nursing/Home based nursing services with facility services through training and ongoing mentoring. AR will support expansion of its current pre-service peer education and introduction of nurse curriculum as aspects of pre- and in-service trainings in 10 LPTFs with existing schools of nursing and midwifery. This activity will help in building the capacity of 300 pre service nurses in support of nursing council of Nigeria's approach to improving pre and in service nurse training.

AR will work closely with the USG team to monitor quality improvement at all sites and across the program. AR will actively participate in and facilitate activities to review best practices in Pediatric HIV care and support particularly GoN technical working group meetings. AR will continue its support for GoN in rolling out the national pediatric HIV care and support guideline, and training curriculum.

AR will offer HIV early infant diagnosis (EID) in line with the National Early Infant Diagnosis scale-up plan from 6 weeks of age using DBS. Implementation and scale out of the EID scale-up will be done under the guidance of the GoN and in conjunction with other IPs who will be conducting the laboratory testing. AR will provide support DBS commodities and transport logistics support for the EID program in collaboration with GoN. Exposed infants will be actively enrolled into pediatric care and support. PMTCT focal persons at all AR LPTFs will keep records of all exposed infants at enrollment soon after birth; informing HIV+ mothers of the 6 weeks the exact dates for DBS collection. AR will encourage parent LPTFs to step down DBS collection at affiliate PMTCT satellite sites and thus decentralize EID activities at these sites. Parent LPTFs will ensure supplies of DBS collecting kits from their own stock to these satellites and the samples collected returned to the parent sites for dispatch to the testing labs. AR will train members of PMTCT support groups in HCT skills. AR will engage PMTCT support groups and the larger support group(s) in tracking unbooked pregnant women and infants in the community, linking them to sites where they can access HCT. AR will strengthen linkages with other health care providers; public and private, proximal to AR LPTFs, with full fledged ANC activities. This will encourage two-way referrals of HIV+ mothers and their infants from these providers to AR LPTFs and thus benefit from EID/ART activities at AR sites. LPTF EID focal persons will ensure prompt dissemination of results to providers and mothers as soon as they are available.

In COP10, AR will continue to strengthen its expanded Quality Improvement Program (QIP) consisting of the annual cross sectional Outcomes & Evaluation (O&E) exercise, the GON/USG supported HIVQual monitoring and the quarterly Continuous Quality Improvement (CQI) activities in order to improve and institutionalize quality interventions. AR QIP specialists will be responsible for spearheading QIP activities in their respective regions working with identified and trained LPTF quality management teams. The quality management teams will be supported to conduct in-house self evaluations with AR developed Quality of Care (QoC) indicator tools using the Plan-Do-Study-Act Model to develop strategies for program strengthening. AR will support experience-sharing and dissemination of CQI intervention strategies amongst LPTFs through site-to-site, regional quality committee TWG meetings and the biannual peer forums. Monitoring and evaluation of the AR care and support programs will be consistent with the national plan for patient monitoring. The QIP specialists will conduct team site visits at least quarterly during which there will be evaluations of the status of their standardized medical records keeping, infection control, the utilization of National PMM tools and guidelines, efficiency of clinic services, referral coordination, and use of standard operating procedures across all disciplines. On-site technical assistance (TA) will continually be provided to address weaknesses when identified during routine monitoring visits. Data generated will be used to provide mortality/morbidity reviews and biannual life table analyses that identify factors associated with favorable outcomes. Each of these activities will highlight opportunities for improvement of clinical practices.

Sustainability lies at the heart of the AR program, and is based on durable therapeutic programs and health systems strengthening. AR will focus on the transition of the management of care and treatment activities to indigenous organizations by actively using its extensive linkages with faith based groups and other key stakeholders to develop a transition plan that is appropriate to the Nigerian context. It will also include strengthening regional training institutions to provide long term training support and capacity development to other LPTFs. The plan will be designed to ensure the continuous delivery of quality HIV care and treatment, and all activities will continue to be implemented in close collaboration with the GoN to ensure coordination, information sharing and long term sustainability. For the transition to be successful, sustainable institutional capacity must be present within the indigenous organizations and LPTFs they support; therefore, AR will strengthen the selected indigenous organizations according to their assessed needs, while continuing to strengthen the health systems of the LPTFs. This capacity strengthening will include human resource support and management, financial management, infrastructure improvement, and strengthening of health management information systems.

CONTRIBUTION TO THE OVERALL PROGRAM AREA:
By adhering to the Nigerian National ART service delivery guidelines and building strong community components into the program, this activity will support the Nigerian government's universal access to ART by 2010 initiative. By putting in place structures to strengthen LPTF health systems, AR will contribute to the long term sustainability of the ART programs.

LINKS TO OTHER ACTIVITIES:
This activity is linked to HCT services to ensure that people tested for HIV are linked to ART services; it also relates to activities in ARV drugs, laboratory services, and care & support activities including Sexual Prevention, PMTCT, OVC, AB, TB/HIV, and SI.

AR will collaborate with the 7-D program of CRS to establish networks of community volunteers. Networks will be created to ensure cross-referrals and sharing of best practices among AR and other implementing partner sites. Effective synergies will be established with the Global Fund to Fight AIDS, Tuberculosis and Malaria through harmonization of activities with GoN and other stakeholders.

POPULATIONS BEING TARGETED:
This activity targets children infected with HIV and their caregivers/HCWs from rural and underserved communities.

EMPHASIS AREAS:
This activity will include emphasis on human capacity development specifically through in-service

training. These ART services will also ensure gender and age equity in access to ART through linkages with OVC and PMTCT services in AR sites and neighboring sites. The extension of ARV services into rural and previously underserved communities will contribute to the equitable availability of ART services in Nigeria and towards the goal of universal access to ARV services in the country. The provision of ART services will improve the quality of life of infected children and thus reduce the stigma and discrimination against them.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | PDTX | 492,800 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Other | HVSI | 750,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HMBL | 40,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HMIN | 75,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVAB | 162,186 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | MTCT | 2,377,179 | |

**Narrative:**

ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS:

In COP09, AIDSRelief (AR) is providing PMTCT services in 34 comprehensive Local Partner Treatment Facilities (LPTFs) and 17 satellite facilities in 16 states (Abia, Adamawa, Anambra, Benue, Delta Ebonyi, Edo, Enugu, FCT, Imo, Kaduna, Kano, Kogi, Nasarawa, Ondo, Plateau, Rivers and Taraba). AR will continue to implement a local government area-wide service coverage strategy in Anambra and other states with AIDSRelief presence. In setting and achieving COP10 targets, consideration has been given to consolidating on AR's rapid PMTCT COP09 accomplishments in order to maintain continuous quality improvement.

AR will continue to provide counseling, testing and results to 47,200 pregnant women. Antiretroviral (ARV) prophylaxis will be provided to 2,000 women and an additional 500 clients will be placed on HAART for their own disease for a total of 1,800women receiving antiretrovirals (4% positivity rate and 75% retention in care based on historical data at AR supported LPTFs). This activity will include routine provider initiated opt-out HIV counseling and testing (HCT) for all women presenting in antenatal clinics (ANC),labor and delivery wards (L&D) in addition to immediate post-delivery settings for women of unknown HIV status. Counseling will be provided using group and individual pre/post- test counseling strategies and rapid testing based on the National testing algorithms. Same day results will be provided to clients. As part of PMTCT services, partner testing and couple counseling will be strengthened with the provision of a "Partners' Slip" and initiation of a facility based monthly "Couples Forum" to enhance disclosure and male involvement. Through its community and faith-based linkages, AR will continue to utilize community and home based care services to promote partner testing. Clients will be provided access to free laboratory services including CD4 counts, STI screening (VDRL), Urinalysis, MP and Ultrasound Sound Screening (USS). Free medications including those for OIs and hematinics will also be provided. Access to cervical screening will be provided to HIV positive women enrolled into PMTCT services. Strong referral systems that incorporate active follow-up will be strengthened to ensure that women requiring HAART are not lost during referral for ARV services. Referral coordinators will be identified in all our sites and the communities with their capacities built in collaboration with other IPs.

For the anticipated number of women not requiring HAART for their own health, the current WHO-recommended short course ARV option will be provided (ZDV from 28 weeks with intra-partum sdNVP and a 7-day ZDV/3TC post-partum tail or ZDV/3TC from 34-36 weeks with intra-partum sdNVP and a 7-day ZDV/3TC post-partum tail). AR will also offer the option of HAART from 1st week of 2nd trimester in facilities with capacity to deliver HAART. Infant prophylaxis will consist of single dose NVP and ZDV for 6 weeks. AR will use its community linkages, mother-to-mother support groups and the provision of incentives to encourage HIV+ pregnant women to deliver in a health facility. The incentive package

("Mama and Baby Packs") contains basic delivery consumables and immediate baby care items including suctioning bulbs, cord clamps, disinfectant, mackintosh, baby soap and face flannel. All infants of HIV positive woman will be referred to OVC services in order to facilitate care to all affected children.

AR will facilitate establishment of MCH teams within facilities to ensure continuum of care by strengthening linkages between the PMTCT and ART, pediatric and OVC programs. For those HIV+ women who deliver at home, the MCH team and community volunteers will follow-up and ensure delivery of required postpartum services.

AR will support the utilization of traditional birth attendants (TBAs) in referral services in addition to the mother-to-mother support groups to reach HIV+ women who deliver outside of the health facility. This activity will help increase referrals, patient tracking and universal precautions to improve PMTCT outcomes. In this regard, a pilot of TBA service training will be done in 3 states in collaboration with the LPTFs. A focal person at each LPTF will be responsible for tracing HIV+ mothers and their infants in the community and re-integrating them into care. AR Community Based Treatment Services (CBTS) specialists will continue to support extension of treatment services to the home and community level. The CBTS Specialists will develop a community volunteer structure in collaboration with the Volunteer Services Organization (VSO) in COP10 to ensure sustainability of services at LPTFs to include psychosocial support and home based care.

HIV+ women will be provided infant feeding counseling in prenatal and postnatal periods with options of exclusive breast feeding with early cessation or exclusive BMS if AFASS criteria can be met using the WHO UNICEF curriculum adapted for Nigeria. AR will support couple counseling and family disclosure that will enhance adherence to infant feeding choices. Full and accurate information will be provided on family planning and prevention services. Women accessing family planning services will be offered HIV Counseling and Testing. Infants of positive mothers will be linked to immunization and well child care services. Cotrimoxazole prophylaxis will be provided to infants from 6 weeks of age until definitive HIV status can be ascertained.

AR will provide training in three cycles to 60 healthcare workers and retraining of additional 30 staff on PMTCT/EID according to the national curriculum. AR will establish sustainable structures and models for training health care providers. Targeted regional LPTF exchange MCH team visits (PMTCT, Pediatrics and OVC focal personnel) within a region to ensure facility ownership of the PMTCT programs will be supported as a stimulus for self evaluation and capacity building. This will include consolidating support for tertiary institutions within the AR network and supporting specialty clinics to manage complex PMTCT cases as part of support for AR's transition sustainability plan for capacity building. Trained LPTF staff will be used as facilitators to step down trainings to other Health Care Workers in their facilities and in nearby

government health facilities as a human capacity development and sustainability activities.

AR will collaborate with UNICEF-supported PMTCT sites and the CRS 7D programs for community and home based PMTCT initiatives in its scale-up plans.

In COP10, AR will continue to strengthen its expanded Quality Improvement Program (QIP) consisting of the annual cross sectional Outcomes & Evaluation (O&E) exercise, the GON/USG supported HIVQual monitoring and the quarterly Continuous Quality Improvement (CQI) activities in order to improve and institutionalize quality interventions. AIDSRelief QIP specialists will be responsible for spearheading QIP activities in their respective regions working with identified and trained LPTF quality management teams. The quality management teams will be supported to conduct in-house self evaluations with AR developed Quality of Care (QoC) indicator tools using the Plan-Do-Study-Act Model to develop strategies for program strengthening. AR will support experience-sharing and dissemination of CQI intervention strategies amongst LPTFs through site-to-site, regional quality committee TWG meetings and the biannual peer fora. Monitoring and evaluation of the AIDSRelief ART program will be consistent with the national plan for patient monitoring. The QIP specialists will conduct team site visits at least quarterly during which there will be evaluations of the status of their standardized medical records keeping, infection control, the utilization of National PMM tools and guidelines, efficiency of clinic services, referral coordination, and use of standard operating procedures across all disciplines. On-site technical assistance (TA) will continually be provided to address weaknesses when identified during routine monitoring visits. Monitoring and evaluation of the AIDSRelief PMTCT program will be consistent with the national plan for patient monitoring. Data generated will be used to provide mortality/morbidity reviews and biannual life table analyses that identify factors associated with good PMTCT outcomes. In addition, at each LPTF an annual cross sectional evaluation of program quality shall consist of a 10% random sample of linked medical records, adherence questionnaires and viral loads to examine treatment compliance and viral load suppression for adult patients who have been on treatment for at least 9 months. A similar process will be undertaken to evaluate outcomes of PMTCT strategies. All these activities will highlight opportunities for improvement of clinical practices.

CONTRIBUTIONS TO OVERALL PROGRAM AREA:
This activity will provide counseling and testing services to 47,200 pregnant women, and provide ARV prophylaxis to 2,000 and 1,800 clients on ART. With 34 operational sites in 16 states, AR PMTCT program supports the rapid scale up of PMTCT services desired by the FMOH.

LINKS TO OTHER ACTIVITIES:
The PMTCT services will be linked to HCT, basic care and support, ARV services, ARV drugs, OVC,

TB/HIV, laboratory services and SI. Pregnant women who present for HCT services will be provided with information about the PMTCT program and referred accordingly. ARV treatment services for infants and mothers will be provided through ART services. Basic pediatric care, including TB care, is provided for infants and children through OVC activities. All HIV+ women will be registered for adult care and support services.

AR PMTCT activities will focus on strengthening community and home-based care services to pregnant women where appropriate and in collaboration with the CRS 7-Diocese program and other family-centered care services provided by UNICEF, GON and the Catholic Secretariat of Nigeria. The AR senior PMTCT specialist will offer technical assistance to 7-Diocese facilities. AR will collaborate with other IPs, particularly IHV-ACTION, working at tertiary institutions for infant diagnosis using dried blood spot (DBS) technology.

POPULATIONS BEING TARGETED:
This activity targets women of reproductive age and their partners, infants and PLWHAs. This activity also targets training of health care providers, TBAs and mothers who will work as peer educators.

EMPHASIS AREAS
This activity has an emphasis on training, supportive supervision, quality assurance/improvement and commodity procurement. Emphasis also is placed on development of networks/linkages/referral systems. In addition, integrating PMTCT with ANC and other family-centered services while ensuring linkages to Mother-Child-Health (MCH) and reproductive health services will ensure gender equity in access to HIV/AIDS services.

In COP10, under 'PEPFAR Nigeria's accelerated PMTCT plan', AIDSRelief, will strengthen its support to PMTCT service delivery by implementing activities that further improve the coverage and quality of PMTCT services. These activities will be directed towards increasing utilization of PMTCT services at existing service outlets through demand creation in collaboration with community resources and ensuring the upgrade of existing supported PHCs offering stand alone HIV counseling and testing to render at least minimal package of PMTCT services. In order to leverage resources, priority will be given to PHCs located in the selected focal states with presence of other donor agencies and in local government areas already earmarked for HSS support through GFATM. Where new sites are envisioned, those that are used for national ANC sero-sentinel surveys but yet to commence PMTCT services as well as PHCs located in communities with high HIV prevalence rates above the National average will be given priority.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HLAB | 3,127,200 | |

| Narrative: | | | |
|---|---|---|---|
| None | | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Treatment | HTXD | 2,066,361 | |
| **Narrative:** | | | |
| None | | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Treatment | HVTB | 450,000 | |
| **Narrative:** | | | |
| None | | | |

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 10101** | **Mechanism Name: HHS/CDC Track 2.0 ECEWS** |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Excellence Community Education Welfare Scheme (ECEWS) | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 1,204,087** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 1,204,087 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

ECEWS will be a continuing partner in COP10 and will implement activities in eight technical areas

including STP,HTC,TB/HIV,Adult BC&S, Peds BC&S,OVC and SI.Activities will provide continued access to services for cliets already recruited in COP09. ECEWS will contribute to the renewed PEPFAR ll of 3-12-12 of treatment ,prevention and Care via activities in Akwa Ibom ,Cross River and Abia states. ECEWS will maintain services to clients recruited in COP 09 in 67 target community sites.The National sentinel survey (2008) puts the National prevence at 4.6% with all our sites having prevalence of Akwa Ibom -9.7%, Cross River-8.0% and Abia- 6%. An estimated 2.95 million PLWH and 2.23 million AIDS orpharns are in need of services in Nigeria. ECEWS will work closely with other IPs in building the capacity of GON in SI and other technical areas to respond adequately.ECEWS will be a continuing partner in the program area of Abstinence/Be Faithful (AB) in COP10. ECEWS will implement its AB programming activities in line with the overall PEPFAR Nigeria goal of providing a comprehensive package of prevention services to individuals reached (thereby improving the effectiveness of this messaging) through a balanced portfolio of prevention activities including condoms and other prevention.The target for this intensive AB messaging campaign is 4,546 individuals. In addition, age appropriate abstinence only messaging and secondary abstinence messaging will be conveyed to 2,000 children and adolescents, particularly focused on in-school youths and orphans and vulnerable children (OVC) receiving home based support.In COP10 ECEWS will continue to provide community outreach to individuals identified as high risk for HIV and direct them to counseling and testing while promoting prevention through activities other than abstinence and be faithful messages. This activity will focus on condom use promotion in most at risk populations and referral to ECEWS supported and/or other local PEPFAR-supported HCT sites. Condoms and other prevention activities will continue in 31 sites (7sites developed under COP07 and 18 sites developed under COP08 and 6 sites in COP09) targeting 9,091 most at risk persons (MARPs) which include GOPD and STI patients, PLWHA, incarcerated populations, youth, police, customs workers, immigration workers and commercial sex workers in Akwa Ibom and Cross River states.

In COP 10 ECEWS will continue and maintain activities in HIV counseling and testing (HCT) and will provide services to 2,500 people who will be counseled, tested, and receive their results. These HCT services will be provided at 10 fixed points of service (POS), including 7 public health care facilities and 3 private health care facilities, and 1 mobile point of service that will target most at risk persons (MARPs) including incarcerated populations, youth, police, customs workers, immigration workers and commercial sex workers, for a total of 11 points of service in the states of Akwa Ibom and Cross River. Staff and volunteers on the mobile team will actively visit communities where MARPs are located through community outreach HCT activities.In COP10 ECEWS will Continue to provide palliative care to 2,500 HIV+ adults/adolescents and 5,000 HIV- PABAs for a total of 7,500 adults reached with care services. This will be provided in 24 sites (10 HCT sites, 4 TBHIV sites and 10 community based sites) in 2 states (Akwa Ibom and Cross River). The care services available to all HIV+ adults includes: prevention with positives services, access to appropriate TB diagnostics and linkage with DOTS programs described under TB/HIV, access to laboratory services (including CD4 count, chemistry, hematology) instruction in

appropriate water purification and provision of water guard, provision of ITNs, linkage to psychosocial support through participation in PLWHA support groups and individual counseling, and access to community home based care services.In COP 2010, ECEWS will continue to provide Pediatric Care and Support to 250 HIV exposed and HIV/AIDS infected children ( 0-14 years) and 500 PABAs for a total of 750 reached with care services. At 4 TB DOTS points of service directly supported by ECEWS, 900 newly presenting TB suspects and patients developing symptoms will be screened for HIV and provided appropriate counseling based on results. It is estimated that approximately 90 of these TB suspects will have TB, and that through HCT 30 will be identified as TB/HIV co-infected. ECEWS' programmatic goals are to ensure adequate and prompt linkage of TB patients and their household contacts to HIV counseling, testing, care and treatment services, to ensure that all HIV patients are screened for TB, and to enable all HIV-infected patients with TB to access services at DOTS and ART clinics. In addition, ECEWS will continue to support TB DOTS sites to provide holistic patient care according to National and IMAI guidelines. States where activities will be conducted include Akwa Ibom and Cross River.
This care service will continue to be provided in 14 facility-based sites in 2 states( Akwa Ibom and Cross River States) aiming at extending and optimizing quality of life for HIV-infected children from the time of diagnosis throughout the continuum of illness, through provision of clinical, psychological, social, spiritual and prevention services. In COP 10 ECEWS will continue its OVC activities by providing preventive care packages to HIV infected children, to families with an HIV infected parent/caregiver, and/or to orphans of HIV/AIDS. ECEWS will provide the full spectrum of OVC services to 2,300 OVC, including HIV+ children, children orphaned by HIV, and caregivers in a minimum of 10 community based sites in Akwa Ibom and Cross River states. In its OVC programming, ECEWS will focus on providing health services, nutrition, psychosocial support, and education to OVCs that it serves. ECEWS will guide OVCs and caregivers to providers of other services such as protection, shelter and care, vocational training, and/or Income Generating Activities (IGA).In COP10 ECEWS will continue activities under the Strategic Information (SI) program area. ECEWS will be supporting the SI activities that will occur across 7 program areas (HCT, TB/HIV, Adult care & support, Pediatric care & support, OVC, AB and COP) for a total of 67 sites in 3 states (Akwa Ibom, Cross River and Abia state ). ECEWS staff and the NGO staff that partner with ECEWS for activities at a variety of these sites will be involved in these site-level SI activities. ECEWS will strengthen Strategic Information (SI) under the "One M&E Framework" by supporting standardized HIV indicator reporting systems at program sites and registering sites in the national M&E system. For facilities where there is other donor support, data collection and indicator reporting will be harmonized and one reporting system will be used in accordance with the national guidelines and indicators. ECEWS will work with USG and GON to include ECEWS-supported facilities in the National Public Health data system launched in 2007 (Voxiva platform) where applicable. ECEWS will be an active participant on the USG SI working group supporting PEPFAR in developing and maintaining a unified national data platform for HIV services in Nigeria.

In line with the renewed PEPFAR II 3-12-12 goal of providing services including prevention, care and treatment services ECEWS will contribute to the overall Nigeria targets. A total of 157 individuals will be trained in ECEWS COP10 activities including 57 HCWs, this will further the overall goal of task shifting and ownership.Strengthening SI will enable timely, transparent, and quality data reporting of 2010 EP targets for Nigeria and through collaboration with the GON will establish one standardized system to monitor National HIV programs. Planned targeted evaluations will guide decisions in improving program implementation and scale-up and will be defined and coordinated with the USG team in-country. Of interest is evaluating barriers and access to care for HIV positives identified and referred through HCT. ECEWS emphasisa will be capacity building and gender in COP10 with priority in maintaining services to persons previously reached with PEPFAR supported services accross her supported sites.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Construction/Renovation | REDACTED |
| Education | 51,776 |
| Food and Nutrition: Commodities | 18,061 |
| Human Resources for Health | 173,629 |
| Water | 121,613 |

## Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Military Population
Mobile Population

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **10101** |
| **Mechanism Name:** | **HHS/CDC Track 2.0 ECEWS** |
| **Prime Partner Name:** | **Excellence Community Education Welfare Scheme (ECEWS)** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Care | HBHC | 200,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HKID | 520,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HVCT | 35,000 | |

**Narrative:**

ACTIVITY DESCRIPTION

In COP 10 ECEWS will continue and maintain activities in HIV counseling and testing (HCT) and will provide services to 2,500 people who will be counseled, tested, and receive their results. These HCT services will be provided at 10 fixed points of service (POS), including 7 public health care facilities and 3 private health care facilities, and 1 mobile point of service that will target most at risk persons (MARPs) including incarcerated populations, youth, police, customs workers, immigration workers and commercial sex workers, for a total of 11 points of service in the states of Akwa Ibom and Cross River. Staff and volunteers on the mobile team will actively visit communities where MARPs are located through community outreach HCT activities.

The national "Heart to Heart" branding logo will be utilized at HCT points of service for easy recognition. Counseling and IEC materials will focus on abstinence, be faithful, and consistent and correct condom use (ABC), providing this messaging in a balanced approach appropriate for each individual client. For clients testing HIV positive, prevention with positives services will be provided, including HCT for family members and sex partners, counseling for discordant couples, counseling on healthy lifestyles and positive living, prevention messages and IEC materials on disclosure. Posttest counseling for those testing negative will focus on prevention using the ABC approach as well, and partner testing will be encouraged when necessary. Based on risk assessment, a follow-up testing interval will be recommended.

Facility based HCT services will ensure that services are available to all high risk individuals within the institution and the catchment area, for example HCT services in a given facility will be available at TB DOTS, inpatient wards and the general outpatient clinics including where STI patients are seen. HCT

staff will round regularly on the wards and, where applicable, with the medical staff will identify inpatients in need of HIV testing. Each of the ECEWS facility POS will be linked to comprehensive treatment hospitals and facilities for referring HIV positive patients for full evaluation including eligibility for ART. Additional strategies such as equipping home based care teams with HCT capacity to implement home based testing and prevention outreach will be evaluated to target high risk discordant couples and family members. ECEWS mobile HCT services will reach substance abuse populations in selected locales. HIV testing will be carried out by counselors using the nationally approved algorithm with results available immediately.

In appropriate settings and in line with GON, testing will be carried out by staff who are not trained laboratory scientists. Where this is the case, ECEWS master trainers will train and work with these staff to ensure that HIV testing provided within the HCT context is of high quality by incorporating HCT sites into the laboratory QA program. Whenever feasible, client witnessed testing will be carried out to encourage client confidence in the result. QA for HIV testing will be carried out regularly and will include retesting of blood samples and routine site assessments. ECEWS will partner with PEPFAR IPs specializing in lab programs to facilitate QA programs to ensure quality of services.

Using established SOPs and a standardized National training curriculum, new counselors will be trained either centrally or at the site level, and refresher courses for existing counselors will be conducted. Counselors will be trained to counsel clients concerning disclosure to spouse and/or sexual partners and to encourage disclosure, while exploring and addressing potential negative consequences. ECEWS will also seek out training opportunities for counselors on couples counseling using a standardized curriculum. ECEWS will train, either itself or through leveraging training programs provided by other PEPFAR IPs, 10 counselors in the provision of HCT. The quality assurance (QA) strategy for counseling will include posttest client surveys and periodic refresher training. Existing site staff will be used as counselors. At high throughput centers, temporary additional staff support may be provided, but sites must agree to include funding for any new position in the next fiscal year site budget.

Condoms, supplied by other donors and provided to all IPs through Society for Family Health will be available at ECEWS-supported centers at no charge or a limited charge. Test kits and disposables for testing will be warehoused by ECEWS, and where feasible in collaboration with the state Ministry of Health. They will be provided to sites based on a pull system using a site level inventory control system linked to the ECEWS warehouse logistics management information system. The current system can be easily harmonized with the national test kit logistics management information system and inventory control system once implemented.

The M&E system will utilize the National HCT registers to maximize time devoted to service provision and

facilitate services at primary health center and community mobile settings. National patient management and monitoring (PMM) forms will also be used. Aggregate site data will be summarized and reported to the national M&E program officer monthly. HCT services will be provided at 11 sites (10 fixed and 1 mobile) in the following 2 states: Akwa Ibom and Cross River.

Contribution to Overall Technical Area
This activity supports the national HCT scale up plan by promoting the accessibility of HCT services using an FMOH approved training curriculum and procedures. HCT services are essential to identify HIV+ people to meet national prevention goals and the national ARV/HIV care scale up goals. HCT services will target most at risk persons to maximize this impact.

Link to Other Activities
This activity is linked to AB (15656.09), Condoms and Other Prevention (5656.09), Care and Support (15657.09), Orphans and Vulnerable Children (15659.09), TB/HIV (15658.09) and SI (15674.09). Prevention for positives counseling will be integrated within posttest counseling for HIV+ persons, thereby providing this care service at HCT POS. Other at risk family members including vulnerable children will be identified through HCT and referred to services such as OVC programming.

Populations Targeted
This activity serves children, youth and adults in the general population who will be offered HIV counseling and testing. However, most at risk persons including commercial sex workers, discordant couples, uniformed service men, out of school youth, mobile populations, and partners/clients of commercial sex workers will be specifically targeted. Other health care workers and community volunteers will be targeted for training.

Legislative Issues
This activity addresses the key legislative issue of "Stigma and Discrimination", since HIV counseling reduces stigma associated with HIV status through education.

Coverage Areas (Focus Countries Only)
Akwa Ibom

Cross River

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | PDCS | 28,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Other | HVSI | 30,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVAB | 60,820 | |

**Narrative:**

ACTIVITY DESCRIPTION

ECEWS will be a continuing partner in the program area of Abstinence/Be Faithful (AB) in COP10. ECEWS will implement its AB programming activities in line with the overall PEPFAR Nigeria goal of providing a comprehensive package of prevention services to individuals reached (thereby improving the effectiveness of this messaging) through a balanced portfolio of prevention activities including condoms and other prevention. Through the involvement of ECEWS in this activity, PEPFAR Nigeria will further its development of an integrated comprehensive prevention portfolio.

ECEWS' goal for its new activities in the AB program is to contribute to a reduction in HIV prevalence among youths, particularly in the most at risk age group of 15-24 year olds, and to promote mutual fidelity among married adults. The 2005 ANC survey in Nigeria indicates that among age cohorts in Nigeria, the 20-29 year old age group has the highest HIV prevalence (4.9% compared to a national prevalence of 4.4%). In addition, the 2005 National HIV/AIDS and Reproductive Health Survey (NARHS) demonstrated a low risk perception (28%) among the general population and significant reports of transactional sex (11%) among young women aged 15-29 years. This age cohort for both men and women represents the working age group in Nigeria; it is expected that a combination of prevention messaging approaches will ensure they are effectively reached with prevention interventions.

This activity will be implemented at the community level and will be reinforced through national level mass media campaigns by other USG partners such as the successful Zip-Up campaign. In COP10, ECEWS will implement AB programming in underserved areas in Nigeria and will couple these activities with condoms and other prevention program services and with counseling and testing program services. The implementation of the AB activities will utilize a combination of multiple strategies, including community awareness campaigns, peer education models, peer education plus activities, and a school-based approach.

AB messages will be balanced with concurrent condoms and other prevention messaging where appropriate and will be integrated with services provided by ECEWS in a total of 20 sites ( 10 school based sites and 10 FBO sites developed in COP08 and 09) in 3 states (Akwa Ibom ,Cross River and Abia states).However AB messaging only will be provided to 10 target community sites including FBOs/CBOs, and A only prioritized only to 10 school based sits in Akwa Ibom ,Cross river and Abia states

The goal of the program is to be focused on the communities targeted and to saturate those communities with messages conveyed in multiple fora. Utilizing such a methodology, a large number of people will be reached with messages received via one strategy or another, but the target group will be those individuals that will have received AB messaging: (1) on a regular basis and (2) via at least three of the four strategies ECEWS will employ (community awareness campaigns, peer education models, peer education plus activities, and school based activities). The police and other uniformed service men, incarcerated persons, and in-school and out-of-school youth will be reached with AB messages. The target for this intensive AB messaging campaign is 4,546 individuals. In addition, age appropriate abstinence only messaging and secondary abstinence messaging will be conveyed to 2,000 children and adolescents, particularly focused on in-school youths and orphans and vulnerable children (OVC) receiving home based support.

In COP 10 a total of 20 counselors, teachers, peer educators, religious leaders will be trained to conduct effective prevention interventions inclusive of AB messaging. Retraining will however be conducted for 80 individuals previously trained under COP 09 and COP 08.

ECEWS will collaborate with community based organizations (CBOs), faith based organizations (FBOs), and PLWHA support groups in the communities in which it will be conducting other PEPFAR programmatic activities. These support groups will also serve as appropriate partners in the dissemination of ABC messaging to other PLWHA utilizing the peer education model. The CBOs and FBOs will serve as appropriate partners in reaching wider audiences through the peer education plus model and community awareness campaigns conducted under the supervision of ECEWS and will include activities such as drama presentations, musical events, and road shows/rallies.

ECEWS also has experience in conducting school based approaches to HIV education and under this program will serve 10 schools in its communities. School based programs will include interactive learning activities that focus on acquisition of skills-based HIV education.

CONTRIBUTIONS TO OVERALL TECHNICAL AREA:

The funding in this activity area will contribute to the overall PEPFAR goals of preventing further infections and reducing HIV rates in Nigeria. It will also help to lay the foundation for more sustainable programs.

LINKS TO OTHER ACTIVITIES:
This activity will be integrated with Counseling and Testing (#15660.09), Basic Care and Support (#15657.09), Other Prevention (#5656.09), and TB/HIV (#15658.09).

POPULATIONS BEING TARGETED:
The focus population for this activity will be youth, young adults and particularly, young women and girls, and in school youths. It will also target community/religious leaders and parents.

COVERAGE AREAS:
Akwa Ibom, Cross River and Abia States

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVOP | 260,267 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HVTB | 70,000 | |

**Narrative:**

ACTIVITY DESCRIPTION

In COP010 ECEWS will continue TB/HIV services, maintaining its HCT services to DOTS sites in line with the National TB and Leprosy Control Program (NTBLCP) to focus on strengthening the integration of high quality TB and HIV care delivery. At 4 TB DOTS points of service directly supported by ECEWS, 900 newly presenting TB suspects and patients developing symptoms will be screened for HIV and provided appropriate counseling based on results. It is estimated that approximately 90 of these TB suspects will have TB, and that through HCT 30 will be identified as TB/HIV co-infected. ECEWS' programmatic goals are to ensure adequate and prompt linkage of TB patients and their household contacts to HIV counseling, testing, care and treatment services, to ensure that all HIV patients are screened for TB, and to enable all HIV-infected patients with TB to access services at DOTS and ART clinics. In addition, ECEWS will continue to support TB DOTS sites to provide holistic patient care according to National and IMAI guidelines. States where activities will be conducted include Akwa Ibom and Cross River.

DOTS site personnel will be trained in HIV diagnosis using HIV rapid test kits and educated in referring HIV+ individuals to comprehensive care for assessment including for antiretroviral treatment eligibility. Provider-initiated HIV counseling and opt-out testing will be employed with TB patients and suspects, respectively.

Nosocomial transmission of TB will be mitigated through attention to principles of TB infection control, including administrative and environmental control measures such as clinic design, good ventilation, appropriate patient triage, staff training, and enforcement of basic hygiene and proper sputum disposal. Patient and staff education on infection control measures will be routinely carried out to ensure program success. The national guidelines on infection control will be implemented in all ECEWS supported sites. ECEWS will bear in mind these principles for any facilities upgrades that may be needed such as basic renovations. ECEWS will also provide support to the sites through procuring supplies and consumables (e.g. sputum containers) where deficiencies are noted.

ECEWS will continue to partner with PEPFAR IPs specializing in lab programs to facilitate QA programs to ensure quality of services. ECEWS master trainers will train and work with TB DOTS staff to ensure that HIV testing provided within the TB DOTS context is of high quality by incorporating TB DOTS sites into the laboratory QA program. An ongoing TB diagnostics QA program will be conducted including: joint site visits with the FMOH or relevant state MOH for observation/retraining, selective review of completed smear examinations, training on X-ray diagnosis / TB treatment and proficiency testing with "unknown" slides provided by the QA team. Refresher/retraining of clinical staff on x-ray diagnostics where appropriate will also be done. Regarding quality of TB treatment being provided, ECEWS will work in close collaboration with the German Leprosy and TB Relief Association (GLRA) to ensure that TB DOTS staff are following the National TB treatment algorithm. ECEWS will support training for 4 staff in COP10, including refresher training, for a total of 12 staff (4 staff in COP 08, 4 staff in COP 09 and 4 staff in COP 10)in TB treatment.

The ECEWS M&E staff will work with sites to ensure that incident TB cases are properly reported to the SMOH and FMOH. ECEWS will network with Global Fund in implementing these plans to avoid duplication of services to be developed under Global Fund. TB/HIV co-infected patients will be referred for appropriate clinical management of their HIV and other opportunistic infections within the network of care and treatment. Cotrimaxozole Preventive Therapy (CPT) will be provided to eligible TB/HIV patients as a component of the ECEWS basic care and support program. HCT in DOTS sites will be established at the secondary and primary health center levels with linkages to tertiary centers to provide accessibility of services to patients.

CONTRIBUTIONS TO OVERALL TECHNICAL AREA
Training and support to improve the quality and integration of TB/HIV services are consistent with FMOH and EP priorities. Goals are co-location of HCT services in the TB DOTS setting, an increased number of TB suspect patients screened for HIV, appropriate referral for care and support of HIV+ clients, and improvement of overall TB services (i.e., diagnostics and treatments) at supported sites. An overarching focus on technical capacity development will ensure sustainability. Smear microscopy QA will be carried out collaboratively with the FMOH or the relevant State MOH to promote sustainability through capacity development and integration into the health sector system.

LINKS TO OTHER ACTIVITIES
This activity is also linked to Counseling and Testing (15660.09), Basic Care and Support (15657.09), OVC (15659.09), Abstinence and Be Faithful (15656.09), and Condoms & Other Prevention (5656.09). Linkage to TB diagnosis and treatment is an important component of adult Care and Support and OVC services.

POPULATIONS BEING TARGETED
TB suspects and patients, PLWHA, and their families and household members who may be at greater risk for TB.

Coverage Areas (Focus Countries Only)

• Akwa Ibom

• Cross River

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 10103** | **Mechanism Name: Lab QA** |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: The Axios Foundation, Inc. | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |

| | |
|---|---|
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 500,000** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 500,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

Over the last six years PEPFAR Implementing Partners have refurbished and equipped more than 375 laboratories throughout Nigeria for the diagnosis and treatment of HIV/AIDs patients. The volume of laboratory testing and diversity of laboratory settings results in a need for a mechanism for the management and evaluation of the consistency of the results produced by these laboratories. Additionally, a process for identifying and developing remediation plans for under-performing facilities is required to facilitate the effective strengthening of the laboratory facilities. Such sustainable laboratory systems strengthening is imperative to maintain and improve the laboratory expertise that has been built over the years in the country through implementation of quality control and quality assurance support functions.

Accordingly, the Axios Foundation, in cooperation with the CDC, PEPFAR Implementing Partners and the Government of Nigeria is developing an External Quality Assessment (EQA) process for PEPFAR laboratories to address these needs. The objectives of the EQA process are to:

• Assess quality of laboratory performance among all PEPFAR laboratories
• Provide assurance to consumers (physicians as well as patients) that results are reliable
• Identify possible deficiencies in laboratory practices and guiding participants in corrective action towards improvement
• Build and strengthen the capability of the national Medical Laboratory Science Council (MLSC) to provide quality assurance and over sight for laboratory services in the country
in a sustainable manner
• Encourage good laboratory practice
• Collect information on the reliability characteristics of particular methods, materials and equipment and taking corrective actions as appropriate
• Encourage implementation of quality assurance and control measures within laboratories
• Collect information on performance of measurement principles in order to guide professionals and/or Government bodies towards achieving harmonization

• Identify laboratories of excellent performance for their involvement in training and education
• Stimulate information exchange and networking among PEPFAR laboratories
• Provide updated information on new developments in HIV diagnostics.

The focus of the project is creation of a national laboratory quality assurance process that is sustainable and scalable so that the EQA objectives can
be applied to all PEPFAR laboratories.
Over the last six years PEPFAR Implementing Partners have refurbished and equipped more than 375 laboratories throughout Nigeria for the diagnosis and treatment of
HIV/AIDs patients. The volume of laboratory testing and diversity of laboratory settings results in a need for a mechanism for the management and evaluation of the
consistency of the results produced by these laboratories. Additionally, a process for identifying and developing remediation plans for under-performing facilities is
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in a sustainable manner
• Encourage good laboratory practice
• Collect information on the reliability characteristics of particular methods, materials and equipment and taking corrective actions as appropriate
• Encourage implementation of quality assurance and control measures within laboratories
• Collect information on performance of measurement principles in order to guide professionals and/or Government bodies towards achieving harmonization
• Identify laboratories of excellent performance for their involvement in training and education
• Stimulate information exchange and networking among PEPFAR laboratories

• Provide updated information on new developments in HIV diagnostics.

The focus of the project is creation of a national laboratory quality assurance process that is sustainable and scalable so that the EQA objectives can be applied to all PEPFAR laboratories.

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## Key Issues

(No data provided.)

## Budget Code Information

| | | | |
|---|---|---|---|
| **Mechanism ID:** | **10103** | | |
| **Mechanism Name:** | **Lab QA** | | |
| **Prime Partner Name:** | **The Axios Foundation, Inc.** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Treatment | HLAB | 500,000 | |

**Narrative:**

This narrative describes Axios Foundation's continuing activities in Health Systems Strengthening through the development of an External Quality Assessment (EQA) scheme for PEPFAR laboratories in Nigeria for COP10.

REDACTED, Axios Foundation will continue the necessary system strengthening and human capacity development activities to have the site begin operations in COP10 in order to harmonize the PEPFAR supported laboratories within Nigeria and take the first steps toward the ultimate goal of WHO AFRO accreditation for the center.

Axios will build on and strengthen partnerships with WHO, Medical Laboratory Science Council (MLSC) and NBTS with an emphasis of inexpensive partnerships to guarantee the sustainability of EQA activities in country. As part of the focus on system strengthening in COP10, Axios will establish a partnership for

mentoring and coaching to be provided by key technical staff within the EQA supply partners of NHLS/NICD in South Africa to Zaria staff and its in-country partners.

This relationship will include a tailored training session by a team of experts from NHLS and will include not only the staff at
Zaria, but selected key individuals from the Medical Laboratory Science Council of Nigeria (MLSCN) and the Center for
Disease Control as well. This training session will either take place in Zaria or South Africa

In COP10, the educational component of the EQA scheme will be refined; high and low performing laboratories will be
identified and mentoring relationships with appropriate training sessions and field visits from Zaria staff to supporting
laboratories will take place.

Building on the initial partnerships established in COP09, Axios will arrange with panel supply partners for the shipments of
HIV serology and CD4 panels for a selected group of USG/PEPFAR laboratories who will form the initial pilot group of the
scheme with a planned phased approach to include all USG/PEPFAR labs by the end of COP10.

Following the initial rounds of panel testing and results submission in COP10, Axios will conduct a brief assessment in to
track improvements in the quality of testing among participating laboratories. Significant challenges will be identified and
the means to address these challenges will be explored in collaboration with the PEPFAR partners. As part of an internal
quality assurance (QA) process, Axios will also assess the feedback loop between the IPs and Zaria EQA center as well
as a feedback loop between the participating laboratories and the IPs. This analysis will be used to identify strengths,
weaknesses, opportunities and threats to the operation of the EQA scheme. Lessons learned and challenges overcome
will be documented and shared through regular written communication such as newsletters with all USG/PEPFAR IPs as
well as all members of the USG partners.

| |
|---|
| As part of the focus on Health Systems Strengthening in COP10, Axios will identify new partnerships and links to source<br>hematology & chemistry EQA panels for Zaria EQA center, followed by an evaluation of the potential to introduce real time<br>polymerase chain reaction (PCR) techniques such as Viral Load Testing and HIV pediatrics (DBS) EQA schemes. To<br>enable such services, a suitable structure within the compound of the National Tuberculosis and Leprosy Centre in Zaria,<br>Kaduna State will need to be identified. REDACTED.<br>of the Zaria staff in PCR technology.<br><br>When the Zaria EQA center is operating, it will systematically gather all relevant operational data to provide an evidence<br>base for replicating and expanding the Zaria model into another region in Nigeria. |

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 10104** | **Mechanism Name: HHS/CDC Track 2.0 ASCP** |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: American Society of Clinical Pathology | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 400,000** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 400,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## Key Issues

(No data provided.)

## Budget Code Information

| | | | |
|---|---|---|---|
| **Mechanism ID:** | **10104** | | |
| **Mechanism Name:** | **HHS/CDC Track 2.0 ASCP** | | |
| **Prime Partner Name:** | **American Society of Clinical Pathology** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Treatment | HLAB | 400,000 | |
| **Narrative:** | | | |
| None | | | |

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| | |
|---|---|
| **Mechanism ID: 10105** | **Mechanism Name: HHS/CDC Track 2.0 CLSI** |
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Clinical and Laboratory Standards Institute | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| |
|---|
| **Total Funding: 350,000** |

| Funding Source | Funding Amount |
|---|---|
| GHCS (State) | 350,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

The Clinical and Laboratory Standards Institute (CLSI) began supporting the Ministry of Health - Nigeria, CDC Nigeria and the Medical Laboratory Science Council of Nigeria (MLSCN) in the implementation of Quality Management Systems (QMS) and Accreditation Preparedness during COP 08, continuing in COP 09.

Goal: To expand and strengthen the National Laboratory Quality System, including a comprehensive, standardized document system; expanded participation in Quality Assurance programs; an effective auditing and monitoring program; and working toward building the capacity of the regulatory body to understand and articulate quality management systems and mentor them through the process of implementing a national accreditation scheme for all of the laboratory tiers.

Objectives:

A. Implement Quality Management Systems (QMS) and internationally recognized laboratory standards in national and regional laboratories.

B. Progressively raise laboratory assessment scores through the WHO-AFRO accreditation scheme and/or acheive accreditation by alternative international standards
accreditation.

C. Work with the MLSCN to continue development of the laboratory operational and quality management personnel to ensure:

* Sustainability of QMS and the achieved laboratory accreditation status.
* Continued expansion of QMS and accreditation for all tiers.

CLSI's standards-driven approach, together with the implementation of QMS, bridges the gap between pre-service training and in-field application. This foundation prepares laboratory personnel to successfully implement and sustain the technical assistance of lab coalition partners across all lab disciplines.

The geographic coverage is national and is acheived by developing Master Trainers to cascade expertise through all laboratory tiers. This improves the quality of national and regional laboratories and increases capacity to augment service quality at all laboratory levels.

CLSI's program strategy targets the training of Master Trainers and the development of Laboratory Operations and Quality Management staff on the application of QMS. Effective implementation of QMS is critical to continued accreditation preparedness and improved quality of service. Building capacity of local laboratory personnel ensures the continuation of accreditation activities allowing a timely exit of the technical assisstance providers. Funding levels directly determine the number of training sessions and mentorships CLSI can conduct. A more intensive program, expanding the number of laboratory interventions, increases the rate of accreditation success.

Collaboration between Lab Coalition partners and MLSCN on training and mentorships is a cost effective way to help ensure the broadest application of technical assistance to rapidly acheive program goals.

Monitoring and evaluation is accomplished through laboratory assessments.

* Development of lab quality indicators and the use of internal focused audits to monitor effectiveness of CQI initiatives.
* Scheduled external assessments to measure progress towards accreditation based on criteria of selected accreditation agencies (e.g. WHO-AFRO, CAP, JCI, SANAS).

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 350,000 |

## Key Issues

(No data provided.)

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **10105** |
| **Mechanism Name:** | **HHS/CDC Track 2.0 CLSI** |
| **Prime Partner Name:** | **Clinical and Laboratory Standards Institute** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HLAB | 350,000 | |

**Narrative:**

| |
|---|
| CLSI will work closely with CDC Nigeria, MOH Nigeria and the MLSCN to provide technical experts to conduct activities that are described in the overview narrative for lab strengthening, including:<br><br>*QMS workshop activities (e.g. QA, internal and external audit, CQI).<br>*Mentorship activities with laboratories and MLSCN.<br>*Gap analysis and accreditation preparedness activities geared toward WHO-AFRO teired accreditation.<br><br>The suggested budget for the full scope of work is estimated for four participating laboratories which will be degignated by CDC Nigeria, MOH Nigeria and the MLSCN. This funding level assumes CLSI administrative costs, indirect cost, and travel-related costs for CLSI staff and volunteer consultants. In-country meeting expenses are not included. CLSI staff works to coordinate program travel within Africa, ensuring judicious use of program funds. |

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 10107** | **Mechanism Name: HHS/HRSA Track 2.0 AIHA** |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Health Resources and Services Administration | Procurement Type: Cooperative Agreement |
| Prime Partner Name: American International Health Alliance | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 400,000** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 400,000 |

## Sub Partner Name(s)

| | | |
|---|---|---|
| Federal School of Social Work | Hunter College School of Social Work | University of Nigeria, Nsukka |

## Overview Narrative

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 400,000 |

## Key Issues

(No data provided.)

## Budget Code Information

| **Mechanism ID:** | **10107** | | |
|---|---|---|---|
| **Mechanism Name:** | **HHS/HRSA Track 2.0 AIHA** | | |
| **Prime Partner Name:** | **American International Health Alliance** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Care | HKID | 400,000 | |
| **Narrative:** | | | |
| None | | | |

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 10110** | **Mechanism Name: HHS/CDC Track 2.0 Pop Council** |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Population Council | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| Total Funding: 712,591 | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 712,591 |

## Sub Partner Name(s)

| | | |
|---|---|---|
| African Health Project | Association for Reproductive and Family Health | Centre for the Rights to Health (CRH) |
| Education As A Vaccine Against AIDS (EVA) | International Centre for Advocacy on Rights to Health, Nigeria (ICARH) (Formerly Alliance Rights Nigeria) | Male Attitude Network (MAN) |
| Mario Stopes International (MSI) | One World, UK | The Independent Project for Equal Rights (TIP) |

## Overview Narrative

Nigeria has a population of approximately 140 million people with a current adult HIV prevalence of 4.4% in 2008 and about 3 million individuals living with HIV in Nigeria. The HIV epidemic in Nigeria has been recently described as "generalised", spreading from the high risk to the general population. The most-at-risks-populations (MARPS) continue to serve as "reservoirs" and bridging populations of the HIV infection, thereby fuelling the epidemic in Nigeria. This group includes female sex workers (FSW), men that have sex with men (MSM), injection drug users (IDU), long distance truckers, uniformed professionals, etc.

The 2007 IBBSS shows varied overall HIV prevalence among MARPS with MSM having the second highest prevalence of 13.5% (25% in Lagos) compared to 25% among FSW. MSMs are particularly a high risk population in Nigeria. The MSM community is socially stigmatized, and receives scanty services to promote healthy sexual behavior and HIV/STI prevention. In Nigeria, nearly all informational education messages focus on heterosexual transmission of STI/HIV, and MSM are not sensitized to their own risk for contracting an STI. In addition, health professionals are largely unaware of their special needs. It is therefore paramount to include MSM in programs to prevent HIV/AIDS, since they are at high risk for HIV/STIs but are historically ignored by prevention campaigns and limited in their access to sexual health services. Other predorminantly male occupations eg transport workers, uniformed professional, male clients of female sex workers, etc were also highlighted by the IBBSS 2007 as having HIV prevalence above the National figures. Same  sex practices are also reportedly prevalent in about 10% of these groups of men.

The Population Council, through this project, seeks to avert new HIV and sexually transmitted infections (STIs) among these men engaged in multiple, concurrent or serial sexual relationships, and those who engage in high-risk sexual practices such as unprotected vaginal and/or anal sex with their male and female partners. We will accomplish this by utilizing a social franchise model to make quality medical care accessible to all men in a hassle-free manner by engaging both public and private sector service providers. This strategy will improve knowledge of risky practices among these men, reduce high-risk sexual practices, reduce barriers to HIV/STI detection and treatment, modify care-seeking behaviors, and promote individual and group assistance through supportive social networks. At its core, this strategy will identify clinicians in private practice in key Nigerian cities and towns and engage them through trainings and continuing medical education (CME) efforts to provide non-discriminatory and appropriate sexual health care for men-at-risk including HIV testing & counseling (HTC), sexually transmitted infection testing and syndromic management (STI-SM), pre-packaged therapy (PPT) for STI, condom/lubricant distribution and referrals to existing services appropriate for the individual's needs. We will also use an online training approach as a CME strategy to train participating clinicians and laboratory staff on good laboratory practice (GLP) and quality diagnosis and treatment of opportunity infections (OIs).

The project focusing on high risk men and MSM, incorporated into a larger sustainability strategy, the Men's Health Network Nigeria (MHNN), will provide a comprehensive package of information, education and communication activities to bring about behavior change, change community norms, improve access to and quality of HTC and STI services, and reduce vulnerability and risk among men engaged in high-risk practices. In addition, it will provide appropriate referrals to MHNN physicians who will in turn provide comprehensive sexual-health clinical services. The project will support social networks of high-risk male subgroups including men who have sex with men (MSM), injection drug users (IDU), transport workers and uniformed military men as same sex and high risk sexual practices occur in a significant proportion among these target groups. This strategy will allow direct intervention to men known to be at high risk and will take advantage of existing structures to improve access to health services and ultimately HIV/STI related prevention and treatment services. As a result, we anticipate that risky sexual behavior will decrease and the opportunity for men to adopt appropriate sexual health behaviours, particularly HIV prevention strategies will increase. Men who test positive or present as HIV positive and who need HIV care and support will be referred to services through existing HIV care and treatment providers.

As MHNN expands, incorporating other high risk groups engaged in same sex relationships such as institutionalized settings, we will target military families and communities around army barracks. Messages such as partner reduction and Men as Partner's will focus on the adult male population. Other messages will include importance of VCT, safer sex interventions and approaches aimed at the entire family. Gender specific out of school Safe Space Youth Groups (SSYGs), and event-based activities will

be developed for adolescents, with a focus on delaying sexual debut for younger children and age-appropriate sexual and reproductive health messaging for older adolescents (including marriage delay messages).

The MHNN project had been rolled out in three (3) cities; Abuja (FCT), Lagos and Ibadan (Oyo) (including the transport corridor along Lagos-Ibadan express way) starting from COP08 and will expand to three more cities: Calabar, Kano and Kaduna and further to meet needs of high risk men in high prevalence areas in COP10. This project targets most-at-risk population of men including men who have sex with men (MSM), injection drug users (IDU), transport workers and uniformed military men.

The MHNN social franchising approach will employ KOLs to interact and engage groups whose members are known to engage in high-risk sexual activity, i.e., MSM and transit workers. In addition to engaging these men for the purposes of providing HIV prevention messages, we will also provide referrals to medical clinics for HIV testing, TB screening and STI syndromic diagnosis and treatment. These clinics will be pre-screened to ensure that providers are comfortable treating and interacting with men with high risk behaviors, particularly MSM, and that they are comfortable discussing appropriate risk-reduction measures with these men. The MHNN recognizes that male health seeking practices among sexually active men are limited to only a few complaints, with sexual dysfunction and STIs being the most prominent. By using principally private sector providers as the entry point, MHNN will allow high risk men to bypass the public sector, in which non-discriminatory care can be elusive.

Procurement of medical commodities will, as much as possible, be sourced through the PEPFAR Nigeria procurement mechanisms as a cost saving effort. We also envisage that lessons learnt within the inception phases of the MHNN project will guide expansion to other cities in COP10. As a result, duplication of costs will be minimized especially by seeking to organize joint trainings with other PEPFAR implementing partners. The project will also seek to leverage resources from the Government of Nigeria through NACA and NASCP especially in areas of technical persons for trainings, provisions of condoms and HIV test kits were necessary.

In order to measure the progress and attainment of the program, the intervention established baseline values with extracts from the IBBSS 2007 and initial interactions with the target communities. The progress of the project will be monitored on an on-going basis with routine service data tools and evaluated in COP10 (third year of the project) with structured and tested tools to measure outcome and impact against baseline. This results of this evaluation will help to strenghthen program strategies and make necessary adjustments.

Long term sustainability of the project will be ensured through the development of a multi-donor social franchising model, the "Men's Health Network Nigeria" which will spin off as an institution of its own.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Gender: Reducing Violence and Coercion | 14,252 |
| Human Resources for Health | 35,630 |

## Key Issues

Addressing male norms and behaviors

Increasing gender equity in HIV/AIDS activities and services

## Budget Code Information

| **Mechanism ID:** | **10110** | | |
|---|---|---|---|
| **Mechanism Name:** | **HHS/CDC Track 2.0 Pop Council** | | |
| **Prime Partner Name:** | **Population Council** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Care | HVCT | 35,000 | |

**Narrative:**

This activity is on-going in 3 sites – Abuja (FCT), Lagos and Ibadan (Oyo) (including the transport corridor along Lagos-Ibadan express way) and will be extended to 3 more sites (Calabar,Kano and Kaduna) during COP10 project activity year. It is designed an an HIV prevention activity consisting of several inter-related components: 1) To promote abstinence and fidelity for male adolescents with abstinence messages, and target men with "be faithful" messages, as part of a comprehensive male involvement curriculum addressing homophobia and violence. 2) To increase demand for and availability of condoms/lubricants and other prevention activities including STI management to high-risk men and their male and female partners; 3) To provide clinic and community-based HIV testing and counseling (HTC) to men in a culturally and gender-sensitive manner; 4) To support a network of key opinion leaders and peer educators to reach their peers and refer them to service providers.

The HCT component of this intervention will include: provide clinic and community-based HTC to high

risk men, including MSM, Transport Workers, Injection Drug Users and Uniformed Professionals in culturally and gender-sensitive manner: 18 clinics will provide confidential HTC to clients; 3,500 clients will have be tested for HIV using nationally approved HIV rapid testing algorithms and received their results; and 24 counselors will be trained in local languages in confidential counseling and testing using the National HTC training curriculum. In addition, the project will provide technical assistance to support 2 networks of advocates around MSM service delivery for strategic information activities, as well as 8 individuals receiving training in strategic information (covered through other funding sources). This includes training in monitoring and evaluation, surveillance, and/or health-management information systems. QA/QC will be performed among public and private laboratories affiliated with the project, though no direct laboratory funding is provided under this grant.

Population council intends to pilot a Computer-Assisted Self Interviewing (CASI) method to aid efficient delivery of HTC services from other funding sources. The HTC component to this program provides a vital linkage to onward referral services for HVOP program areas, specifically for men engaged in high risk practices, and serves as an essential gateway for linked/clustered services under the Global Fund strategy of clustered providers for STI treatment, ART, and care and support. Access to quality condoms and lubricants as well as STI syndromic management and other health services will improve through the establishment of men-friendly network of healthcare providers. In COP10, three public/private sector clinics will be selected and shaped into men-friendly clinics.

Policy-level interventions are not specified in this activity; however significant engagement with Government of Nigeria (NACA, NASCP) is on-going and will be intensified in COP10 essential steps to gradually move forward with a public health focused rights-based agendas to support protection of services to high risk and hghly stigmatized groups such as MSM and IDUs.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVAB | 324,372 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVOP | 353,219 | |

**Narrative:**

None

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 10111** | **Mechanism Name: HHS/CDC Track 2.0 Vanderbilt** |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Vanderbilt University | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 2,029,310** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 2,029,310 |

## Sub Partner Name(s)

| | | |
|---|---|---|
| Basic Health Clinic – Olufadi | Gawu Babangida Rural Hospital | Ibrahim Badamasi Babangida Hospital |
| IHVN | Kaffin Koro Primary Care Center | Kaffin Koro Rural Hospital |
| Kuta Rural Hospital | Lafiagi General Hospital | Meharry |
| Okelele Primary Health Center | Pategi General Hospital | Sobi Specialist Hospital |
| Westat | | |

## Overview Narrative

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Construction/Renovation | REDACTED |
| Food and Nutrition: Commodities | 78,772 |
| Food and Nutrition: Policy, Tools, and Service Delivery | 39,386 |

| | |
|---|---|
| Human Resources for Health | 196,931 |

## Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
Mobile Population
Safe Motherhood
TB
Family Planning

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **10111** |
| **Mechanism Name:** | **HHS/CDC Track 2.0 Vanderbilt** |
| **Prime Partner Name:** | **Vanderbilt University** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HBHC | 187,250 | |
| **Narrative:** | | | |
| None | | | |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HKID | 75,000 | |
| **Narrative:** | | | |
| None | | | |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HTXS | 531,900 | |
| **Narrative:** | | | |

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HVCT | 25,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | PDCS | 28,500 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | PDTX | 35,750 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Other | HVSI | 60,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | MTCT | 228,418 | |

**Narrative:**

ACTIVITY UNCHANGED FROM FY2009

ACTIVITY NARRATIVE
In COP09 Vanderbilt University (VU) counseled, tested, and provided HIV test results to 6000 pregnant women in 8 sites in Kwara and Niger states. In COP10, VU will build on the successes achieved in COP09 by supporting the government of Nigeria in providing prevention of mother-to-child transmission (PMTCT) of HIV services to a total of 11,280 pregnant women in a total of 8 sites and will provide antiretroviral prophylaxis to 338 HIV-infected pregnant women. To achieve this goal we anticipate training and/or re-training 10 health care workers (HCWs) to provide PMTCT using the National PMTCT

Training Curriculum.

In COP10, PMTCT services will continue to be offered at 8 sites in line with the National PMTCT Guidelines. Group health information will be provided to ANC clients during the morning health talk and opt-out HIV testing will be offered to all attendees according to the current Nigerian HIV-testing algorithm. Same day HIV test results will be provided to clients during individual post-test counseling. While we have experienced low levels of partner testing thus far, we will continue to encourage and promote partner testing through the use of "love letters" and personalized invitations for partners.

Women who test positive for HIV will be sent for onsite CD4 testing (where available) or referred to a PEPFAR sponsored comprehensive centers for CD4 testing. Those eligible for treatment will be offered HAART and those eligible for prophylaxis will be provided with ARV prophylaxis consistent with the recommendations of the National PMTCT Guidelines. Replacement doses of anti retro virals will be available in the labor wards of project-supported facilities for women who for any reason have not ingested their medications prior to admission and have not brought them to the labor ward.

Despite availability of HIV testing in ANC, some women will present to the labor ward unaware of their HIV status. In order to provide testing services to these women, VU will continue to support labor ward-based, point-of-care, opt-out HIV testing in all PMTCT sites. Women who test positive will be provided with antiretroviral prophylaxis along with their HIV-exposed infants. Women who present postpartum will be offered HIV testing in the postpartum ward. If the woman tests positive, her infant will receive the standard postpartum infant regimen. All HIV-infected women who are not already receiving comprehensive HIV care will be referred to a comprehensive HIV care and treatment center.

VU will support the training of 10 health care workers on PMTCT using the National PMTCT Training Curriculum in COP10. We anticipate training staff at one new satellite site in COP10 as well as training new staff at our existing sites. In addition, VU will continue to update the skills of previously trained site staff through onsite training and refresher courses.

In COP10, maternal and infant nutrition will remain a priority. PMTCT staff at VU supported sites will continue to provide infant feeding counseling to HIV-infected women according to the National Infant Feeding Training Guidelines. This training arms site staff with the knowledge needed to appropriately counsel HIV-infected women on infant feeding choices and to provide women with unbiased information on infant feeding following AFASS criteria which helps to ensure that replacement feeding is acceptable, feasible, affordable, sustainable, and safe. Four staff members at the new PMTCT site will also participate in this training. VU will continue to conduct nutritional counseling and assessments and provide iron and folic acid to HIV-infected pregnant women. A priority in COP10 will be to further support

maternal nutrition through the provision of food supplements for pregnant women. We are currently looking for food support programs in our catchment areas from which we can leverage support.

VU supported community outreach activities will continue to raise awareness of the PMTCT program, encourage pregnant women to receive HIV testing, and encourage the spouses and other family members of pregnant women to be tested for HIV. We will partner with other groups participating in the national network of care and treatment, government institutions and community-based NGOs in the project area in order to ensure that mechanisms are in place to effectively respond to the treatment needs of HIV positive pregnant women attending our ANCs. We will continue to support and expand community outreach programs aimed at increasing community and patient education about PMTCT, encouraging clients to adhere to medication through understanding of treatment and the importance of follow up visits. Using site based home-based care workers, VU will encourage routine follow up of pregnant HIV-infected clients both before and after delivery. We will strengthen the capacity of community institutions to provide quality health-related wrap-around services including family planning, safe motherhood, nutritional support and other services as appropriate.

In COP10, under 'PEPFAR Nigeria's accelerated PMTCT plan', VU, will strengthen its support to PMTCT service delivery by implementing activities that further improve the coverage and quality of PMTCT services. These activities will be directed towards increasing utilization of PMTCT services at existing service outlets through demand creation in collaboration with community resources and ensuring the upgrade of existing supported PHCs offering stand alone HIV counseling and testing to render at least minimal package of PMTCT services. In order to leverage resources, priority will be given to PHCs located in the selected focal states with presence of other donor agencies and in local government areas already earmarked for HSS support through GFATM. Where new sites are envisioned, those that are used for national ANC sero-sentinel surveys but yet to commence PMTCT services as well as PHCs located in communities with high HIV prevalence rates above the National average will be given priority.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HLAB | 470,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HTXD | 184,992 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HVTB | 202,500 | |
| **Narrative:** | | | |
| None | | | |

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 10113** | **Mechanism Name: HHS/CDC Track 2.0 Johns Hopkins** |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Johns Hopkins University | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 295,523** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 295,523 |

## Sub Partner Name(s)

| | | |
|---|---|---|
| COHEDEP | Federation of Muslim Women Association in Nigeria, Kebbi | Save the Children US |

## Overview Narrative

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 34,279 |

## Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

## Budget Code Information

| | | | |
|---|---|---|---|
| **Mechanism ID:** | **10113** | | |
| **Mechanism Name:** | **HHS/CDC Track 2.0 Johns Hopkins** | | |
| **Prime Partner Name:** | **Johns Hopkins University** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Care | HVCT | 25,000 | |
| **Narrative:** | | | |
| None | | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Prevention | MTCT | 270,523 | |
| **Narrative:** | | | |

BUDGET CODE 1 Narrative: PMTCT (MTCT)

ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS:
As a result of significantly reduced funding (less than 30% of award level), the project's planned expansion to Akwa Ibom State will be shelved in COP10. As an alternative, ZAIHAP will consolidate its activities in the existing HVCT sites in Zamfara State and activate 2 additional HCT sites.

Activity Description
This activity is linked to HCT (HVCT).
The Zamfara Akwa Ibom HIV/AIDS Project (ZAIHAP) will use evidence-based technical and

programmatic approaches to improve access to quality PMTCT services in Zamfara State. In the first years of the project (COP08), 3 health facilities in Zamfara State were supported to provide PMTCT services. In COP09 and another 2 PMTCT sites will be supported to make a total of 5 ZAIHAP PMTCT sites. Given the significant reduction in program budget from its award level, the planned expansion of the ZAIHAP project to Akwa Ibom State in COP10 will again be further delayed. Rather, ZAIHAP will consolidate its foothold in Zamfara State in COP10.

The overall goal of the proposed project is to establish sustainable approaches for the reduction of morbidity and mortality due to HIV/AIDS among vulnerable populations. By using platforms of integrated health services and community outreach to scale-up PMTCT and HCT programs, ZAIHAP will strengthen the capacity and expansion of primary prevention of HIV infection.

ZAIHAP will continue to work with the State Ministry of Health (SMOH) and State Agency for Control of AIDS (SACA) to increase access to and use of high quality PMTCT services at facility and community levels in Zamfara States. Using a network approach with basic PMTCT secondary health care centers linked to primary health care centers, ZAIHAP will provide a hub and spoke model of PMTCT services across all supported sites.

Group health information will be provided to all antenatal clients. HIV testing and counseling using the opt-out approach will be provided to all pregnant women at the time of antenatal booking. All points of service will provide same-day results. An estimated 7385 pregnant women accessing ANC services in ZAIHAP supported health facilities will have known HIV status following the addition of 2 PMTCT sites in Zamfara States. Partner testing will be offered as part of counseling at the PMTCT site. Women who are HIV-negative will be counseled on how to remain negative, safer sexual practices, safe delivery and safe motherhood. Healthcare providers from these sites will participate in the national couple counseling training.

An estimated 294 known positive pregnant women will be provided with a complete course of ARV prophylaxis in Zamfara State. Pregnant women who are found to be infected with HIV will also receive other services at PMTCT sites including medical evaluation, laboratory analysis including CD4 count (onsite or within HIV Care and Treatment Network in the states through specimen transportation), and treatment of opportunistic infections (OIs). For women not requiring HAART, the National PMTCT Guideline consisting of ZDV from 28 weeks or ZDV/3TC from 34 weeks will be prescribed. They will also be placed on intrapartum NVP and a 7-day ZDV/3TC postpartum tail. Infant prophylaxis will consist of single dose NVP at birth and ZDV for 6 weeks. Cotrimoxazole prophylaxis will be given to exposed infants at birth till HIV infection can be excluded.

All HIV positive women will be counseled on appropriate Infant Feeding options. This counseling will be done using the National PMTCT Guidelines where unbiased counseling will be offered and informed choice made between Exclusive Breastfeeding (EBF) and Replacement Feeding. All HIV exposed infants will be followed up and referred diagnosis using DNA PCR or Antibody tests as appropriate. Jhpiego will participate in the next phase of National Early Infant Diagnosis program scale-up and all PMTCT sites will be linked for Dry Blood Spot (DBS) sample collection. HIV exposed infants will also be linked to the nearest OVC services if needed.

Pregnant women requiring HAART for their own health will be referred for Care, Treatment and Support based on the National Treatment Guidelines at Comprehensive sites within the HIV Care and Treatment Network in Zamfara State. Women will be linked to PLWHA support groups within the Care and Support network which will provide both education and ongoing support around Infant Feeding choices.

Jhpiego will train 20 health workers from the two (2) new sites in Zamfara State on the provision of PMTCT services using the National PMTCT Training Curriculum. ZAIHAP will apply the Community Action Cycle (CAC) and Partnership Defined Quality (PDQ) methodologies which will bring service providers and community members together to define quality of care, identify and prioritize problems and create solutions. This will empower and mobilize local communities to support and increase demand for uptake of PMTCT services. Support groups for mothers will be established/ strengthened to promote uptake of PMTCT and other maternity services and adherence to treatment protocols, using the Mothers-2-Mothers Model.

The project will ensure that after delivery, all HIV+ women are properly referred for treatment and directed to wrap-around services such as health and psychosocial support, gender-based violence prevention and response, support for formal and informal education, skills and vocational training and income generation.

Jhpiego will use national PMTCT Registers across all our sites and train twenty-five (25) healthcare workers (including staff of new PMTCT sites and Local Government M&E Officers from ZAIHAP LGAs) in Zamfara State using the National PMTCT MIS System. The Local Government M&E officers will play a critical role in building the capacity of the LGA M&E System and will also send Monthly Reports which will be sent to the SASCP.

Contribution to Overall Program Area
Jhpiego's work at her PMTCT sites will contribute to achieving the PEPFAR/USG COP10 12-2-3 Legislative Goals of preventing 12 million new HIV infections, providing care to 12 million people infected

or affected by HIV/AIDS and providing treatment for at least 3 million people. To measure and report on progress toward achieving program objectives, Jhpiego will implement a detailed Monitoring and Evaluation (M&E) plan which acknowledges the critical importance of collecting and reporting on the PEPFAR program-level indicators and will institute reporting on the Next Generation Indicators. Program-level indicators will be collected routinely and reported quarterly, semi-annually and annually during site visits through available project records, Client Registers, and the Nigerian National Response Information Monitoring System (NNRIMS), as appropriate. Jhpiego's Training Information Monitoring System (TIMS) will also be used to track persons trained and facilitate follow-up.

While recognizing that data from the Jhpiego-supported sites will be reported to the Federal Ministry of Health to calculate the outcome indicators on a national level, Jhpiego will also calculate these indicators on a project level to ensure proper project implementation and management.

Understanding the importance of the 'Three Ones', Jhpiego will work with the Federal Ministry of Health, UNAIDS, and other donors to implement the National M&E Plan and support the National HIV/AIDS Strategy.

Links to Other Activities
Jhpiego is currently working in Zamfara State to implement the ACCESS Program which focuses on strengthening primary and secondary health facilities to provide Emergency Obstetric and Newborn Care (EmONC) services as well as increasing demand for these services through community mobilization activities. The ZAIHAP project is leveraging support from the ongoing ACCESS program in Zamfara State which has strong community mobilization and demand generation interventions. ZAIHAP will continue to take advantage of ACCESS/MCHIPs existing community mobilization network and add messages on the benefits of PMTCT, the existence of PMTCT services to reduce the likelihood of HIV transmission to infants, and appropriate infant feeding choices. The PMTCT activities can serve as a platform through which other family members are targeted for HCT services. ZAIHAP activities will be linked to other important services such as HIV care and treatment, and other services including psychosocial support and economic empowerment schemes, through referral to nearby services. The National HCT (Heart-2-Heart) Logo will be conspicuously displayed at all PMTCT sites.

ZAIHAP is partnering with two (2) local NGOs in Zamfara State, Federation of Muslim Women's Associations of Nigeria (FOMWAN) and Community Health Development Project (COHEDEP) to further mobilize communities through advocacy to political and traditional rulers, community dialogue, community rallies and development of radio messages to be aired across the state. This partnership will be maintained to the extent that it remains beneficial to the ZAIHAP project.

Target Population
The target population is pregnant women and their infants. These women will be reached through both facility based (antenatal clinic) and community based activities. Women reached through community activities will be encouraged to utilize antenatal care services in the health facilities.

Key Legislative Issues
This activity addresses the key legislative issue of gender as pregnant women will be provided with ARV prophylaxis and treatment. Data from these women will demonstrate this.

Emphasis Areas
The activity includes a major emphasis on local organization capacity building, quality assurance, quality improvement, supportive supervision and minor emphases on commodity procurement and infrastructure.

In COP10, under 'PEPFAR Nigeria's accelerated PMTCT plan', Jhiepgo, will strengthen its support to PMTCT service delivery by implementing activities that further improve the coverage and quality of PMTCT services. These activities will be directed towards increasing utilization of PMTCT services at existing service outlets through demand creation in collaboration with community resources and ensuring the upgrade of existing supported PHCs offering stand alone HIV counseling and testing to render at least minimal package of PMTCT services. In order to leverage resources, priority will be given to PHCs located in the selected focal states with presence of other donor agencies and in local government areas already earmarked for HSS support through GFATM. Where new sites are envisioned, those that are used for national ANC sero-sentinel surveys but yet to commence PMTCT services as well as PHCs located in communities with high HIV prevalence rates above the National average will be given priority.

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 10114** | **Mechanism Name: HHS/CDC Track 2.0 APIN** |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: APIN LTD | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| Total Funding: 12,497,627 | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 12,497,627 |

## Sub Partner Name(s)

| | | |
|---|---|---|
| Lagos University Teaching Hospital, Lagos | Nigerian Institute for Medical Research, Yaba, Lagos State | Northwestern University, Chicago |
| Public Health Clinic, Iru-VI, Lagos | Sacred Heart Catholic Hospital, Lantoro, Ogun State | University of Ibadan-Oyo State DOTS |

## Overview Narrative

During COP10, APIN will provide program management and capacity building support for comprehensive HIV/AIDS prevention, care and treatment programs at 1 tertiary level hospital, 3 secondary level hospitals, 1 medical research institute and 1 primary health center. In collaboration with the Oyo State government and the University of Ibadan, we will support 43 DOT centers for HIV/TB activities across the state. Clinical activities will be implemented in accordance with APIN clinical protocols, which are harmonized with National protocols.

In accordance with the PEPFAR program priorities, the major goals of the APIN program are to:

1. Achieve primary prevention of HIV through expanded counseling and testing (HVCT) and prevention of mother-to-child transmission (MTCT) programs.

We will achieve this goal through collaboration with partner institutions in Nigeria to support existing programs and further scale-up HIV voluntary counseling and testing to maximize identification of HIV positive individuals for ART and care. We will be providing PMTCT services at all our clinical sites. HCT activities will focus on outreach to most at risk populations (MARPs) and be coupled with HIV prevention messages. These collaborations will include support for the expansion of PMTCT programs, through linkages with OB/GYN programs and ANC clinics and capacity building for pediatric care at our partner sites.

2. Improve and expand care and treatment of HIV/AIDS, other STDs, OIs (including TB).

Achievement of this goal will involve the provision of support for the infrastructure at our sites to provide

HIV care and ARV treatment in accordance with best clinical practices. In particular, we will continue with Health Systems Strengthening (OHSS) activities at the 43 TB DOT centers that we support in Oyo State. REDACTED. Health workers' training will also be intensified based on need.

This will include rapid follow-up of HIV-infected patients identified through our HCT and PMTCT programs to ensure that clinical criteria are met. These patients are referred to adult and pediatric ARV clinics to ensure access to care and treatment services. We will also provide prophylaxis, diagnosis and treatment of STDs, and relevant HIV-related infections including TB to reduce co-morbidity. ARV care and treatment services will be provided in accordance with the APIN clinical protocols. We will continue to support TB/HIV in 43 Oyo State DOT centers, with HCT screening, TB diagnostics and downward referral for co-infected patients. These modalities will be supported by an established centrally managed ARV drug and commodity procurement system.

In COP10, APIN will provide testing and counseling services to 14,200 women and provide complete prophylaxis to 852 HIV-positive pregnant women. At the end of COP10, APIN will have provided ART to 15,600 adults and 1,200 pediatric patients, while 23,950 adults and 2,200 pediatric patients will be provided with basic care and support and 2,500 co-infected patients, treated for TB. HVCT services will be offered to 10,200 clients, with a strategy targeting MARPs and clients at ART clinics, while 1,000 children will receive OVC services and 7,192 clients will be provided condoms and other prevention services.

In order to improve the sustainability of HIV/AIDS care and treatment activities at clinical sites, we will strengthen human resource capacity in these areas. Our training efforts will include the provision of central training in ARV services and modalities to new health care providers at partner sites and refresher trainings for existing staff. We will also provide regular site visits that are aimed at evaluating clinical quality of care and providing staff training. Additionally, we will provide clinical training to staff with a focus on expanding health care worker knowledge and skills. Expanding ARV services will also require support for capacity building in the area of laboratory services at each of the program sites. This will include the implementation of quality assurance surveys at each of the sites and refresher training for laboratory staff.

3. Strengthen systems to select, procure, store, track, distribute and provide ART.

In previous years, under the APIN Plus/Harvard PEPFAR program, Harvard has managed supply chain management of pharmaceuticals and other commodities. During COP10, we will continue the transition to APIN staff, who will directly order some drugs from Nigeria. APIN will continue to receive support from Harvard and Northwestern Universities. Such support will be aimed at ensuring that drug needs are

accurately projected and procurement proceeds smoothly. Harvard and Northwestern will continue providing staff training on Supply Chain Management Systems planning and procurement software and in drug ordering processes and conduct periodic reviews of systems. Scale-up in this area will include the hiring of additional staff to for supply chain management to ensure that systems are sufficiently robust to be compliant with U.S. government regulations and to handle increasing purchasing needs as funding levels and the numbers of sites being supported increase.

In order to build APIN's capacity for management of ARV drugs, APIN will re-build a Central Medical Stores warehouse in Lagos, at the NIMR. The facility is necessary to provide central management of commodities that are purchased for program use, including pharmaceuticals, equipment and other supplies. Under the Harvard PEPFAR program, a Central Medical Stores Warehouse which served this purpose was originally constructed at NIMR in 2006. However, in April 2008, a fire at the warehouse resulted in a complete destruction of the structure and its contents. Since that time, all drug storage and supply chain management has been through smaller storage facilities at NIMR, short-term storage space at the CDC warehouse in Abuja, and leased storage space from DHL in Lagos. The result has been fragmented logistics management and increased complexities in tracking procurements, disbursements, and storage. Thus, it is essential to reestablish a centralized storage facility to ensure smooth supply chain management for the increasing number of clinical sites managed by APIN. In addition, this facility will serve the Harvard sites. Thus, in future grant years, as Harvard sites are transitioned to APIN, there will be minimal impact on the logistics management process.

4. Strengthen the capacity of in-country data collection, reporting, surveillance, disease monitoring, clinical quality improvement and laboratory activities.

We will achieve this goal by supporting the implementation of M&E plans, which are aimed at monitoring the implementation of the described programs for clinical efficacy, at each of our sites. In addition, we will support efforts to provide ongoing training and infrastructure building for data management, which will facilitate the implementation of effective M&E programs. Data reviews, using program indicators, will be conducted by the M&E teams at the sites and by central program management staff. These reviews are aimed at ensuring that sites are meeting targets for patient enrollment and health systems strengthening. Deliberate efforts will be made to encourage data use at all APIN sites for better decision-making to improve management of processes and quality of care to patients.

In previous years, quality improvement activities have been centrally managed by Harvard, through the APIN Plus/Harvard PEPFAR program. In COP10, we will transition these activities to APIN staff. This will include training on reviews of electronic data for quality indicators. Additionally, APIN staff will be responsible for formulating the yearly quality improvement plan for site assessments. APIN will also be

responsible for leading quality reviews and the development of tools and data utilities in this area. In COP10, efforts in this area will focus on harmonization with GON and CDC quality improvement goals and building capacity for sites to conduct periodic internal reviews for ongoing monitoring of quality indicators.

5. Enhance the sustainability of program management through capacity and infrastructure building efforts for APIN as an indigenous NGO and for partner sites.

APIN will continue to build on the foundations for sustainable management that it has laid and effect corrective measures from the recent HRSA visit into its planning and operational processes for better efficiency and effectiveness. We will continue to review and adjust our administrative and financial management structures for improved performance. We will add additional program and administrative staff as indicated to ensure effective coordination of ongoing activities at our sites and integration with the USG and National ART Program. We also plan to conduct an external financial audit of APIN accounts, as well as the accounts of all partner sites, as against the first audit involving only APIN program offices. The audits will be conducted by Deloitte, a U.S.-based accounting firm, in accordance with generally accepted accounting principles. Such an audit is aimed at ensuring transparency in the financial management process as well as building capacity for robust financial controls at the sites. Our capacity building efforts will also include ongoing training and infrastructure building for collaborating partners to enhance program sustainability.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Construction/Renovation | REDACTED |
| Economic Strengthening | 173,078 |
| Education | 40,504 |
| Food and Nutrition: Commodities | 98,768 |
| Food and Nutrition: Policy, Tools, and Service Delivery | 554,895 |
| Gender: Reducing Violence and Coercion | 160,965 |
| Human Resources for Health | 1,638,439 |

## Key Issues

Impact/End-of-Program Evaluation

Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
Military Population
Mobile Population
Safe Motherhood
TB
Workplace Programs
Family Planning

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **10114** |
| **Mechanism Name:** | **HHS/CDC Track 2.0 APIN** |
| **Prime Partner Name:** | **APIN LTD** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HBHC | 1,967,596 | |

**Narrative:**

ACTIVITY UNCHANGED FROM F2009

NARRATIVE:
During COP09, APIN assumed management responsibility for 2 Harvard sites (LUTH and NIMR), in addition to the initial 4 sites - Sacred Heart Catholic Hospital in Lantoro, Ogun State and Primary Health Center-Iru on Victoria Island, Lagos, Mushin General Hospital, Onikan General Hospital, 43 UCH Oyo State DOT Centers. APIN will maintain a strong collaboration with Harvard University. In COP10, APIN will provide support for treatment at 3 treatment sites (2 tertiary care, 1 secondary sites) located in two states of Lagos and Ogun. In COP10, APIN will provide support for ACS services at the 6 treatment sites (2 tertiary care, 3 secondary sites, 1 PHC).

This activity will provide care and support services to a total of 23850 PLWHA; (8150 ART-ineligible and 15600 ART-eligible). An additional 47700 People Affected By HIV/AIDS (PABAs) will be reached through the community and home-based care (HBC) program of the PLWHA; therefore, it is expected

that a total of 71550 people will access services. At our 2 secondary level and 1 primary level PMTCT sites, there will also be ACS provided for eligible pregnant women. Harvard and APIN will collaborate in order to ensure a smooth transition of clinical services.

Patients are identified through HCT services, including facility-based, mobile and family-centered strategies. All HIV-positive individuals are provided with care and support services in line with national guidelines and pre-assessed for ART eligibility. ART-eligible patients are provided with ART services, in accordance with a standardized programmatic protocol, which follows the current National ART Guidelines. All HIV+ patients are provided with care and support services, consistent with the National Palliative Care Guidelines. These services include clinical care (nursing care, pain management, OIs and STI prophylaxis and treatment, nutritional assessment and support and end-stage care, labs – baseline haematology, chemistry, CD4 count baseline and follow-up, OI diagnosis and pegnancy test if indicated), with basic care kits, psychosocial and spiritual support, economic empowerment, community HBC, Prevention with Positives (PwP) and other prevention services. HIV+ individuals are provided with cotrimoxazole prophylaxis according to national guidelines. Diagnostics for common opportunistic infections (OIs) may include: Candida albicans, bacteriology, protozoal infections, malaria and gastrointestinal parasites etc. All HIV+ patients are also symptomatically screened for TB and confirmed with laboratory and radiological diagnostics as indicated. APIN will support integration of syndromic management of STIs and risk reduction interventions into care All enrolled patients will be provided with a basic care kits including water vessel, water guard, ITN, soap, ORS, latex gloves, and IEC materials. Pain management assessments will also be conducted by clinicians and HBC providers and analgesics will be provided.
APIN uses the hub and spoke model of care for service delivery. APIN will also expand provision of care and treatment services to the primary health centers. APIN will explore the possibility of a pilot program on cervical cancer screening among patients in some selected sites.

ART-ineligible individuals enrolled in care receive periodic follow-up to identify changes in eligibility status. Scheduled physician visits for all patients are at 3, 6, and 12 months and every 6 months thereafter. ART patients follow the same clinical visit schedule with more intensified monitoring and pick up drugs monthly. At each visit, clinical exams, hematology, chemistry, viral load, and CD4 enumeration are performed. All tertiary site labs perform the necessary lab assays. Secondary and primary sites with limited lab capability send samples to an affiliated tertiary site lab for analyses. Electronic clinic and lab records provide data for high-quality patient care and centrally coordinated program monitoring. As additional medical needs of patients are identified through clinic visits, patients are provided with the services by clinicians or referred for specialty care as necessary.

All enrolled into care will receive risk assessment and behavioral counseling to achieve risk reduction. These activities are provided through individual counseling. Activities that focus on PWP include HCT for family members and sex partners, counseling for discordant couples, disclosure, healthy lifestyles and positive living, prevention messages, provision of condoms and IEC materials . Patients are also encouraged to refer family members for HCT. ART patients are provided ART Education adherence counseling (EAC) prior to and during ART provision, which follows the National Curriculum for Adherence Counseling and includes partner notification, drug adherence strategies and other prevention measures. ART EAC is reinforced with PLWHA support groups at each site, which serve all HIV+ patients and their families. ART patients are encouraged to have a treatment support partner to whom he/she had disclosed status to improve adherence and to optimize care. APIN also partners with community based PLWHA support groups and CBOs to mobilize communities, provide psychosocial support to PLWHAs and their families, provide ART adherence counseling, and assist with patient follow-up and HBC activities. In addition, the program will identify, collaborate with and strengthen the capacities of support groups and CBOs, to deliver care and support services, including the provision of community and HBC services such as domestic support, management of minor ailments, pain management, referral services, and counseling services. Supported CBOs will provide a range of facility and HBC services, including PwP services (balanced ABC messaging as appropriate), clinical care, prophylaxis and management of OIs, lab support, adherence counseling, psychosocial and spiritual support, and active linkages between hospitals, health centers, and communities.

Facility-based and community-based HBC teams partner to provide a continuum of HBC services depending on client needs. Community HBC activities will be supervised by a site HBC team comprising of a clinician, nurse, counselor, social worker and volunteers. The community HBC teams comprise of support groups members and other volunteers. When ART patients miss scheduled clinic visits or bed ridden clients are reported by the community HBC team, the site HBC team provides follow-up according to a program based SOP, utilizing a HBC kit provided to these outreach teams. The HBC provider kit includes ORS, bleach, cotton wool, latex gloves, soap, calamine lotion, vaseline, gentian violet. The team will provide basic medical assessments of signs and symptoms, basic nursing care, nutritional assessments and psychosocial support and make appropriate referrals. HBC teams will also provide refills of cotrimoxazole, paracetamol, additional clean water kits and additional ITNs to patients and their families. The Harvard Loss to Follow Up (LTFU) utility will help in picking up patients that might soon be lost to follow up. The list generated is sent to the LTFU team and support group to initiate a process of tracking and bringing patients back into care. APIN will continue to facilitate facility and community support group activities focused on pre-ART patient retention.

All sites focus on the integration of Care and treatment services for all patients regardless of the source of funding for different components of treatment (e.g. external funding sources for services or lab

commodities). At each site, support is provided for the management of electronic data and patient medical records for use in the provision of clinical care. TB diagnosis and treatment is provided to all patients via facility co-location of DOTS centers and/or referral of HIV+ patients into ART from DOTS sites. ART-eligible patients identified through HCT conducted for all TB patients at DOTS sites will be provided with ART.

Clinical staff at APIN and Harvard sites meets monthly for updates and training. As clinical training needs are identified for new sites or new staff at existing sites, Harvard provides training on relevant topics including regimen switching. In COP09, APIN will make use of the comprehensive Quality Improvement (QI) Plan incorporated by Harvard using standardized quality indicators. This includes periodic external site assessments and chart reviews as well as quarterly internal reviews, based on electronic databases. This QI Plan has been harmonized with HIVQual activities for participating sites and will continue to be implemented in COP10. APIN will support the training of 197 health workers including PHC HCWs to provide care and treatment services to 23850 HIV-infected adults by the end of COP10 .REDACTED. A total of 13100 patients will be provided with ART services.

For patients enrolled through the GON National ART Program, we anticipate GON provision of 1st line ARV drugs and PEPFAR support for care and treatment services. As patients require alternative or 2nd line drugs, they will receive PEPFAR provided drugs. GON provision of 1st line drugs allows for additional care and treatment targets. APIN estimates that additional adults will receive ART through the leveraging of GON drugs. APIN will partner with Harvard, Clinton Foundation and Global Fund as appropriate to leverage resources for providing ARVs to patients. The site investigators and project managers will actively participate in the GON National ART program. Harmonization of data collection for M&E will be coordinated with USG and GON efforts. APIN has provided technical assistance and training expertise to the National training programs and will continue in COP10. APIN will continue to participate in the USG coordinated Clinical Working Group to address emerging topics in care and treatment service provision and to ensure harmonization with other IPs and the GON. APIN will participate in national activities including the development of the national HIV Nutritional guideline and training curriculum, national ART evaluation and task shifting policy development.

Commodities distributed as a part of the care and treatment services are procured centrally through the Abuja program office and Central Medical Stores in Lagos. Distribution of commodities to individual sites is coordinated through supply chain mechanisms in place for laboratory test kits and ART drugs. During COP09, APIN will collaborate with Harvard, SCMS for the procurement and distribution of specified OI drugs.

CONTRIBUTION TO OVERALL PROGRAM AREA

ACT activities are consistent with the PEPFAR goal of scaling up capacity to provide ARV drugs, care and treatment services and lab support to serve more HIV+ people. APIN will continue to support the expansion of ARV services into more rural areas by strengthening a network of secondary or primary health care clinics providing ART services that are linked to tertiary health care facilities. These networks will ensure that facilities are able to develop linkages, which permit patient referral from primary health centers and the provision of specialty care support. A tiered structure for ARV provision and monitoring established in COP08 and COP10 provides a model for additional expansion efforts in COP09 in order to meet PEPFAR treatment goals. The program will also contribute to strengthening human capacity through training of health workers, community workers and PLWHAs and their families.

Additionally, as part of our sustainability building efforts, APIN will receive technical assistance and support from Harvard to assume program management responsibility for ACT activities. This will include the implementation of a plan to transition site oversight, management and training over to APIN. The goal of these efforts is to provide for greater assumption of responsibility for management and implementation of PEPFAR programming by Nigerian nationals through an indigenous organization.

LINKS TO OTHER ACTIVITIES

This activity is linked to ART drugs (HTXD), OVC (HKID) and Pediatric Care and Treatment (PDTX), PMTCT (MTCT), TB/HIV (HVTB), Lab (HLAB), HCT (HVCT),and SI (HVSI).

POPULATIONS BEING TARGETED

These activities target HIV-infected adults and family members for care, clinical monitoring and ART. The operational elements of these activities (M&E, health personnel training, infrastructural supports, technical assistance and quality assurance) target public and private program managers, doctors, nurses, pharmacists and lab workers at PEPFAR sites. The expansion of ART services to PHCs will increase access to underserved areas.

EMPHASIS AREAS

This program seeks to increase gender equity in programming through counseling and educational messages targeted at vulnerable women and girls. Furthermore, through gender sensitive programming and improved quality services the program will contribute to reduction in stigma and discrimination and address male norms and behaviors by encouraging men to contribute to care and support in the families. We provide a focus on malaria and wraparounds.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HKID | 236,143 | |

**Narrative:**

ACTIVITY UNCHANGED FROM F2009

During COP09, APIN assumed management responsibility for 2 Harvard sites (LUTH and NIMR), in addition to the initial 4 sites - Sacred Heart Catholic Hospital in Lantoro, Ogun State and Primary Health Center-Iru on Victoria Island, Lagos, Mushin General Hospital, Onikan General Hospital, 43 UCH Oyo State DOT Centers. APIN will maintain a strong collaboration with Harvard University. In COP10, APIN will provide support for OVC services at the 6 treatment sites (2 tertiary care, 3 secondary sites, 1 PHC). These OVC sites constitute a network of delivery points including 2 tertiary hospitals, 2 secondary hospitals, and 1 primary health center.

APIN will identify HIV-infected and -affected OVC through PMTCT, HCT, site support group activities, ART centers, as well as HBC activities and hospitals as entry point into OVC. OVC will be identified in the community through the HBC,CBOs,FBOs,Support groups for PLWHA, health care facilities, including Community development and leadership programme Most at risk children will be enrolled into the OVC program through a family centered approach using a vulnerability, need assessment checklist and Child Status Index (CSI).Those identified through an HIV-positive adult family member or caregiver (PMTCT client, adult treatment client or adult care and support client) will be offered HCT. APIN will strengthen the coordination of PMTCT, ART and OVC services for seamless movement of HIV-infected and uninfected children across the various services. The experience gained from the initial rounds of this activity will assist in more efficient implementation of OVC activities in the new centers.
In addition, APIN will provide OVC services to HIV-negative children whose parents or caregivers had or have HIV/AIDS.

OVC will receive multiple services through APIN activities. Preventive care services for all OVC, including diagnostic testing for common infections (OIs) such as TB, and malaria will be performed at pre-assessment. In addition, APIN will ensure that children receive all scheduled childhood immunizations, growth monitoring and other child survival interventions according to the national policy. Preventive care kits will be distributed to all caregivers of children supported under this activity; kits include multivitamins, clean water kits, ORS (preparation and use), water guards and bed nets. All OVCs are also provided with nutritional counseling, assessments and support, psychosocial support, and referrals to other wraparound services based on identified needs such as economic empowerment for caregivers, legal protection referrals. During COP10, APIN will provide educational support for some OVC which will include educational materials (books, sandals, bags, and uniforms) as well as pay tuition for education in government-approved schools. APIN will prioritize partnering with USG-supported wraparound services in states where the activities are co-located with APIN. APIN will target adolescent OVC through outreach efforts and link them with appropriate services.

APIN will partner with persons living with HIV/AIDS (PLWHA) support groups to provide outreach to OVC and their families and caregivers through psychosocial and spiritual support, stigma reduction, risk reduction and basic child health education including danger signs, nutritional demonstration and verification of appropriate use of basic preventive commodities. APIN will collaborate with other PEPFAR donors to provide therapeutic nutritional support commodities. The program will build the capacity of the OVC support groups through training and mentoring to develop more innovative means of addressing OVC issues such as recreational, psychosocial, economic empowerment and life skills. APIN will also explore partnerships with other OVC providers in the communities in which it works for potential synergy of activities in the spirit of proper networking.

Monitoring and evaluation of all aspects of the OVC program will be conducted as a part of the SI activities which will include the use of the CSI tool. APIN will use the electronic database developed by Harvard to continue collecting electronic data on OVC clients and services which is used for site and program specific evaluation of services provided to OVC. In addition the progress of children benefiting from educational support will be monitored through registers and their school records; follow-up services with school administrators, teachers and OVC care givers will be coordinated by program staff. These data are used to conduct program evaluations and provide feedback to site investigators on a quarterly basis. On-site data managers will conduct monthly evaluations. APIN will utilize its QA/QI program to provide feedback to sites on performance and identify best practices and areas for strengthening and support.

This funding will also support training for 106 healthcare providers and caregivers of HIV-infected and affected OVC and volunteers on OVC services. Healthcare providers to be trained include pediatricians, general duty medical doctors, pharmacists, counselors and nurses in the area of OVC services. Training in this area will be coordinated with FMOH and USG following the National Guidelines on OVC. These activities will strengthen the capacity of sites to provide comprehensive OVC services to 1000 children and 732 will be provided with food and nutritional supplements.

APIN will advocate and support the state ministry of women affairs in building their capacity to provide oversight and reporting functions for OVC programs. APIN will participate in the development of the national OVC training curriculum and other instruments.

EMPHASIS AREAS:
Emphasis is placed on training through activities focused on training healthcare providers and caregivers in the care of HIV-infected and affected OVC. These activities will also place an emphasis on the development of networks and referral systems in order to support the development of a comprehensive

system of care through links to community PLWHA support groups and PMTCT, HCT, TB/HIV and ART sites.

POPULATIONS BEING TARGETED:
These activities seek to target OVC who have been exposed to HIV through pregnancy and breastfeeding from an HIV-infected mother through the identification of exposed infants from PMTCT programs. We will also identify OVC from other areas as targets for supportive pediatric care and family outreach. Outreach initiatives also seek to target mothers and family members of HIV-infected OVC and their siblings, including PLWHA, to ensure comprehensive support. Caregivers of OVC are also targeted to encourage HCT for potentially exposed children. APIN also targets caregivers by providing them with preventive care packages to be utilized for the benefit of the OVC. APIN will target street youth and out-of-school youth through community outreach initiatives based in HCT clinics.

CONTRIBUTION TO OVERALL PROGRAM AREA:
Outreach activities through PLWHA support groups will seek to provide comprehensive psychosocial support for OVC and their families. These services are consistent with the National Plan of Action for OVC in Nigeria and the Standard Operational Guidelines for OVC services. Additionally, APIN seeks to strengthen the capacity of the PLWHA support groups through training to continue to provide psychosocial support and outreach to PLWHA and OVC. Capacity development at the community and facility levels and consistency with national guidelines will ensure sustainability. Through working with pediatric ART and PMTCT sites to provide pediatric C&S services for HIV-infected OVC, APIN will scale-up the ability of participating sites to provide comprehensive and sustainable services for this OVC population, which is consistent with national objectives and the second round PEPFAR 5-year strategy.

LINKS TO OTHER ACTIVITIES:
This activity also relates to activities in PMTCT (MTCT) through a system of referrals to provide pediatric care and support services to HIV-infected pregnant women and their infants. In addition, active PMTCT programs at the sites will identify HIV-exposed infants who will require PCR diagnosis and clinical assessment to determine ART eligibility.
Linkages will be made to adult and pediatric care and support (HBHC, PDCS) activities and TB/HIV activities (HVTB) in order to ensure a comprehensive system of care for OVC and their families. ART-eligible OVC will be linked to ART services funded under APIN pediatric treatment (PDTX) activities. The integration of pediatric treatment services (PDTX) and care linked to active PMTCT and adult ART (HTXS) centers will facilitate the development of the overall network of care for HIV-infected families and communities. APIN will provide linkages, care and monitoring through the pediatric care and support (PDCS) program to HIV-positive children who are on ART, HIV-positive children not yet eligible for ART, HIV-infected infants identified through the PMTCT activities, and HIV-infected children identified through

the HCT and home-based activities. Linkages to outreach initiatives and HCT (HVCT) activities seek to improve the utilization of care opportunities created through PEPFAR funding. Outreach through the PLWHA support groups will also encourage utilization of HCT services by other family members. Additionally, through SI activities (HVSI) information about efficacy of care, derived from data collected on the patients treated under this activity, may be used to develop new treatment protocols to increase the quality of pediatric OVC services.

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| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HTXS | 4,949,994 | |

**Narrative:**

ACTIVITY UNCHANGED FROM F2009

NARRATIVE:

During COP09, APIN assumed management responsibility for 2 Harvard sites (LUTH and NIMR), in addition to the initial 4 sites - Sacred Heart Catholic Hospital in Lantoro, Ogun State and Primary Health Center-Iru on Victoria Island, Lagos, Mushin General Hospital, Onikan General Hospital, 43 UCH Oyo State DOT Centers. APIN will maintain a strong collaboration with Harvard University. In COP10, APIN will provide support for treatment at 3 treatment sites (2 tertiary care, 1 secondary sites) located in two states of Lagos and Ogun. This activity will provide ART services to a total of 15600 eligible adult patients (2500 new and 13100 mainenance) by the end of the reporting period. At our 2 secondary levels and 1 primary level PMTCT sites, there will also be AT provided for eligible pregnant women. APIN and Harvard will collaborate in order to ensure a smooth transition of clinical services.

Patients are identified through HCT services, including facility-based, mobile and family-centered strategies. All HIV-positive ART-eligible patients are provided with ART services, in accordance with a standardized programmatic protocol, which follows the current National ART Guidelines. All HIV+ patients and ART ineligible are referred for care and support services, while ART eligible individuals are provided ARVs with cotrimoxazole prophylaxis according to current national guidelines. Diagnostics for common opportunistic infections (OIs) may include: Candida albicans, protozoal infections, and gastrointestinal parasites. All HIV+ patients are also symptomatically screened for TB and confirmed with laboratory and radiological diagnostics as indicated. APIN will support integration of syndromic management of STIs and risk reduction interventions.

APIN uses the hub and spoke model for service delivery. APIN will also expand provision of treatment services to the primary health centers. APIN will explore the possibility of a pilot program on cervical

cancer screening among patients in some selected sites.

ART patients are monitored 6 monthly for lab exams, and pick up drugs monthly. At the 6 monthly visit, clinical exams, hematology, chemistry, viral load, and CD4 enumeration are performed. All tertiary site labs perform the necessary lab assays. Secondary and primary sites with limited lab capability send samples to an affiliated tertiary site lab for analyses. Electronic clinic and lab records provide data for high-quality patient treatment and centrally coordinated program monitoring. As additional medical needs of patients are identified through clinic visits, patients are provided treatment by clinicians or referred for specialty treatment as necessary.

Patients are also encouraged to refer family members for HCT. ART patients are provided ART Education adherence counseling (EAC) prior to and during ART provision, which follows the National Curriculum for Adherence Counseling and includes partner notification, drug adherence strategies and other prevention measures. ART EAC is reinforced with PLWHA support groups at each site, which serve all HIV+ patients and their families. Patients on ART are encouraged to have a treatment support partner to whom he/she had disclosed status to improve adherence and to optimize treatment. APIN also partners with community based organizations to support ART adherence counseling, and assist with patient follow-up. When ART patients miss scheduled clinic visits or bed ridden such clients are reported by the community HBC team for intervention.

All sites focus on the integration of Care and treatment services for all patients regardless of the source of funding for different components of treatment (e.g. external funding sources for services or lab commodities). At each site, support is provided for the management of electronic data and patient medical records for use in the provision of quality treatment. TB diagnosis and treatment is provided to all patients via facility co-location of DOTS centers and/or referral of HIV+ patients into ART from DOTS sites. ART-eligible patients identified through HCT conducted for all TB patients at DOTS sites will be provided with ART.

Clinical staff at APIN and Harvard sites meets monthly for updates and training. As clinical training needs are identified for new sites or new staff at existing sites, Harvard support training on relevant topics including regimen switching. In COP10, APIN will make use of the comprehensive Quality Improvement (QI) Plan incorporated by APIN using standardized quality indicators. This includes periodic external site assessments and chart reviews as well as quarterly internal reviews, based on electronic databases. This QI Plan has been harmonized with HIVQual activities for participating sites and will continue to be implemented in COP10. APIN will support the training of 200 health workers consisting of doctors, nurses, pharmacists, counselors providing ART services to 15,600 HIV-infected adults by the end of

COP10. REDACTED.

For patients enrolled through the GON National ART Program, we anticipate GON provision of 1st line ARV drugs and PEPFAR support treatment. As patients require alternative or 2nd line drugs, they will receive PEPFAR provided drugs. GON provision of 1st line drugs allows for additional treatment targets. APIN estimates that additional adults will receive ART through the leveraging of GON drugs. APIN will partner with Harvard, Clinton Foundation and Global Fund as appropriate to leverage resources for providing ARVs to patients. The site investigators and project managers will actively participate in the GON National ART program. Harmonization of data collection for M&E will be coordinated with USG and GON efforts. APIN has provided technical assistance and training expertise to the National training programs and will continue in COP10. APIN will continue to participate in the USG coordinated Clinical Working Group to address emerging topics in treatment service provision and to ensure harmonization with other IPs and the GON. APIN will participate in national activities including the development of the national HIV guideline and training curriculum, national ART evaluation and task shifting policy development.

Commodities distributed as a part of the treatment services are procured centrally through the Abuja program office and Central Medical Stores in Lagos. Distribution of commodities to individual sites is coordinated through supply chain mechanisms in place for laboratory test kits and ART drugs. During COP10, APIN will collaborate with Harvard, SCMS for the procurement and distribution of specified OI drugs.

CONTRIBUTION TO OVERALL PROGRAM AREA
Adult treatment activities are consistent with the PEPFAR goal of scaling up capacity to provide ARV drugs, and treatment services to more HIV+ people. APIN will continue to support the expansion of ARV services into more rural areas by strengthening a network of secondary or primary health care clinics providing ART services that are linked to tertiary health care facilities. These networks will ensure that facilities are able to develop linkages, which permit patient referral from primary health centers and the provision of specialized treatment. . A tiered structure for ARV provision and monitoring established in COP08 and COP09 provides a model for additional expansion efforts in COP10 in order to meet PEPFAR treatment goals. The program will also contribute to strengthening human capacity through training of health workers, community workers and PLWHAs and their families.

Additionally, as part of our sustainability building efforts, APIN will receive technical assistance and support from Harvard to assume program management responsibility for AT activities. This will include the implementation of a plan to transition site oversight, management and training over to APIN. The goal

of these efforts is to provide for greater assumption of responsibility for management and implementation of PEPFAR programming by Nigerian nationals through an indigenous organization.

LINKS TO OTHER ACTIVITIES
This activity is linked to ART drugs (HTXD), OVC (HKID) and Pediatric Care and Treatment (PDTX), PMTCT (MTCT), TB/HIV (HVTB), Lab (HLAB), HCT (HVCT), and SI (HVSI).

POPULATIONS BEING TARGETED
These activities target HIV-infected adults and family members for ART. The operational elements of these activities (M&E, health personnel training, infrastructural supports, technical assistance and quality assurance) target public and private program managers, doctors, nurses, pharmacists and lab workers at PEPFAR sites. The expansion of ART services to PHCs will increase access to underserved areas.

EMPHASIS AREAS
This program seeks to increase gender equity in programming through counseling and educational messages targeted at vulnerable women and girls receiving treatment. Furthermore, through gender sensitive programming and improved quality services the program will contribute to reduction in stigma and discrimination and address male norms and behaviors by encouraging men to contribute to treatment in the families. We provide a focus on malaria and wraparounds.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HVCT | 64,039 | |

**Narrative:**

ACTIVITY UNCHANGED FROM F2009

NARRATIVE:
During COP09, APIN assumed management responsibility for 2 Harvard sites (LUTH and NIMR), in addition to the initial 4 sites - Sacred Heart Catholic Hospital in Lantoro, Ogun State and Primary Health Center-Iru on Victoria Island, Lagos, Mushin General Hospital, Onikan General Hospital and 43 UCH Oyo state DOT Centers. In COP10, APIN will provide support for HCT services at the 6 treatment sites (2 tertiary care, 3 secondary sites, 1 PHC) and 43 DOT Centers.

In COP10, APIN plans to support provision of comprehensive HIV counseling and testing (HCT) services to at risk individuals, delivered through 49 service outlets (5 comprehensive sites, 1 PHC and 43 DOT

centers) in 3 states (Lagos, Ogun and Oyo). At these sites 10200 (including TB) and 4500 (excluding TB) individuals will receive HIV counseling & testing and receive their results (targeted populations include Most At Risk Populations (MARPs), clients presenting to the health care facilities, blood donors, and family members of PLWHA. Provider initiated HIV testing is utilized as an additional strategy to reach clients at the health care facilities. The sites will include DOT centers in at least one health facility in every local government area (LGA) in Oyo State.
In COP09, APIN supported provision of comprehensive HIV counseling and testing (HCT) services to at risk individuals, delivered through 49 service outlets (5 comprehensive sites, 1 PHC and 43 DOT centers) in 3 states (Lagos, Ogun and Oyo).

Individuals identified as positive at APIN sites will be referred to PMTCT and ART clinics for treatment and palliative care services. Prevention for HIV positive individuals will be incorporated into HCT activities including promotion of HCT for family members and sex partners, counseling for discordant couples, counseling on healthy lifestyles and positive living, prevention messages and Information, Education & Communication (IEC) materials on disclosure. APIN sites use family counseling sessions and "love letter" strategies to encourage partners of HIV-infected patients to access HCT so that couples receive HIV counseling and testing together. Counselor training will include couple HIV counseling and testing (CHCT) to strengthen this program. Pediatric patients that are identified at testing points of service will be enrolled into the APIN supported OVC program and ART as necessary. HCT will also be offered to patients receiving TB services at each of the APIN sites throughout TB/HIV program activities. HCT is offered to blood donors as per Blood Safety activities. Patients identified as HIV-infected are provided with referrals to ART and palliative care services.

APIN will use the National "Heart to Heart" logo at supported HCT sites so as to reflect the integration within the national program. At all HCT outlets, patients are provided with IEC materials on HIV prevention and referrals for ART services and palliative care as appropriate. The materials will address HIV prevention using the "ABC" model, providing information about healthy behaviors, safer sexual practices, STI prevention, PMTCT, and condom usage. The sites will also provide HIV testing as well as pre- and post-test counseling and condom distribution.

HCT services are also provided in community settings in conjunction with projects in Lagos state that serve specific MARPs including: outpatient STI patients, bar workers, sex workers. Mobile HCT services coordinated through PHC-Iru will be used to reach these populations. Activities targeting these populations are linked with APIN sites to provide referral linkages to PMTCT, Palliative HIV/TB and ART services depending on eligibility for ART.

Condoms will be made available at all HCT sites in conjunction with the delivery of ABC messages. The

Society for Family Health (SFH) will supply condoms. Training of 20 individuals in counseling and testing will use the new National serial testing algorithm and will educate trainees on appropriate counseling messages specific to the different high risk groups with which they work. Refresher training will be provided to a subset of the target trained during the year, particularly after final revision of the National training curriculum. HIV testing is performed with rapid test assays and same day results are given. Following HIV diagnosis with the National testing algorithm, immunoblot confirmation will be provided during assessment for ART. This is done by HIV laboratories at APIN comprehensive ART treatment centers.

To meet up with the increase demand for services, non-laboratorians, including nurses, counselors and lay counselors would be trained to provide counseling and testing services at one visit using finger prick. These would be supervised by laboratory scientists and quality of testing would be ensured by proficiency testing and quarterly supervisory visits. The UCH Virology lab supported through Harvard will establish and coordinate a regular QA/QC program to insure that HIV serologic testing at APIN HCT centers meets national and international standards. This lab will also ensure coordination of HIV testing SOPs and provide regular training for new lab personnel. The USG team will be providing APIN with rapid test kits that will be managed by the pharmacy logistics team in Lagos and stored and distributed from the APIN central medical stores warehouse. APIN in collaboration with Harvard will continue to harmonize the logistics process with GON LMIS and ICS activities.

EMPHASIS AREAS:
These activities will also address gender equity issues by providing equitable access to HCT services for men and women. In some cases, the activities seek to target men who may be at high risk for HIV in order to provide a mechanism for HCT as a means of prevention and access to services for their sexual partners. Male targeted counseling seeks to address male norms and behaviors in order to encourage safer sexual practices. Counseling also seeks to address sexual norms and issues of HIV related stigma and discrimination.

TARGET POPULATIONS:
These activities target adults for HIV counseling and testing, particularly those from most at risk populations, as described above. Targeting these populations is important to encourage utilization of HCT services and provide ART treatment for eligible HIV infected individuals. Counseling provided through these activities also seeks to target PLWHA who are newly diagnosed by encouraging them to bring their partners and other family members in for HCT. In addition, target populations include orphans and vulnerable children.

CONTRIBUTION TO OVERALL PROGRAM AREA:

APIN HCT activities are consistent with the PEPFAR 2009 goals for Nigeria, which aim to increase uptake of HCT by supporting HCT centers, which are linked to treatment and care services, and to expand their reach through mobile testing services. By continuing to support and build the capacity of HCT centers and provide linkages to treatment and care centers, these activities will be able to meet the increasing utilization of these services, expected to result from HCT outreach initiatives identifying infected individuals. The network of HCT centers linked to HIV services and care will provide a sustainable network for infected and affected individuals in Harvard catchments areas.

Additionally, as part of our sustainability building efforts, APIN will receive technical assistance and support from Harvard to assume program management responsibility for these HCT activities. This will include the implementation of a plan to transition site oversight, management and training over to APIN. The goal of such efforts is to provide for greater assumption of responsibility for management and implementation of PEPFAR programming by Nigerian nationals through an indigenous organization.

LINKS TO OTHER ACTIVITIES:
This activity also relates to activities in Adult Care and Treatment (HTXS), Pediatric Care and Treatment (PDTX), Sexual Prevention (HVAB and HVOP), TB/HIV (HVTB), and OVC (HKID).APIN will link up with the Harvard's network of community, research-based and tertiary care institutions should provide sustainable and high quality HIV and related services to the communities served. Furthermore, both primary and satellite APIN sites are linked in order to provide laboratory and specialty care support, as related to the HCT activities.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | PDCS | 244,978 | |

**Narrative:**

ACTIVITY UNCHANGED FROM F2009

NARRATIVE:
During COP09, APIN assumed management responsibility for 2 Harvard sites (LUTH and NIMR), in addition to the initial 4 sites - Sacred Heart Catholic Hospital in Lantoro, Ogun State and Primary Health Center-Iru on Victoria Island, Lagos, Mushin General Hospital, Onikan General Hospital, 43 UCH Oyo State DOT Centers. APIN will maintain a strong collaboration with Harvard University. In COP10, APIN will provide support for Pediatric Care and Support services at the 6 treatment sites (2 tertiary care, 3 secondary sites, 1 PHC). Patients are identified through PMTCT and HCT services, including facility and community based, mobile, and family-centered strategies. Any pediatric patient presenting with acute history of sexual assault will be provided with post-exposure care, support and psychosocial counseling

services and monitored according to national guidelines.

All HIV-positive children are provided with care and support services in line with national guidelines referred for clinical assessment for ART eligibility. ART-eligible children are referred for services, and all HIV+ children are provided with care and support services, consistent with the National Care and support Guidelines. These services include nursing care, pain management, OIs prophylaxis , nutritional assessment and support and end-stage care, labs – baseline haematology, chemistry, CD4 count baseline and follow-up, OI diagnosis, Pregnancy test if indicated),provision of basic care kits, psychosocial and spiritual support, leverage resources support for economic empowerment for caregivers, community HBC, PwP and other prevention services. HIV+ children are provided with cotrimoxazole prophylaxis according to national guidelines. Diagnostics for common opportunistic infections (OIs) may include: Candida albicans, protozoal infections, and gastrointestinal parasites. All HIV+ children are also symptomatically screened for TB and confirmed with laboratory and radiological diagnostics as indicated. APIN through Harvard support will provide education on risk reduction interventions. All families of enrolled children will be provided with basic care kits including water vessel, water guard, ITN, soap, ORS, latex gloves, and IEC materials. Pain management assessments will also be conducted by clinicians and HBC providers and analgesics will be provided.
APIN uses the hub and spoke model of care for service delivery to the primary and secondary health centers.

ART-ineligible children that are enrolled in care will have periodic follow-up until ART eligibility status changes. Scheduled clinic visits for all are every 6 months. All tertiary and secondary site labs perform the necessary lab assays. Secondary and primary sites with limited lab capability send samples to an affiliated tertiary site. Electronic records provide data for high quality patient care and centrally coordinated program monitoring. As additional medical needs are identified through HBC visits, HIV+ children will be provided with a package of preventative care services, including cotrimoxazole prophylaxis according to national guidelines and ensure immunization, growth monitoring and other child survival services. All HIV+ children will also be symptomatically screened for TB using Tuberculin Skin Test (TST), laboratory and radiological diagnostic methods as indicated. HIV+ children are also provided with nutritional counseling and supplements, including multivitamins and other micronutrients like Vit. A. Iron. All HIV+ children are linked into the system of OVC services in order to ensure a continuum of care. The Loss to Follow Up (LTFU) utility will help in tracking and picking up children that might soon be lost to follow up. The list generated is sent to the tracking team and support group to initiate a process of tracking and bringing children back into care. APIN will continue to facilitate facility and community support group activities focused on pre-ART patient retention. Home visit by the HBC teams will encourage children to continue to access care and support. APIN will strengthen the linkage between facility and community OVC services to promote retention of children.

Commodities distributed as a part of the care and support services are procured centrally through the Abuja program office and Central Medical Stores in Lagos. Distribution of commodities to individual sites is coordinated through supply chain mechanisms in place for basic care kits and other commodities. During COP10, APIN will collaborate with Harvard, SCMS for the procurement and distribution of specified pediatric OI drugs and other HBC commodities

All children enrolled into care will receive age-appropriate risk assessments and behavioral counseling to achieve risk reduction. These activities are provided through individual counseling and outreach by site PLWHA support groups. Caregivers are also encouraged to seek out HCT and refer other family members for HCT. Caregivers of HIV+ children are provided pre-ART education and adherence counseling (EAC) prior to and during ART provision, which follows the National Curriculum for Adherence Counseling. Care and support. EAC is reinforced with PLWHA caregivers support groups at each site, which serves all clients and their families. APIN will also partner with community based PLWHA support groups and CBOs to mobilize communities, provide psychosocial and spiritual support to PLWHAs and their families, provide ART adherence counseling, and assist with patient follow-up and HBC activities.

Facility-based and community-based HBC teams partner to provide a continuum of HBC services depending on client needs and assessment. When ART patients miss scheduled clinic visits or bed-ridden clients are reported by the community HBC team, the site HBC team provides follow-up according to a program based SOP, utilizing a HBC kit provided to these outreach teams. The HBC provider kit includes ORS, bleach, cotton wool, latex gloves, soap, calamine lotion, petroleum jelly, and gentian violet. The team will provide basic medical assessments of signs and symptoms, basic nursing care, nutritional assessments and psychosocial support and make appropriate referrals. HBC teams will also provide refills of cotrimoxazole, paracetamol, additional clean water kits and additional ITNs to patients and their families. The hospital HBC team comprises of a counselor, social worker, PLWHA, nurse and volunteers. The community HBC teams comprise of support groups members and other volunteers

All sites focus on the integration of pediatric care and support services (PCS) for all patients regardless of the source of funding for different components of treatment (e.g., external funding sources for services or lab commodities). At each site, support is provided for the management of electronic data and patient medical records for use in the provision of care and support services. TB diagnosis and care is provided to all patients via facility co-location of DOTS centers and/or referral of HIV+ patients into ART from DOTS sites. HIV+ patients identified through HCT conducted for all TB patients at DOTS sites will be referred to comprehensive PCS services.

APIN and Harvard care and support team meets monthly for updates planning, evaluation and training. As training needs are identified for new sites or new staff at existing sites. In COP09, Harvard incorporated standardized quality indicators into a comprehensive Quality Improvement (QI) Plan for the sites, which includes periodic external site assessments and chart reviews as well as quarterly internal reviews, based on electronic databases. APIN will support the training of 106 health workers including PHC HCWs to provide care and support services to 2200 HIV-infected children in care and support. REDACTED.

For pediatric patients enrolled through the GON ART Program, we anticipate GON provision of 1st-line ARV drugs and PEPFAR provide support for PCS services. As patients require alternative or 2nd-line drugs, patients will receive PEPFAR-provided care and support commodities. GON provision of 1st-line drugs allows for additional PCS targets. . APIN will partner with Harvard and Clinton Foundation as appropriate to leverage resources for providing OI drugs to patients. The site investigators and project managers will actively participate in the GON pediatric care and support program. Harmonization of data collection for M&E will be coordinated with USG and GON efforts. APIN has provided technical assistance and training expertise to the National pediatric C and S treatment training program, which will continue in COP09. APIN will support the development of the National Pediatric Care and Support Guideline and Training curriculum.

In addition to providing training of site-based HCWs to improve care at supported sites, A total of 106 health care and non-health care workers will be trained in PCS services in line with the National Pediatric Care and Treatment Guidelines and Training Curricula.

In addition, the program will identify, collaborate with and strengthen the capacities of support groups and CBOs, to deliver care and support services, including the provision of community and HBC services such as domestic support, management of minor ailments, pain management, referral services, and counseling services. Supported CBOs will provide a range of facility and HBC services, including prevention for positives, clinical care, prophylaxis and management of OIs, lab support, adherence counseling, psychosocial and spiritual support, and active linkages between hospitals, health centers, and communities. Through counselors and HBC staff, volunteers at all sites, APIN will provide referrals for TB, wraparound services and child survival programs as appropriate.

CONTRIBUTION TO PROGRAM

PCS activities are consistent with the PEPFAR goal of scaling up capacity to provide OI drugs, care and support services and lab support to serve more HIV+ children. APIN will continue to support the expansion of PCS services into more local areas by developing a network model. These networks will ensure that facilities are able to develop linkages, which permit patient referral from primary health centers and the provision of specialty care support. A tiered structure for OI drug, other commodities

provision and monitoring established through Harvard provides a model for additional expansion efforts in COP09 in order to meet PEPFAR treatment goals. In addition, pediatric care and support services will be provided to HIV+ children and PABA for a total of people served. The program will also contribute to strengthening human capacity through training of health workers, community workers and HIV+ children and their families.

Additionally, as part of our sustainability building efforts, APIN will receive technical assistance and support from Harvard to assume program management responsibility for the PCS activities. This will include the implementation of a plan to transition site oversight, management and training over to APIN. The goal of such efforts is to provide for greater assumption of responsibility for management and implementation of PEPFAR programming by Nigerian nationals through an indigenous organization.

LINKS TO OTHER ACTIVITIES
This activity is linked to OI drugs (HTXD), OVC (HKID), TB/HIV (HVTB), to provide OI to patients with TB, Lab (HLAB) to provide OI diagnostics, HCT (HVCT) as an entry point to ART, and SI (HVSI) will provide the GON with crucial information for use in the evaluation of the National ARV program This program is linked to PMTCT services to optimize the follow-up on children that become HIV-infected through their mothers. By training local personnel, we are also contributing to the program area of Human Capacity Development (HCD). With our focus on helping young girls, we also contribute to the Gender program area.

POPULATIONS BEING TARGETED
The care and support components of these activities target HIV+ children for care, monitoring and provision of OI drugs. The operational elements of these activities (M&E, health personnel training, infrastructural supports, technical assistance and quality assurance) target public and private program managers, doctors, nurses, pharmacists and lab workers at PEPFAR sites. The expansion of care and support services to primary and secondary health facilities will increase access to underserved areas.

EMPHASIS AREAS
APIN's major emphasis is on strengthening capacity of health care workers to provide high quality PCS services. Emphasis will be on child survival wrap-around programming, through the provision of clean water kits, growth monitoring, immunization nutritional supports, treatment of OIs and other illnesses, and counseling for caregivers on hygiene and nutrition for HIV-infected children.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | PDTX | 401,302 | |

**Narrative:**

ACTIVITY UNCHANGED FROM F2009

NARRATIVE:
During COP09, APIN assumed management responsibility for 2 Harvard sites (LUTH and NIMR), in addition to the initial 4 sites - Sacred Heart Catholic Hospital in Lantoro, Ogun State and Primary Health Center-Iru on Victoria Island, Lagos, Mushin General Hospital, Onikan General Hospital, 43 UCH Oyo State DOT Centers. APIN will maintain a strong collaboration with Harvard University.
In COP09 APIN provided comprehensive pediatric treatment (PT) services in 5 comprehensive ART sites (2 tertiary and 3 secondary facilities); located in two states of Lagos and Ogun. This will provide ART services to a total of 1200 ART eligible children at the end of the reporting period. (This includes 200 new and 1000 maintenance) ART ineligible children are referred for care and support. .

Patients are identified through PMTCT and HCT services, including facility-based, mobile, and family-centered strategies. Through linkages with PMTCT services and pediatric wards at our sites, early infant diagnosis (EID) is performed for children <18 months utilizing Dried Blood Spot (DBS) at secondary and primary sites for transportation to 2 tertiary sites where DNA PCR are carried out.

Any pediatric patient presenting with acute history of sexual assault will be provided with post-exposure prophylaxis, investigations and psychosocial counseling services and monitored according to national guidelines.
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All HIV-positive children are clinically pre-assessed for ART eligibility. ART-eligible children are provided with ART services, in accordance with a standardized programmatic protocol, which follows the Current National ART Guidelines. HIV+ children are provided with cotrimoxazole prophylaxis according to national guidelines. Diagnostics for common opportunistic infections (OIs) may include: Candida albicans, protozoal infections, and gastrointestinal parasites. All HIV+ children are also symptomatically screened for TB using laboratory and radiological diagnostics as indicated. APIN through Harvard support will provide education on risk reduction interventions
APIN uses the hub and spoke model of treatment for better service delivery to the primary and secondary health centers.

ART eligible children will be followed periodically with scheduled clinic visits as follows - 3, 6, 9 and 12 months and every 6 months, patients pick up drugs monthly. At each visit, clinical exams, hematology, chemistry, viral load and CD4% enumeration are performed. All tertiary and secondary site labs perform the necessary lab assays. Secondary and primary sites with limited lab capability send samples to an affiliated tertiary site. Electronic clinic and lab records provide data for high quality patient treatment and

centrally coordinated program monitoring. As additional medical needs are identified patients will be provided clinical services by clinicians or referred for specialty care as necessary. HIV+ children will be provided ARVs including cotrimoxazole prophylaxis according to national guidelines and referrals for immunization, growth monitoring and other child survival services. All HIV+ children will also be symptomatically screened for TB using Tuberculin Skin Test (TST), laboratory and radiological diagnostic methods as indicated. All HIV+ children on treatment are linked into the system of OVC services in order to ensure a continuum of care. The Loss to Follow Up (LTFU) utility will help in picking up children on treatment that might have defaulted. The list generated is sent to the tracking team to initiate a process of tracking. During COP09, APIN will collaborate with Harvard, SCMS for the procurement and distribution of specified pediatric ARVs and OI drugs.

Caregivers are also encouraged to seek out HCT and refer other family members for HCT. Caregivers of HIV+ children are provided ART education and adherence counseling (EAC) prior to and during ART provision, which follows the National Curriculum for Adherence Counseling.

When ART patients miss scheduled clinic visits or bed-ridden clients are referred to the community HBC and tracking teams, to provide follow-up accordingly.

All sites focus on the integration of Pediatric treatment (PT) services regardless of the source of funding for different components of treatment (e.g., external funding sources for services or lab commodities). At each site, support is provided for the management of electronic data and patient medical records for use in the provision quality treatment. TB diagnosis and treatment is provided to all patients via facility co-location of DOTS centers and/or referral of HIV+ patients into ART from DOTS sites. HIV+ patients identified through HCT conducted for all TB patients at DOTS sites will be referred to PT services.

Clinical staff at APIN and Harvard sites meets monthly for updates and training. As clinical training needs are identified for new sites or new staff at existing sites, Harvard support training on relevant topics including regimen switching. In COP08, Harvard incorporated standardized quality indicators into a comprehensive Quality Improvement (QI) Plan for the sites, which includes periodic external site assessments and chart reviews as well as quarterly internal reviews, based on electronic databases. APIN will support the training of 106 health workers including PHC, HCWs to provide treatment to1200 ART eligible HIV-infected children by the end of COP10. REDACTED.
For pediatric patients enrolled through the GON ART Program, we anticipate GON provision of 1st-line ARV drugs and PEPFAR support for PT services. As patients require alternative or 2nd-line drugs, patients will receive PEPFAR-provided drugs. GON provision of 1st-line drugs allows for additional PT targets. APIN estimates that additional children will be placed on ART through the leveraging of GON drugs. APIN will partner with Harvard and Clinton Foundation as appropriate to leverage resources for

providing ARVs to patients. The site investigators and project managers will actively participate in the GON pediatric ART program. Harmonization of data collection for M&E will be coordinated with USG and GON efforts. APIN has provided technical assistance and training expertise to the National pediatric treatment training program, which will continue in COP10. APIN will support the development of the National Pediatric treatment Guideline and Training curriculum.

APIN will also fully support the training of doctors, nurses, counselors and lab scientists working at GON and GF supported sites in early infant diagnosis techniques. A total of106 health care and non-health care workers will be trained in PT services in line with the National Pediatric Treatment Guidelines and Training Curricula.

In addition, the program will identify, collaborate with and strengthen the capacities of clinicians, nurses, pharmacist, to deliver quality pediatric treatment at all sites. APIN will provide referrals for TB, wraparound services and child survival programs as appropriate.

CONTRIBUTION TO PROGRAM

PT activities are consistent with the PEPFAR goal of scaling up capacity to provide ARV drugs, and lab support to serve more HIV+ children. APIN will continue to support the expansion of PT services into more local areas by developing a network model. These networks will ensure that facilities are able to develop linkages, which permit patient referral from primary health centers and the provision of specialty treatment. A tiered structure for ARV provision and monitoring established through APIN provides a model for additional expansion efforts in COP09 in order to meet PEPFAR treatment goals. The program will also contribute to strengthening human capacity through training of health workers, community workers and HIV+ children and their families.

Additionally, as part of our sustainability building efforts, APIN will receive technical assistance and support from Harvard to assume program management responsibility for patient treatment. This will include the implementation of a plan to transition site oversight, management and training over to APIN. The goal of such efforts is to provide for greater assumption of responsibility for management and implementation of PEPFAR programming by Nigerian nationals through an indigenous organization.

LINKS TO OTHER ACTIVITIES

This activity is linked to ART drugs (HTXD), OVC (HKID), TB/HIV (HVTB), to provide ART to patients with TB, Lab (HLAB) to provide ART diagnostics, HCT (HVCT) as an entry point to ART and SI (HVSI) will provide the GON with crucial information for use in the evaluation of the National ARV program and recommended drug regimens. This program is linked to PMTCT services to optimize the follow-up on children that become HIV-infected through their mothers. By training local personnel, we are also

contributing to the program area of Human Capacity Development (HCD). With our focus on helping young girls, we also contribute to the Gender program area.

POPULATIONS BEING TARGETED
The treatment components of these activities target HIV+ children for clinical monitoring and treatment. The operational elements of these activities (M&E, health personnel training, infrastructural supports, technical assistance and quality assurance) target public and private program managers, doctors, nurses, pharmacists and lab workers at PEPFAR sites. The expansion of ART services to primary and secondary health facilities will increase access to underserved areas.

EMPHASIS AREAS
APIN's major emphasis is on strengthening capacity of health care workers to provide high quality PT services. Minor emphasis will be on child survival wrap-around programming, through the provision of clean water kits, growth monitoring, immunization nutritional supports, treatment of OIs and other illnesses, and counseling for caregivers on hygiene and nutrition for HIV-infected children.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Other | HVSI | 495,818 | |

**Narrative:**

ACTIVITY UNCHANGED FROM F2009

NARRATIVE:
During COP09, APIN assumed management responsibility for 2 Harvard sites (LUTH and NIMR), in addition to the initial 4 sites - Sacred Heart Catholic Hospital in Lantoro, Ogun State and Primary Health Center-Iru on Victoria Island, Lagos, Mushin General Hospital, Onikan General Hospital, 43 UCH Oyo State DOT Centers.

In COP10, APIN will provide support for SI activities at the 6 treatment sites (2 tertiary care, 3 secondary sites, 1 PHC) and 43 DOT sites.

The activities include: data management and data quality assurance, monitoring and evaluation (M&E), health management information systems (HMIS) and operational research studies in all supported sites. Funds will also be utilized to continue building the capacity of site staff in the above areas in order to promote effective use of data to improve services and programs and to influence policy. In addition, a major goal in the coming year is to further achieve sustainability. APIN will receive technical assistance

from Harvard in the area of data management. APIN staff includes a database specialist, IT specialist, an M&E Officer and an M&E Consultant, who will assist the sites with on-site clinical, pharmacy, laboratory and project reporting. In line with the PEPFAR-Nigeria indigenous capacity-building strategy, APIN in collaboration with Harvard will strengthen local capacity at primary, secondary and tertiary health facilities. A major goal of our activities this coming year is to further: 1) build M&E capacity at the local level; 2) promote increased utilization of data in evidence-based decision making; 3) evaluation of clinical outcomes and intervention efforts; 4) evaluation of program outcomes.

The APIN program will utilize a relational database system developed through Harvard PEPFAR. The database is linked by a unique patient ID number and contains data required for patient management and monitoring (PMM). The electronic database is functional and fully harmonized with the GON PMM forms to allow for full integration into the broader Nigerian national health information systems in order to strengthen the Third One: One National M&E system. The APIN/Harvard forms collect clinical visit, pharmacy pick-up, laboratory assessment, toxicity, virological/immunological failure and discontinuation information for adult and pediatric care and treatment as well as PMTCT services. APIN will collaborate with Harvard to develop electronic databases to capture OVC services; these databases will be fully harmonized with the GON forms. APIN will use the utilities developed through Harvard to maximize the efficient use of data for improved patient management, data quality, reporting, and program management. This includes a treatment response utility, which provides a graphical display of patients' CD4 counts, viral loads, and drug pick-up history, as well as a loss to follow-up utility, which serves as an early warning system for patients that miss drug pick-ups. Information is generated and used for site and program-specific evaluation of services, such as assessment of CD4 counts, viral load, adherence, and loss to follow-up.

APIN will continue to maintain computer hardware and software provided by Harvard to support sites as services are being maintained. SOPs are in place to govern data entry, security, management and reporting based on the ARV treatment and care protocol. Refinement of instruments and databases is ongoing to accommodate program reporting requirements from Harvard, USG and the GON. The PMM forms are stored in the patient hospital folders and kept in locked file cabinets or locked rooms. National registers are also in use at APIN-supported sites. Data from PMM forms and registers are entered into the databases by trained data entry staff at the respective sites. The data are then uploaded to a password protected web server, accessible to authorized personnel and data managers at the Nigerian sites and at Harvard. Data managers prepare timely reports for GON and USG using the electronic databases and the web-based portal for data reporting: LHPMIP, where feasible i.e. electronic database system is in place. . Facility-based data are reported using harmonized national reporting system. The Boston and Nigerian data management team and the M&E officer provide regular feedback on data collected and on reports to the sites. Site M&E committees are in place to implement an annual M&E

plan; M&E results are fed back to the sites to promote systems improvement. APIN+ will facilitate good working relationships with state level M&E committees and staff and will regularly communicate on monitoring activities, thereby encouraging their active involvement. This involvement will build the capacity of the state-level staff and promote sustainability. The APIN SI team will continue to participate actively in the National M&E technical workgroup (TWG) and the USG-Nigeria SI TWG and respond to the goals of the one national reporting system.

In COP10, APIN will scale up the QI activities to all the APIN sites, building on the Harvard supported internal quality improvement (QI) initiative, designed at collecting qualitative and quantitative data regarding indicators on the provision of adult, pediatric and PMTCT services at each site. In order to continually improve and monitor data quality, each site will be visited regularly by APIN M&E staff throughout COP10; on-site TA and supportive supervision will be provided. Regular inter-site interactions will be encouraged, facilitated by APIN+/Harvard personnel. In COP09, all supported sites constituted M&E committees; these committees meet to evaluate the site M&E data and use the information towards improving quality of care and making evidence-based clinical decisions. In COP10, sites will work on fully developing QA/QI committees to conduct quarterly reviews of quality of care. During COP10, we will continue to encourage and monitor the activities of the site M&E and QA/QI teams. We are also working on developing a database utility that will allow the sites to quickly pull out data on patients that are lost to follow-up, showing signs of toxicity or failure, or that may require other focused attention, to further improve quality of care. Finally, HIVQUAL using additional QI indicators is being implemented in six selected APIN supported sites.

In COP10, 161 individuals will be trained in database management, monitoring and evaluation (M&E), surveillance, and HMIS. The trainees will include staff from the state and LGA institutions. The APIN central office will conduct 10 training sessions centrally. In addition, regional data management trainings for personnel working with medical records and patient data will be conducted on a regular basis. Data management and M&E modules are incorporated into respective technical training for other disciplines such as clinicians, nurses, pharmacists and laboratory staff etc.

EMPHASIS AREAS:
These activities emphasize monitoring, evaluation, and reporting through data collection, data analysis, data use and data dissemination. Emphasis is placed on strategic information, human capacity development and local organization capacity-building.

This activity will highlight gender issues by providing gender disaggregated data on patients accessing HIV/AIDS related services. Through this analysis, we will be able to contribute to national surveillance on utilization of HIV services and impact of HIV intervention on both sexes. This data will be essential to the

development of outreach, treatment programs and education to reach an equitable number of men and women.

TARGETED POPULATIONS:
The SI activities target program managers and M&E officers, site coordinators and principal investigators to provide them with skills and tools for programmatic evaluation. The data collection and management components of these activities target medical record staff, data staff, and other health care workers who are involved in the implementation of these processes. Lastly, the M&E and capacity-building efforts target implementing organizations, including private, community-based and faith-based organizations involved in the provision of ART, HCT, pediatric and adult BC&S, TB/HIV and PMTCT services.

CONTRIBUTIONS:
SI activities supported by APIN are consistent with the PEPFAR goals to build indigenous capacity-building in the area of SI. APIN SI activities are consistent with these goals in that funding will be used to strengthen local capacity in the area of database management, data analysis, data use, M&E and QA/QI. APIN will also provide SI support to its local administrative office, central pharmacy and warehouse.

LINKS TO OTHER ACTIVITIES:
These activities are linked to PMTCT (MTCT), OVC (HKID), TB/HIV (HVTB), HCT (HVCT), ART (HTTX and PDTX), and Basic Care & Support Services (HBHC and PDCS), where SI (HVAI) is used for M&E and QA/QI. In M&E activities, APIN will link to the National M&E TWG and Nigeria MEMS. Additionally, through the provision of IT support and data management personnel, APIN will provide linkages between all supported sites as related to data sharing and HIV surveillance in PEPFAR program areas. Through operational research studies, APIN will collaborate with Harvard, the FMOH, GON, NNART committee and the NIAID/NIH.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HMIN | 9,204 | |

**Narrative:**

In COP10, as a part of the PEPFAR Nigeria effort to diversify it's portfolio of local partners, APIN will assume responsibility for five sites providing injection safety services currently supported by Harvard University. This shift is congruent with the plan to transition an increasing amount of Harvard-supported sites to APIN, Ltd. Injection safety activities carried out at these sites will be a continuation of ongoing activities currently supported by Harvard and described in their COP09 activity narrative.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Prevention | HVAB | 60,819 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVOP | 284,955 | |

**Narrative:**

ACTIVITY UNCHANGED FROM F2009

NARRATIVE:
During COP09, APIN assumed management responsibility for 2 Harvard sites (LUTH and NIMR), in addition to the initial 4 sites - Sacred Heart Catholic Hospital in Lantoro, Ogun State and Primary Health Center-Iru on Victoria Island, Lagos, Mushin General Hospital, Onikan General Hospital and 43 UCH Oyo state DOT Centers. In COP10, APIN will continue Other prevention programming activities at all 6 sites in line with the overall PEPFAR Nigeria goal of providing a comprehensive package of prevention services to individuals reached with condoms and other prevention (HVOP). APIN will assist PEPFAR Nigeria in extending its reach of condom and prevention services as APIN is presently active in 3 states. Through its other program areas, APIN has a large population of HIV-positive adults, adolescents and children to which it is already providing services; this group forms part of the core target population for age appropriate messaging that is provided by APIN through its prevention with positives (PwP) activities including STI screening and management, condom provision, sexual risk reduction, disclosure, adherence, reduction of alcohol consumption, and testing of sex partners and children in the HIV clinic setting.. In addition, APIN will target activities to HIV-negative persons in its catchment areas in order to minimize their risk behaviors and contribute to an overall reduction in HIV prevalence.

In COP10, APIN will implement COP activities at both the facility and community levels utilizing the minimum prevention package strategy as contained in the National Prevention Plan. This package includes: 1) community outreach campaigns including CT, condom messaging and distribution and balanced messaging; 2) Infection control Measures in clinical setting including universal precaution and post exposture prophylaxis; 3) Prevention with Positives; and, 4) STI management/treatment. The goal of the program is to focus on targeted communities and saturate those communities with messages conveyed in multiple fora. Utilizing such a methodology, a large number of people will be reached with messages received via one method or another, but the target group will be those individuals that will have received HVOP messaging: (1) on a regular basis; and, (2) via at least 3 of the 4 strategies employed by APIN.

APIN sites will target Most At Risk Populations (MARPs), including outpatient STI patients, border traders, fashion designers, young male market agents, and motor mechanics. APIN's HCT site at PHC-Iru on Victoria Island serves the Kuramo area, a community with a large number of MARPs where most residents are sex and bar workers, and have a HIV prevalence greater than 60%. Prevention activities at these clinics provide educational materials based on the risks that this population faces and distribute condoms. In addition to comprehensive counseling on HIV prevention and risk reduction, HIV-infected individuals identified through this activity will be referred for palliative care and evaluation for ART eligibility. An emphasis on men with high-risk behaviors through these community-based efforts will also enhance prevention efforts and facilitate access to their partners.

A focus of the program in COP10 will be continued improvement of the integration of prevention activities into the HIV care and treatment settings; specifically, healthcare providers and lay counselors in care and treatment settings will be trained to appropriately deliver integrated ABC prevention messages and incorporate the messages into routine clinic visits using IEC materials and job aids. An appropriate balance of ABC will be tailored to the needs and social situation of each individual client in its presentation. In addition to the integration of such services into the HIV-specific treatment setting, prevention activities will be assimilated into other points of service in each health facility (general outpatient clinics, emergency services, etc.), particularly into reproductive health services including, family planning counseling, STI management and counseling, and risk-reduction counseling.

This funding will also be used to support the procurement and distribution of written prevention messages and condoms. The materials will provide patients and clients with HIV prevention information using the "ABC" model, including information about healthy behaviors, safer sexual practices, PMTCT, and condom usage.  Prevention messages will also include information about other STIs. Condoms will be offered to all individuals at all sites and will be provided to APIN by the Society for Family Health (SFH).

The target for Condom and other prevention) is 7197 individuals. Additional staffing and training of counselors will also be provided by this funding, including a dedicated full-time staff person. This activity will provide support for training of 99 individuals in condom promotion, STD prevention and risk reduction.

EMPHASIS AREAS
ABC programming emphasizes local organization capacity building, human capacity development and efforts to increase gender equity in HIV/AIDS programs. These activities also promote a rights-based approach to prevention among positives and other vulnerable members of society and equal access to information and services. Reduction of stigma and discrimination are also key to the program. Through ABC activities, we place major emphasis on community mobilization and participation, as an element of

outreach for prevention efforts. Additionally, we place major emphasis on training as well as infrastructure and human resources in order to build the capacity of counselors and providers in a full range of prevention strategies. We also reinforce that information, education and communication are essential elements of outreach to high-risk populations, and that developing networks for linking these activities to HCT, PMTCT, and other ART activities serve as a source of prevention information.

These activities address gender equity issues by providing equal access to prevention services for men and women. In some cases, our activities seek to target men who may be at high risk for HIV in order to promote condom use as a means of prevention and access to services for their sexual partners. Male-targeted counseling seeks to address male norms and behaviors in order to encourage safer sexual practices. Strong prevention programs that accommodate the array of societal and cultural norms can also help reduce stigma and discrimination. The provision of such services at the community level will serve as an important platform from which general HIV/AIDS information can be provided and risk reduction strategies discussed.

POPULATIONS TARGETED:
Key populations targeted are the healthcare community in treatment facilities, PLWHA, youths and adults accessing HCT services at either static or mobile within catchment areas of the treatment sites, high-risk populations, support group members and immediate families of PLWHA. Other target populations include discordant couples, pregnant women and religious leaders. Targeting these populations is important to encourage safe sexual practices, HCT and other prevention measures. Health care workers will also be targeted for training on the most effective prevention measures for various risk groups.

CONTRIBUTION TO OVERALL PROGRAM AREA
These prevention activities are consistent with PEPFAR's goals for Nigeria, which aim to support a number of prevention strategies as a comprehensive prevention package. In order to be maximally effective, the prevention messages developed at different sites will be tightly targeted to various high-risk groups that they serve. Furthermore, these activities are consistent with the PEPFAR 5-year strategy, which seeks to scale-up prevention services, build capacity for long-term prevention programs, and encourage testing and targeted outreach to high-risk populations. The establishment of networks and referral systems from prevention efforts at the community level to PMTCT and HIV care and treatment will help facilitate the scale-up of the overall program.
LINKS TO OTHER ACTIVITIES:
ABC activities relate to HCT, by increasing awareness of HIV. They also relate to adult and pediatric care and support (HBHC and PDCS) activities through dissemination of information by home-based care providers and ultimately by decreasing demand on care services through decreased prevalence. Linkages also exist to OVC programming (HKID) by targeting OVC. The provision of such services at the

community level will serve as an important platform from which general HIV/AIDS information can be provided and risk reduction strategies discussed. This program area also links to SI (HVSI) as all progress will be monitored by the SI programming and to Gender as specific programs will be targeted to be gender-appropriate.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | MTCT | 591,846 | |

**Narrative:**

ACTIVITY UNCHANGED FROM F2009

NARRATIVE:
During COP09, APIN assumed management responsibility for 2 Harvard sites (LUTH and NIMR), in addition to the initial 4 sites - Sacred Heart Catholic Hospital in Lantoro, Ogun State and Primary Health Center-Iru on Victoria Island, Lagos, Mushin General Hospital, Onikan General Hospital, 43 UCH Oyo State DOT Centers.

COP10 funding will support a comprehensive PMTCT program in line with the revised National PMTCT Guidelines (2007), at 6 service outlets in 3 states (Lagos, Oyo and Ogun ). This consists of 2 tertiary, 3 secondary and 1 PHC sites. "Opt-out" testing and counseling with same-day test results will be provided to all pregnant women presenting for antenatal care (ANC), labor and delivery (L&D). The current level of PMTCT counseling and testing uptake from women presenting for ANC or L&D is 90%. All women are provided post-test counseling services on prevention of HIV infection, including the risks of MTCT. They are encouraged to bring partners and family members for on-site HCT. The program has a target of providing HCT with 14200 receiving results. PMTCT prophylaxis will be provided to approximately 852 women in line with the national guidelines. In addition, APIN will provide basic care and ARV prophylaxis to 852 HIV-exposed infants. Infant follow-up care linked with PMTCT activities includes nutritional counseling and support, growth monitoring, co-trimoxazole prophylaxis and other preventative care services. EID will be carried out using whole blood at the tertiary and DBS at the secondary and primary level in line with the national EID scale up plan.

Through this program area, APIN will provide linkages to other prevention, care and treatment services. All ART-ineligible women will be placed on zidovudine from 28 weeks, zidovudine and lamivudine from 34/36 weeks until delivery and will be enrolled into care and support services (HBHC) at the time they access MTCT services. Following delivery, mothers will be monitored in the HBHC program, where services include on-site enrollment or referrals for family planning and other reproductive health services. In addition, PMTCT services are integrated into a system of maternal and child services designed to

promote maternal and child health. All ART-eligible pregnant women will be provided with ART through the adult treatment (HTXS) program area in line with National guidelines. Children who become HIV-infected during the time they are being monitored as part of the MTCT program will be linked to the pediatric treatment (PDTX) and care programs (PDCS). Those HIV-exposed children placed on single dose nevirapine at birth and zidovudine for 6 weeks remain uninfected at 18-months following the completion of ARV prophylaxis will be linked to the OVC program (HKID) for continued care services.

Counseling on infant feeding options occurs during the antenatal period, at L&D, and throughout infant follow-up is done according to the National PMTCT and Infant Feeding Guidelines. Infant feeding counseling will be performed in an unbiased manner and women will be supported in their choice of method. Clients will also be counseled on the beneficial effect of couple/partner HCT/disclosure on adherence to infant feeding choice. A follow-up team consisting of counselors and a home-based care (HBC) support group of PLWHAs will assist in home and community tracking of positive mothers to provide nutritional support and ascertain infant diagnosis. This funding will support the ANC, labs, ARV prophylaxis intervention to mothers and babies (not ART), and training of personnel involved in PMTCT.

A regular training program will be established at all sites to train and retrain health personnel involved in the PMTCT program using the National PMTCT Guidelines. Non laboratory personnel will also be trained in HIV testing. Indirect targets include training traditional birth attendants (TBAs) using an adapted curriculum in local areas, also include PMTCT counseling, training PMTCT counselors in the National PMTCT Program, providing technical assistance for the development of the National Infant Feeding Counseling Manual, and providing a zonal training of trainers with this manual

During COP10, APIN will scale up the Harvard initiated QA/QI activities to the APIN-supported PMTCT sites. The program will also continue to monitor and utilize electronic data captured through SI activities to measure the quality of services provided as well as the associated patient outcomes.

APIN will partner with Harvard and other implementing partners (IPs) in the implementation of the PEPFAR-Nigeria local government area (LGA) coverage strategy in the program areas of PMTCT, OVC and TB/HIV, designed to ensure the provision of PMTCT and TB/HIV services in at least one health facility in Oyo state. Under the coverage strategy, these facilities are all linked with primary health facilities, which provide HCT and referrals for PMTCT services for HIV-infected mothers.

EMPHASIS AREAS
This activity will place major emphasis on the development of networks through expansion into more local areas through a network of secondary or primary PMTCT clinics, with rural outreach to community healthcare workers and TBAs involved in home delivery; all community workers and TBAs with whom we

work are linked to tertiary health care facilities. In addition, major emphasis will be placed on building organizational capacity in order to work towards sustainability of PMTCT centers. These system strengthening activities are led by local investigators at current PMTCT sites who participate in new site assessments, overseeing QA/QI, capacity development and training for new PMTCT centers. Minor emphasis is placed on performing targeted evaluations of PMTCT interventions, to estimate the rate of transmission with each of the ARV prophylaxis regimen used.

POPULATIONS BEING TARGETED

In addition to providing PMTCT services for pregnant women that know their HIV infection status, this program also targets women who may not know their HIV status and may be at greater risk for MTCT. Furthermore, it targets infants, who are most at risk of becoming infected from an HIV positive mother during the antepartum, intrapartum and postpartum periods. Through the HVCT program area, APIN seeks to target a broader group of adults by encouraging women to bring their partners and family members in for HCT. Furthermore, training activities will train public and private health care workers on the implementation of PMTCT protocols and HIV-related laboratory testing.

CONTRIBUTIONS TO OVERALL PROGRAM AREA

Through the PMTCT program, APIN will provide T&C with test results to 14200 pregnant women. Additionally, treatment and prophylaxis will be provided to 852 pregnant women. Implementation of the National PMTCT Guidelines in 6 sites contributes to the PEPFAR goal of expanding ART and PMTCT services. Counseling will encourage mothers to bring their partners and family members for testing, to reach discordant couples and expand the reach of HCT, based on the new PEPFAR 5-year strategy. This program is implemented in geographically networked sites to optimize training efforts and provide collaborative clinic/lab services as needed. APIN will train and retrain 111 health care personnel from the PMTCT sites, including doctors, nurses, pharmacists and counselors. Training will build capacity at local sites to implement PMTCT programs and provide essential treatment support to pregnant women with HIV/AIDS. Capacity building efforts are aimed at future expansions of PMTCT programs. QA/QI will be carried out through personnel training, data collection from sites for monitoring and evaluation and supervisory visits from key program management staff, which may include representatives from the USG and GON.

The program will increase gender equity by specifically targeting pregnant females for HCT and PMTCT prophylaxis and their male partners for HCT. Data collection on PMTCT regimens provides a basis for developing strategies to ensure that all pregnant women have access to needed and optimally effective PMTCT services. This program addresses stigma and male norms and behaviors through the encouragement of partner notification and bringing other family members in for HCT. Infant feeding counseling, including on the appropriate use of exclusive breastfeeding or exclusive use of breast milk

substitute (BMS) where AFASS is available, will be in line with the National PMTCT Guidelines. Referrals to income generating activities (IGAs) will also be provided to women as a part of palliative care and counseling activities.

LINKS TO OTHER ACTIVITIES
This activity is also linked to counseling and testing (HVCT), OVC (HKID), adult treatment (HTXS), pediatric treatment (PDTX), adult care and support (HBHC), sexual prevention (HVAB, HVOP), biomedical prevention (HMBL, HMIN), SI (HVSI), health capacity development (HCD), and gender. Pregnant women who present for HCT services will be provided with information about the PMTCT program and referred to the PMTCT program if they are eligible for these services. ART services for HIV-infected infants and mothers will be provided through adult and pediatric treatment services. Basic pediatric care and support, including support for chosen feeding option and TB care, is provided for all infants and children through our OVC activities; all exposed infants identified through PMTCT services will be linked to these OVC services. Pregnant women are at high risk for requiring blood transfusion. Personnel involved in patient care will be trained in universal precautions as a part of injection safety activities. Additionally, these activities are linked to SI, which provides support for monitoring and evaluation of the PMTCT activities and QA/QI initiatives.

In COP10, under 'PEPFAR Nigeria's accelerated PMTCT plan', APIN, will strengthen its support to PMTCT service delivery by implementing activities that further improve the coverage and quality of PMTCT services. These activities will be directed towards increasing utilization of PMTCT services at existing service outlets through demand creation in collaboration with community resources and ensuring the upgrade of existing supported PHCs offering stand alone HIV counseling and testing to render at least minimal package of PMTCT services. In order to leverage resources, priority will be given to PHCs located in the selected focal states with presence of other donor agencies and in local government areas already earmarked for HSS support through GFATM. Where new sites are envisioned, those that are used for national ANC sero-sentinel surveys but yet to commence PMTCT services as well as PHCs located in communities with high HIV prevalence rates above the National average will be given priority.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HLAB | 1,565,577 | |

**Narrative:**

ACTIVITY UNCHANGED FROM F2009

NARRATIVE:

During COP09, APIN assumed management responsibility for 2 Harvard sites (LUTH and NIMR), in addition to the initial 4 sites - Sacred Heart Catholic Hospital in Lantoro, Ogun State and Primary Health Center-Iru on Victoria Island, Lagos, Mushin General Hospital, Onikan General Hospital, 43 UCH Oyo State DOT Centers.

In COP10, APIN will provide support for laboratory development at the 6 treatment sites (2 tertiary care, 3 secondary sites, 1 PHC) and 43 DOT sites. We also propose to add additional expansion sites by building the infrastructure and capacities of 2 labs in secondary health facilities in Lagos state to have capabilities for hematology, automated chemistry analyzers, and laser-based lymphocyte subset enumeration. In COP09, we expanded the capacity of 1 lab in a primary health facility in Lagos state. We also expanded the capacity of the lab at Sacred Heart Catholic Hospital, a secondary health facility in Ogun state, to have capabilities for hematology, automated chemistry analyzers, laser-based lymphocyte subset enumeration.

By the end of COP10, HIV rapid testing would be performed at the HCT centers with the labs providing supervisory roles. 3 ART sites will have western blot capacity to confirm HIV status prior to initiation of ART. HIV serology, hematology, chemistries, and CD4 enumeration will be supported at all secondary hospitals with referral to the tertiary labs for PCR diagnostics and viral loads. Primary health care facilities are closely partnered with secondary and tertiary care facilities, allowing for baseline and periodic evaluation with full lab monitoring. The primary facilities provide limited lab monitoring with basic clinical, hematologic and CD4 assays. We will screen for TB by sputum and/or pulmonary X-ray at all ART sites. We will also provide screening for STIs, including Syphilis and Chlamydia at all of our sites. Our 2 labs with infant PCR diagnostic capabilities (NIMR, LUTH) will continue to assist other PEPFAR IPs, using dried blood spots (DBS) to test transport specimens from distant satellite sites.

Standardized lab protocols were developed in previous COP years by Harvard to accompany the clinical protocols and computerized lab results are linked with patient records. In order to ensure continuity of care and services, these protocols will continue to be implemented at APIN sites. These protocols include provisions for the disposal of biomedical waste in accordance with good laboratory practices. Quality control/quality assurance (QA/QC) policies have been developed and detailed annual assessments of all lab activities are conducted. . In our pursuit to meet the expected quality requirements in compliance with the shift in focus from target to quality of service, APIN shall review and strengthen its existing QA/QC program and make it more aggressive. Preparatory for the WHO-AFRO accreditation exercise, APIN shall review its laboratory quality policy and guidelines to integrate the components of the WHO checklist into the existing laboratory quality system elements in our protocol. The reviewed quality policy and guidelines, alongside the PEPFAR Lab Technical Working Group (LTWG) harmonized monitoring tool, as well as the WHO checklist shall be used as the standard framework for laboratory audit and evaluation.

Internal quality assessment activities shall be enhanced with the site quality managers effectively empowered to perform daily QA monitoring; monthly site assessment visits shall be conducted by APIN lab team with technical support from Harvard, while management review meetings shall hold quarterly. . International EQA program for lab tests was established in COP07 by Harvard and is operational for CD4, HIV, HCV and HBV serology, chemistries, VL and HIV PCR diagnostics; through individual lab registration with UK-NEQAS and CAP. We intend to continue this with all APIN labs. APIN shall likewise effectively partner with the proposed national PEPFAR EQA centre in Zaria (with technical support from National Health Lab Services, South Africa) and actively participate in the national PEPFAR EQA scheme by enrolling all our supported labs. All PCR labs will participate in the CDC's DBS DNA PCR proficiency program (EID QA). We provide support for lab staff persons (based at sites), responsible for implementation of lab protocols, data entry and performance of lab tests.

APIN provide support for 3 APIN staff who provide technical assistance to sites. We will continue our efforts to increase our laboratory technical staff in order to address increased training and laboratory needs for the overall PEPFAR program. To further strengthen the capacity of the lab staff in line with the health system strengthening mandate, APIN shall review its training policy to provide for a more effective and regular lab training and retraining to allows for enhanced staff competence and the development of high quality lab standards in our PEPFAR labs. The trainings shall be networked to our secondary and primary labs with specific tailoring to the needs and skills at each level, and also based on the need to address identified deficiencies and non-conformities. In conjunction with Harvard Lab Infrastructure activities, staff at APIN sites will be linked to centralized and/or regional biannual trainings provided on specific techniques/topics integrating QA/QC, good lab practices and biosafety. On-site competency monitoring/evaluations and refresher trainings will be provided within individual labs. APIN shall continue to provides support for NIMR (Lagos) and UCH (Ibadan) which are both comprehensive hands-on training centers with lecture room capacity and personnel skilled in training. These training centers provide training in all areas, with special focus on viral load and drug resistance testing. As a result of encountered disruptions on testing activities during practicum training sessions in this centre, APIN plans to equip the training labs with dedicated equipment. PEP protocols have been implemented at each of our labs, supported under our ART drugs activities.

A laboratory information system (LIS) will be implemented at sites, with appropriate capabilities, to streamline the capture of lab data, minimize transcription errors and facilitate data entry and results output. With technical support from Harvard, using FileMaker Pro data software a program has been developed to support data generation, capturing and analysis. APIN shall continue to support for this system and ensure the provision of uninterrupted internet access at all labs, and continue in building the capacity of the lab data officers at all sites.

We will participate in the quarterly LTWG meetings to ensure harmonization with other IPs and the GON, including the development of a common lab equipment platform (appropriate for each lab level).

Procurement of lab reagents is structured in two ways. Reagents available in Nigeria will be procured directly by the sites from specific distributors. Labs will be advised to maintain a 3 month reagent buffer. Most reagents needing importation will be ordered by APIN and shipped to the APIN Central Medical Stores warehouse in Lagos. PEPFAR funding supports procurement of lab equipment, generators and water purifiers necessary for lab work at APIN sites. Equipment costs for labs can be high in the first year, but represents significant infrastructure development. REDACTED. APIN shall continue to provide service support for all equipment and ensure an effective implementation of an equipment management and maintenance policy. We shall continue to partner with equipment manufacturers and their in-country representatives/service vendors in the provision of equipment service support. Additional equipment shall be procured to provide additional back-up needs.

APIN will perform 254492 tests in COP10, including HIV diagnosis (47098) and tests for disease monitoring including CD4 (73944) enumeration, PCR diagnosis of infants (1200) and VL, which provide support for ARV treatment for 15600 adult and 1200 pediatric patients at APIN sites in Lagos, Oyo and Ogun states.  In addition, we seek to train199 lab staff members in COP10.

EMPHASIS AREAS:
This program is centered on laboratory system strengthening and human capacity development through training and retraining of lab personnel, provision of managerial, supervisory and technical support for sustainability. . Increased lab capacity will permit the sites to provide quality treatment for both women and men.  We also place emphasis on TB services as our lab activities include the provision of support for TB and HIV diagnostics at 43 TB DOTS sites in Oyo state.

POPULATIONS BEING TARGETED:
This program targets public and private health care workers with training to maintain high quality lab standards.  Laboratory diagnostics and monitoring supported through these activities also target PLWHAs who are provided with treatment through our Adult and Pediatric Care and Treatment activities.

CONTRIBUTION TO OVERALL PROGRAM AREA:
These activities contribute to the goal of maintaining high quality services as the PEPFAR program expands. Training lab staff will assist in building the human resource capacity of our sites to provide sustainable lab support to sites providing high quality HCT and ART treatment. Two labs at tertiary care hospital and research institute will have the capacity to perform early infant diagnosis (EID) by HIV DNA PCR. These labs are also linked to PMTCT sites, to provide a mechanism for EID as a part of the

PEPFAR supported national scale-up plan (consistent with 2009 PEPFAR objectives for Nigeria). APIN will partner with the Harvard, GON and Clinton Foundation for procurement of EID test kits and specimen collection supplies. The NIMR PCR lab will provide QA support for the EID program in the Southern half of Nigeria (through retesting). APIN shall continue to partner with FMOH in its plan to scale up the EID program and strengthen PMTCT services. Through a tiered system of labs at tertiary, secondary and primary sites we are able to ensure that patients at community based primary facilities are provided with a full complement of lab monitoring as a part of ART treatment and care. Our training activities include management and competency training, which seeks to build sustainability.

Additionally, as part of our sustainability building efforts, APIN will recieve technical assistance and support from Harvard to assume program management responsibility for our Lab Infrastructure activities. This will include the implementation of a plan to transition site oversight, management and training over to APIN. The goal of such efforts is to provide for greater assumption of responsibility for management and implementation of PEPFAR programming by Nigerian nationals through an indigenous organization.

LINKS TO OTHER ACTIVITIES:
These activities relate to activities in PMTCT (MTCT), Counseling & Testing (HVCT), Palliative Care TB/HIV (HVTB), Adult Care and Treatment (HTXS), Pediatric Care and Treatment (PDTX) and OVC (HKID). Our labs are crucial in providing adequate HIV diagnostics in PMTCT, HCT, OVC, Palliative care and ART services. Furthermore the lab provides other diagnostics such as OIs. As a part of this activity, we seek to build linkages between labs and our patient care sites in order to ensure that lab information is fed back into patient records for use in clinical care. Our SI (HVSI) activities provide support in M&E, including data management of testing results.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HTXD | 1,018,412 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HVTB | 606,943 | |

**Narrative:**

ACTIVITY UNCHANGED FROM F2009

NARRATIVE:

During COP09, APIN assumed management responsibility for 2 Harvard sites (LUTH and NIMR), in addition to the initial 4 sites - Sacred Heart Catholic Hospital in Lantoro, Ogun State and Primary Health Center-Iru on Victoria Island, Lagos, Mushin General Hospital, Onikan General Hospital, 43 UCH Oyo State DOT Centers. APIN will maintain a strong collaboration with Harvard University.

In COP10, APIN will provide support for TB/HIV services at the 6 treatment sites (2 tertiary care, 3 secondary sites, 1 PHC) and 43 DOT sites).

ACTIVITY DESCRIPTION:
In COP10, APIN sites will identify HIV infected patients through PMTCT, HCT centers and ART centers and hospitals and outreaches. These sites constitute a network of delivery points in 3 states (Lagos, Ogun and Oyo) and include 2 tertiary hospitals, 3 secondary hospitals, 1 PHC and 43 DOT centers. In COP10, APIN plans to execute a universal coverage strategy in Oyo state, by providing support for TB-HIV services in all state government supported DOTS centers throughout the state. This is an essential step toward universal access to TB/HIV services, and will focus on developing programming at the secondary and primary level. All HIV-infected individuals are clinically pre-assessed for eligibility for ART treatment; it is expected that 2500 HIV positive clients will be screened for TB in COP09. TB screening is conducted according to national guidelines. The15,600 new and maintenance patients already on ART will also be monitored for TB. All HIV infected women (852 from our 6 treatment sites) will be assessed for ART eligibility and screened for TB. The TB clinics at 2 of our sites are National TB centers offering the government DOTS program. At all of our associated DOTS clinics, we will implement HCT for 5,700 clients and suspects presenting to the DOTS center (4000 registered TB patients). In all, it is expected that 2500 TB/HIV co-infected patients will be identified and will receive treatment for TB and be linked to and APIN ART clinics for evaluation of eligibility for ART and provision of care and treatment.

The National Tuberculosis Reference Laboratory (NTRL) at NIMR will provide an important resource to APIN sites in strengthening their capacity for TB diagnosis and cross-training of health care workers in TB/HIV. The NTRL will provide screening for MDR-TB. TB services provided at these clinics will be integrated with ART services and HCT in order to promote the development of a comprehensive system of care for individuals with HIV/TB co-infection. This will be part of the 148 health care workers in both HIV and TB clinical and laboratory settings to be trained in COP09. APIN TB/HIV program officers and facility staff will be provided with formal TB/HIV training to enhance their productivity, including retraining on x-ray diagnostic skills and co-management of TB/HIV for clinicians; and retraining on good sputum specimen collection and laboratory AFB sputum smear diagnosis for laboratorians. There will also be training on TB infection control and HCT. A dedicated TB program officer provides TB expertise to all Harvard and APIN sites and is responsible for training efforts and reporting of TB patients to the NTPLCP.

APIN will implement the global 3 "I"s strategy in COP10 through intensified TB case finding amongst HIV positive patients and close contact of TB patients, TB infection control in all our sites and INH Prophylaxis Therapy (IPT). APIN will prevent nosocomial transmission of TB to HIV+ patients through such measures and principles such as basic hygiene, proper sputum disposal, and good cross ventilation at clinics. Facility co-location of TB/HIV services is preferred to clinic co-location. The national guidelines on TB infection control will be implemented in all sites. Patient and staff education on infection control measures will be routinely carried out to ensure program success. APIN will upgrade facilities as needed through infrastructure support such as basic renovations and space modification to ensure effective infection control, upgrading equipment and procuring supplies and consumables (e.g. sputum containers).

To date, more than 30% of APIN+ clinic attendees present with pulmonary tuberculosis. TB/HIV Co-infected patients will be treated following National guidelines. All co-infected patients will receive cotrimoxazole prophylaxis (CPT). INH prophylactic therapy (IPT) will be provided on a case by case basis through the ART clinics following national guidelines. The TB DOTS sites will be supported to provide holistic patient care according to National and IMAI guidelines. Cross-referrals and linkages between TB and HIV programs will be strengthened.

APIN home-based care providers will track family members and contacts of TB patients who are at risk of developing TB and get them screened for TB, as well as HIV. This will result in higher TB case detection and increased HCT uptake. They will also track treatment defaulters and provide adherence support for TB and ARV drugs. Site support groups will be involved in community mobilization and will include TB education in their outreach messages.

At NIMR, APIN will provide technical assistance in the implementation of MDR-TB and XDR-TB surveillance activities in Nigeria. TB diagnostic capacity will include culture, PCR, and sequencing for resistance testing.

In COP10, APIN will work with 43 DOTS centers in all LGAs of Oyo state. These DOTS centers will be linked with two tertiary care sites for specialty care. At each DOTS center, we will provide HCT for TB patients and support the provision of broad HIV/TB services for all patients served, including referrals to ART centers for patients identified as HIV infected. To ensure continuous availability of drugs and commodities in supported sites, APIN will partner with Harvard and the USG PEPFAR team to strengthen logistics management within the states where it works.

EMPHASIS AREAS:
Emphasis areas include gender, health-related wrap around activities. This activity will increase gender

equity by focusing on strategies which seek to reach an equitable number of co-infected men and women. Furthermore, it seeks to provide additional focus on support for pregnant women who have TB/HIV. Through data collection and patient surveillance from this activity, APIN will be able to show the breakdown of men and women who are accessing TB diagnostics and treatment services. Outreach activities and patient counseling also seek to address stigma and discrimination and increase access to information, education and TB diagnosis and treatment for women and girls with HIV. In addition, we will focus on providing linkages to wrap around services for TB, which will focus on MDR-TB detection and treatment. Focus will also be places on intensified case detection through developing linkages with community based health care facilities to build capacity for TB screening.

POPULATIONS BEING TARGETED:
This activity targets adults and children with HIV and TB co-infection by providing a mechanism for critically important TB diagnosis and treatment both prior to the initiation of ART and also during the course of ART therapy. Newly enrolling ART patients will be prescreened for TB in COP09 and TB that develops in patients that are currently on ART therapy will be diagnosed and treated. All HIV infected pregnant women participating in APIN PMTCT programs will also be eligible for TB diagnosis and treatment under this program. TB patients/suspects at DOTS clinics will be screened for HIV. Their family members and contacts will also be targeted for TB and HIV screening.

CONTRIBUTION TO OVERALL PROGRAM:
The provision of TB diagnostics and treatment within participating ART facilities is consistent with the PEPFAR goal of ensuring that all facilities offering ART develop the ability to diagnose TB and provide support to DOTS sites within their facility. There will a deliberate attempt to locate HCT services within DOTS centers so as to increase detection of co-infected TB/HIV patients. At these facilities, APIN estimates that it will provide clinical treatment for TB to 2825 patients with HIV/TB co-infection either prior to or during their ART therapy, thus contributing significantly to the 2009 PEPFAR goals. At all APIN sites referral to co-located or near by DOT centers will be provided. The provision of TB diagnosis and treatment, infrastructure building and health care personnel training under this program will work towards building and maintaining Nigerian National tuberculosis treatment capacity, which is consistent with the PEPFAR 5-year strategy.

Additionally, as part of our sustainability building efforts, APIN will receive technical assistance and support from Harvard to assume program management responsibility for the TB/HIV Activities. This will include the implementation of a plan to transition site oversight, management and training over to APIN. The goal of such efforts is to provide for greater assumption of responsibility for management and implementation of PEPFAR programming by Nigerian nationals through an indigenous organization.

| |
|---|
| LINKS TO OTHER ACTIVITIES:<br>This activity also relates to activities in HCT (HVCT), Adult Care and Treatment (HTXS), Pediatric Care and Treatment (PDTX), PMTCT (MTCT) and OVC (HKID). Through this activity linkages between participating treatment sites and the National Tuberculosis Reference Laboratory will be provided. Additionally, linkages to potential patient populations through outreach initiatives, HCT activities, and ART services will improve utilization of care opportunities created through PEPFAR funding. This activity is linked to care and support and ART services because TB diagnosis and treatment are provided as a part of patient basic care and support at sites which also provide ART. A high TB co-infection rate has a major impact on ART management. |

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 10115** | **Mechanism Name: HHS/CDC Track 2.0 URC** |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: University Research Corporation, LLC | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 1,764,192** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 1,764,192 |

## Sub Partner Name(s)

| | | |
|---|---|---|
| Crown Agents | Vision Africa | |

## Overview Narrative

In COP 10 URC will continue to consolidate the gains made in COP 09. Enugu state ,with a prevalence rate of 5.8% is 12th overall in Nigeria and 1st in the states in the South East geopolitical zone(source: NHSS: 2008), is the recognized capital of the South East, remains an important commercial, cultural and transport hub.

Within the state there continue to be pockets of higher incidence both geographically and within most at risk populations. Achi joint in Oji River has a prevalence of 12.7% according to antenatal sentinel surveillance and is one of our key intervention regions. URC recognizes the shift in PEPFAR II from an emergency response to one of consolidating gains and building local capacity. Capacity building will focus on the community health facility, local government and the State. To this end we will continue to favour a more targeted approach that maximizes the effective and efficient use of resources. This will primarily be achieved by keying into the priority response areas as articulated by the Federal Government of Nigeria's National Strategic plan and raising the profile and enhancing the coordinating function of the State AIDS Control Agency, State MOH and Local government's primary health care programme.
URC in COP 10 will continue to implement comprehensive HIV services for the prevention of the transmission of HIV from mother to child (PMTCT), HIV testing and counselling (HTC), Adult care and support, Paediatric care and support, TB/HIV integration, Adult treatment, Paediatric treatment, ARV drugs, Orphans and Vulnerable Child (OVC), Laboratory infrastructure support and Strategic information. URC will also seek to provide support to the strengthening of the health system in Enugu and to undertake work to help in efforts to combat HIV stigma and discrimination and ensure meaningful involvement of people living with HIV. Added impetus will be focused on increasing TB and HIV collaborative activities, in recognition of the twin epidemics Complementarity in terms of morbidity and mortality with closer working with the TB programme cognizant officers in the state to improving case detection, diagnosis and infection control initiatives.
Further, we note the fundamental need to continue to provide the correct mix of HIV prevention, care and support services. Long term, new infections will need to reversed and halted and this will be achieved by continued provision of preventative services. Every opportunity will be utilized to promote prevention messages for both HIV positive and negative in all URC-supported facilities and activities, using evidence-driven approaches and working in partnership with the State and other actors.
URC recognizes the importance of ensuring that all services provided as part of its comprehensive community centred approach are of the highest quality. This begins with the strengthening of the supervisory functions of the State mechanisms and adhering to nationally and PEPFAR approved quality improvement and assurance strategies. Weaknesses within the health system have further contributed to the challenges in the provision of quality services. URC will support health system strengthening initiatives including strengthening the supply chain, enhancing strategic information, adoption of national and state policies and partnering with other organizations in addressing health workers shortages, address stigma, gender, policy implementation and health sector financing.
With the shift to consolidation, ownership of services by the community will acquire increasing importance. To promote improved community participation and demand for services, URC will work to augment the interaction between health facility staff and local leaders and community structures.
Overall we will continue to enhance the established linkages between PEPFAR programme areas within and between health facilities. We will seek to leverage resources with other initiatives like the President's

initiative on Malaria (PMI), Global fund, UNICEF's Safe motherhood and child programmes, the DFID funded PATHS II project all of which have a presence within the state. In addition we will seek to enhance collaboration with reproductive health, family planning, nutrition, water and sanitation programmes.
URC is committed to ensuring that support provided will be sustainable in the long term. We will concentrate our focus on increasing state led initiatives and advocate for increased funding to the health sector with emphasis on health worker retention, strategic information, supply chain strengthening, infrastructure capital investments, capacity building, pre-service training of health workers, adherence to national and state policies and a right-based approach in service provision. URC will work with PEPFAR and non-PEPFAR partners to leverage resources prevent duplication and create cross functional synergies to better enhance not only HIV services but improvement in the entire health system.
In COP 10, URC will continue to harness the power of our partnership with the State, the local government and the community. We will contribute to the HIV response by targeting all our interventions and consolidating service delivery. We will improve the continuum of services from prevention to treatment and support and target those most at risk. We will work to keep those on comprehensive services adherent to therapy, seek to shift focus towards local and state ownership through capacity building, synergize our activities and leverage resources with other partners and continually look to strengthen the overall health system. Capacity building will form the cornerstone of our approach with strong emphasis on community ownership, continuous improvement and contribution to the overall HIV response.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Construction/Renovation | 60,488 |
| Food and Nutrition: Commodities | 15,122 |
| Food and Nutrition: Policy, Tools, and Service Delivery | 7,561 |
| Gender: Reducing Violence and Coercion | 15,122 |
| Human Resources for Health | 66,536 |
| Water | 15,122 |

## Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services

Malaria (PMI)
Child Survival Activities
Safe Motherhood
Family Planning

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **10115** |
| **Mechanism Name:** | **HHS/CDC Track 2.0 URC** |
| **Prime Partner Name:** | **University Research Corporation, LLC** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HBHC | 144,985 | |
| **Narrative:** | | | |
| None | | | |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HKID | 20,000 | |
| **Narrative:** | | | |
| None | | | |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HTXS | 412,875 | |
| **Narrative:** | | | |
| None | | | |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HVCT | 25,000 | |
| **Narrative:** | | | |
| None | | | |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | PDCS | 23,500 | |
| **Narrative:** | | | |

ACTIVITY DESCRIPTION

CONTINUING ACTIVITY

In COP 10, URC will continue to provide care and support services to 260 HIV positive paediatric clients. We will continue to work in coordination with the state government of Enugu, the health commissioner and ENSACA, the primary HIV/AIDS program implementing agency in Enugu to provide services in 5 of the 7 health districts in the State.

We will consolidate our support to HIV care and support services. URC will continue to assist facilities to strengthen the referral system including internal and external referral linkages in order to promote access and continuum of care of enrolled PLWHA through regularly scheduled meetings between the referral focal persons of supported facilities and other implementing agencies and the state and Local Government AIDS coordinator. Not all service providers/ facilities will be able to offer care and support within their facilities. In such cases, URC will work with the State Department of Health to develop referral linkages to ensure that clients have easy access to services. We will train 20 individuals to provide care and support, including community workers and PLWHA to provide home-based care and support services for people living with HIV/AIDS.

Paediatric care and support services will the family centred and child friendly. As far as possible services will be co-located with maternal and child and immunization services that target children. Referral linkages will be greatly strengthened. All clinicians will be closely mentored to build confidence in the management of paediatric HIV. Parents and or caregivers will remain as important partners in ensuring adherence to clinic appointments and all medication. Early infant diagnosis of HIV is one of the main entry points to care and support, linkages to EID programmes and our PMTCT programme will be enhanced and continually promoted. Our PMTCT and Paediatrics Advisor will as far as possible seek to co-locate our PMTCT and paediatric services. We will create stronger links with immunization services, child health, nutritional programmes and child welfare and OVC services.

URC will address the shortcomings of supported health facilities in Enugu through on site mentorship and training of health workers and community extension workers. We will seek to support and increase the supportive supervision role of the local and state government technical officers in care and support. We will provide care services including clinical care, distribution of basic care kits, psychological, spiritual, social, preventive services, and home-based care. Clinical care will include basic nursing and end-of-life care, management of pain and other symptoms, nutritional assessment and intervention, OI prophylaxis and management, and non-Art laboratory services. All enrolled clients will receive a basic care kit which includes ITN, water vessel, water guard and ORS, latex gloves, IEC materials, condom, and soap. The minimum care package includes the basic care kit with clinical care, plus two supportive services of those listed above.

Cotrimoxazole prophylaxis will be provided to all paediatric patients and close attention will be paid to all clients to assess for sulphur allergies. URC will help with the integration of nutrition support into the care

and support programme. This support will include nutritional assessment using growth monitoring charts. To achieve this, all paediatric clients will have their height and weight measured and recorded. Further all clients that qualify will have nutrition support by prescription through the provision of high energy macro and micronutrients. URC will strengthen referral linkages to nutritional support programmes and will collaborate with these programmes by providing gap support for nutritional supplements. Patient nutrition education and counselling will also form a major part of the support provided. URC will support clinicians at facility level to stage and manage patients according to national standards including determination of the appropriate time to commence ART. These will be achieved through training and on site mentorship support.

URC will work with its partner Vision Africa to support home based care activities. Through this collaboration current and volunteer providers will be accessed and trained on the provision of appropriate support within the home. This will include identification of cases for referral, psychosocial support, patient education, basic first aid and adherence support according to the nationally accepted guidelines. We will provide increased clinic-based and home/community-based activities to adults or adolescent HIV-positive individuals through the training of healthcare workers, PLWHA and community workers in adherence counselling, management of opportunistic infections, diagnosis and relief of symptoms, psychological and spiritual support, clinical monitoring, related laboratory services and delivery of other palliative care services to the community including culturally appropriate end-of-life care as per Nigeria's National Palliative Care Standards and Guidelines.

All enrolled clients will have an initial CD4 and 6 monthly CD4 monitoring to ensure that those eligible for ART after their initial assessment commence therapy on time. Laboratory services for the diagnosis of opportunistic infections will be provided for both PLWHA on ART and those not on ART. URC will work to ensure that commodity support for drugs and laboratories will support roll out and scale up of care and treatment services. Adherence counselling will be closely linked to treatment initiation and maintenance with initial, one month and six monthly counselling sessions. Close links will also be formed with home based care providers to maintain adherence within the home setting. Client and family centred approaches will be used. Defaulter registers will be maintained in the health facilities and used to track defaulters and those lost to follow up. Facility based community meetings with community gate keepers will be held to help improve community treatment literacy. As part of improving and increasing the effectiveness of care and support, URC will work together with other PEPFAR partners to support the proposed development of a national policy on task shifting. This programme, under the leadership of the Government of Nigeria, aims to shift non essential and routine follow up of clients from MDs to nurses ( for ongoing follow up of stable clients on ART) and from nurses to counsellors( for adherence counselling and support.)

URC will train 10 health care workers on site, using the national curriculums for paediatric palliative care. This training will be supplemented by on site close support mentoring to ensure proper skills transfer and usage. Local trainer of trainers will be capacitated to provide this training. In addition URC recognizes the

work and role of the current implementing partners in Enugu and will use their current expertise to prevent the duplication and wastage of training and other implementation resources.
The ongoing monitoring of the programme as implemented will play a critical role in improvement initiative. The use of data, the application of quality improvement initiatives including the plan, do, study, act cycle, standard setting and tracking, best practice sites with intentional spread and collaboration is the signature hallmark of URC programmes. URC will strengthen the national data capture and reporting systems at site level. In addition on-site data collected will be analyzed and used for process and programme improvement. This support will be provided by URC's technical team in collaboration with site staff to increase sustainability and ownership.
URC recognizes the importance of ensuring uninterrupted supply of drugs, laboratory and allied commodities and will work together with its partner Crown Agents, through the Federal Government and PEPAR supported central supply systems. This support will supplement the national commodity supply. Locally sourced and USFDA/PEPFAR approved commodity will be procured through this mechanism.
CONTRIBUTIONS TO OVERALL PROGRAM
Training and support to improve the quality and integration of care and support services are consistent with FMOH and PEPFAR priorities and are permanently linked with the capacity of the health system overall, other HIV/AIDS program area capacities and the community. URC will hold workshops to promote sharing of knowledge and best practices in all HIV-related services which will allow rapid and effective spread of good practices throughout Enugu State. Our care and support program will build on our partner, Vision Africa's network in Enugu which is affiliated with dozens of FBOs, CBOs and CSOs in Enugu State, including Enugu State's branches of The Network of People Living with HIV/AIDS in Nigeria (NEPWHAN) to train community workers and PLWHAs in the delivery of home-based care services. Additionally, our work in this area will also involve training and new reporting on performance indicators as specified by PEPFAR. This activity in the region will strengthen all reporting, accountability of facilities and data collection in all areas of the health sector in Enugu State. URC will also focus part of its programming on improvement of referral systems to improve the coordination between lower and higher level public healthcare facilities as well as between the public and private sector. This will be accomplished through the scheduling of regular meetings with the primary care coordinator for each relevant LGA in Enugu, the state, private and NGO-supported facilities to jointly develop indicators that are followed so that weak areas among these facilities can be addressed.
EMPHASIS AREAS
The emphasis areas for this program activity are:
1. Linkages with other paediatric supportive services including immunization, nutritional and integrated management of child hood illnesses.
2. Capacity Building of agencies, organizations and health facilities responsible for delivery of HIV interventions
3. Collaboration and coordination to improve referral systems and availability of services

4. Community outreach and involvement as described above.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | PDTX | 24,750 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Other | HVSI | 60,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | MTCT | 405,506 | |

**Narrative:**

ACTIVITY DESCRIPTION
CONTINUING ACTIVITY

In COP 09, URC will provide PMTCT services to 3,000 women in Enugu State through work at 18 sites. This will be implemented in coordination with the government of Enugu and the state SASCP. In COP 10 URC will support and strengthen PMTCT services in all 18 sites to ensure that clients have easy access to PMTCT services. URC will help set up and improve linkages between comprehensive ART sites in secondary and tertiary facilities and primary and secondary facilities attending to pregnant women in Enugu state. Following the national PMTCT guidelines, the hub and spoke model will be utilized. The comprehensive sites will form the hub and the primary cares sites will be the spokes. This will allow for increased access to diagnostic and monitoring tests for PMTCT. Stand alone PMTCT points of service at the primary care level will be liked to adult and paediatric care as part of a comprehensive PMTCT network.
At URC supported PMTCT service points 3,000 pregnant client will be provided opt-out provider initiated HIV testing, counselling and results. URC will train 20 Health care workers to provide PMTCT services using current national training manuals. HIV positive pregnant women identified in facilities without CD4 machine will be linked to those with the facility for CD4 testing and further management. The prevention for positives package will be utilized in all sites. This will provide an opportunity to interrupt heterosexual transmission, especially in discordant couples. HIV testing and counselling will be provided during routine antenatal and during labour and delivery for unbooked cases by facility supported staff.

URC will support facilities to provide highly active antiretroviral therapy (HAART) to pregnant women if their CD4 is less than 350 in accordance with the National PMTCT guidelines. For the women not requiring HAART, the current national guidelines recommended short course ARV option will be provided which includes ZDV from 28 weeks, ZDV/3TC from 34-36weeks and intra-partum NVP, and a 7 day ZDV/3TC post-partum tail. This will result in the provision of ARV prophylaxis to 186 pregnant women. All HIV+ women will be linked post-partum to an HIV/ARV point of service, which will utilize a family centred care delivery model whenever feasible, co-locating adult and paediatric care and providing a linkage to family planning services this approach will involve providing the services at the points most appropriate and convenient including maternal and child services.

URC will ensure that all HIV+ pregnant women gain access to the basic care package of insecticide treated nets, water vessels, water guard and soap. URC will support the training of 20 health workers on infant feeding using the National Infant feeding training manual. HIV+ women will be counselled on infant feeding practices pre and post natally. The options will include early cessation of breast feeding, exclusive breastfeeding with abrupt weaning and replacement feeding if acceptable, affordable, available, safe and feasible. Couple counselling will help support and sustain the infant feeding choices. Mothers will be linked to peer support groups within the community.

HIV Exposed Infants will be provided with single dose NVP at birth and ZDV for 6 weeks in accordance with Nigerian National PMTCT Guidelines. Cotrimoxazole suspension for all exposed infants will also be provided from 6 weeks until definitive HIV diagnosis. Testing of infants will be carried out using dried blood spot (DBS) specimen collection. We will actively participate in the national early infant diagnosis initiative by providing infant for DBS testing from 6weeks of age.

All capacity development undertaken by URC for its PMTCT programme will adhere to nationally approved training curriculum and will utilize the existing trainer of trainers (TOT) manual in Enugu to support the training and retraining of 20 health workers on PMTCT across all sites.

URC notes the importance of ensuring post partum follow up for completion of prophylaxis, early infant diagnosis, Cotrimoxazole prophylaxis and referral of mothers for ongoing care, support and treatment if indicated. URC with its partners Vision Africa will work with community health workers to prevent loss to follow up outside the health facility. Within the health facility, URC will encourage the formation of multidisciplinary teams to adapt national referral procedures and to oversee programme implementation and improvement. URC will ensure the use of the national PMTCT registers across all supported sites and work to strengthen data collection and transmission and encourage the use of this data at site level to improve implementation.

The PMTCT programme will work closely with the care and support programme to ensure no mothers are lost to follow up. Particular attention will be paid to community linkages through community health workers as many women obtain most of their pre and post partum support care from them. These workers will be trained and supported to improve referrals to hospitals for antenatal care and to help track and refer clients for delivery. URC's partner Vision Africa will continue its work, supported by URC, in this

area.
POPULATIONS BEING TARGETED
This activity targets pregnant women who will be offered HCT, HIV+ pregnant women for ARV prophylaxis and infant feeding counselling, and exposed infants for prophylaxis and EID.
KEY LEGISLATIVE ISSUES ADDRESSED
This activity addresses Gender since treatment will be provided to women and will focus on family centric issues including male involvement in PMTCT programming.
EMPHASIS AREAS
Major emphasis of this activity focuses on training and network/linkages. Minor emphasis includes other sectors and initiatives, commodity procurement, and community mobilization/participation.

In COP10, under 'PEPFAR Nigeria's accelerated PMTCT plan', URC, will strengthen its support to PMTCT service delivery by implementing activities that further improve the coverage and quality of PMTCT services. These activities will be directed towards increasing utilization of PMTCT services at existing service outlets through demand creation in collaboration with community resources and ensuring the upgrade of existing supported PHCs offering stand alone HIV counseling and testing to render at least minimal package of PMTCT services. In order to leverage resources, priority will be given to PHCs located in the selected focal states with presence of other donor agencies and in local government areas already earmarked for HSS support through GFATM. Where new sites are envisioned, those that are used for national ANC sero-sentinel surveys but yet to commence PMTCT services as well as PHCs located in communities with high HIV prevalence rates above the National average will be given priority.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HLAB | 470,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HTXD | 72,576 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HVTB | 105,000 | |

**Narrative:**

| |
|---|
| None |

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 10116** | **Mechanism Name: HHS/CDC Track 2.0 Pathfinder** |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Pathfinder International | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 253,418** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 253,418 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 64,164 |

## Key Issues

(No data provided.)

## Budget Code Information

| | | | |
|---|---|---|---|
| **Mechanism ID:** | **10116** | | |
| **Mechanism Name:** | **HHS/CDC Track 2.0 Pathfinder** | | |
| **Prime Partner Name:** | **Pathfinder International** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Care | HVCT | 25,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | MTCT | 228,418 | |

**Narrative:**

ACTIVITY UNCHANGED FROM FY2009
Pathfinder (PI) in COP09 supported PMTCT activities in a total of ten facilities (three General Hospitals and seven Primary Health Centers) in three local government areas (LGAs) of Edo state. In COP10, Pathfinder will strengthen these sites and networks to provide quality PMTCT services and community outreach activities. The PMTCT Facility Management Committee in each focal health facility will be strengthened for project sustainability. This will support the community component of health system strengthening shaping the demand element of communities for responsiveness and fair distribution of service delivery.

The PMTCT activity will promote gender equity in HIV/AIDS programs and increase access to services by the vulnerable groups of women and children. It will help increase service uptake, promote positive male norms and behaviors, especially as it relates to discordant couples, and help reduce stigma and discrimination while building community ownership and sustainability.

Interventions to be carried out during year three by Pathfinder International in Edo State are described below, including activities that are being carried over from year two.

Objective 1: Prevent new HIV infections and provide quality comprehensive care to HIV + pregnant women and mothers

1.1 Advocacy and Sensitization
To expand availability, access and use of PMTCT services, Pathfinder will work with facility, community,

and local authorities (including traditional and government leaders) to continue building support and acceptance for services. Advocacy, as in previous years, will target all the key stakeholders at Edo state and LGA ( Owan East and Ovia South West) levels including the Local Government Council members, the Legislature and communities will be mobilized to garner support for PMTCT services. In addition, the importance of PMTCT to all family members including all pregnant women to attend ANC and access PMTCT services will be reiterated.

Advocacy efforts will include securing the support of the leaders for the strengthening of the PMTCT Facility Management Committees which are expected to play a greater role in the reporting of Primary Health Care services within other beneficiary committees.

1.2 Facility Supplies Support
Effective supportive supervision will identify gaps in equipment and material resources as quality PMTCT services continue to be provided to the populace at the supported sites. The project will provide necessary supplies required to fill these gaps, as well as ARVs and test kits for quality PMTCT service delivery. This may include materials for universal precautions for infection prevention and consumables.

1.3 Technical and Management Training for Facility Staff

PMTCT/HTC Updates for Facility staff
Knowledge and skill updates serve as a way of providing further support for technical persons and addressing some of the gaps identified during monitoring and supervision. A 3 day update training on PMTCT and HTC to further increase their knowledge and sharpen their skills is planned. This training will utilize a consultant from the national pool of trained PMTCT trainers.

Laboratory Updates for Facility staff
In addition, a 2 day update training will take place (facilitated by a consultant) for laboratory scientists and technicians on laboratory safety skills using on-site training approach.

1.4 Update meetings for four different groups: PHCs, Private practitioners, TBAs and male motivators
A one-day update meeting for these different target groups will hold to provide the groups on progress and for discussing opportunities and challenges that have arisen in the last year. Using a participatory approach, new strategies will be developed to increase ANC attendance & PMTCT clientele at supported facilities.

1.5. Provision of PMTCT services
Pregnant women, postpartum mothers, their partners including HIV exposed infants and HIV infected

children will be targeted and supported so that they have full access to HTC at multiple entry points of care. HTC will be done for pregnant women on a three-monthly basis till she delivers. Pregnant women are being supported to deliver in health facilities through the provision of the national safe motherhood program delivery kits ("mama kits") presently supplied by the LGA authority. The use of ART for PMTCT will follow the National PMTCT guidelines. Women presenting at labor will be offered rapid testing and if HIV-infected provided with SD-NVP.

All infants born to HIV-infected women will receive SD-NVP at birth and AZT for 6 weeks. An estimated 70 mother-baby pairs will receive ARV prophylaxis. During ANC, HIV positive women will receive counseling on infant feeding options and after delivery will be supported to initiate whatever option she settles for before going home. Promotion of Nutritional support in terms of nutritional counseling and referring for food support will be offered.

Health facilities will be supported to provide basic laboratory services and will be linked to a laboratory network model in which CD4 testing can be performed via specimen transport systems. In addition, linking with FP counseling and service provision and effective condom promotion (including post-partum FP) will be done. Exposed infants will be actively linked to pediatric care and treatment through under-5 cards issued in labor and delivery.

Pathfinder will work in close partnership with IHV and the Clinton Foundation on HIV infant diagnosis and referrals for HIV infant diagnosis testing through a Dried Blood Spot (DBS) from 6 weeks of age. HIV positive infants will be linked to appropriate care and treatment.

1.6 Strengthen Referrals and Linkages
The referral network developed in the previous two years will still be utilized to aide the facilities and communities in making and accessing referrals.

Referrals: The entry point for recruiting pregnant women for the program include – during community mobilization, ANC and personal contact by the community resource persons. When a HIV + pregnant woman is identified during a community mobilization event she is referred to the facility for continued care by the team and, if permission is granted, her contact information obtained. The lay counselor provides follows up support to encourage women to access services. Other women who show up at the clinic (perhaps from community mobilization or TBA and personal contacts) are also counseled and tested and those that are positive are enlisted in the program for follow-up. Other HIV + pregnant women who already knew their status before being pregnant are referred to the comprehensive care and support centres.

Linkages will be established for services that the Pathfinder program cannot provide. Such services will include CD4 count; ART support after delivery for women who tested positive during that pregnancy; facility and community based care and support services; and pediatric follow-up. This will be coordinated centrally by each M & E focal person of the LGA /GH with the involvement of the respective PHC M& E focal persons. The above tasks will be facilitated by the provision of a minimal amount on recharge cards. The M&E focal persons for the focal health facilities will ensure validation of referrals from PHCs to other centres, either secondary or tertiary. They will also track clients who deliver with TBAs to ensure Nevirapine compliance when in labor.

1.7 Expanding the PMTCT Facility Management Committee

The PMTCT Facility Management Committee existing in each focal health facility for the last two years will be expanded to include more members from the surrounding community so as to strengthen it as a coalition. They were set up to facilitate community involvement and ensure successful program implementation by exchanging information and reviewing data trends of the facility and at the same time doing a SWOT analysis. By including more members of the community, these committees will strengthen their functions for effective advocacy, mobilization and communication, and fundraising so as to also consider issues of sustainability for provision of quality services to the populace including the source or raise of funds if necessary and liase with government and other voluntary agencies in finding solutions to health and social issues.

1.8 Community Mobilization (in all ten health- facility communities)

Community mobilization activities will create awareness and demand for PMTCT services. Health facilities will be supported to organize sensitization events including rallies using special days like World AIDS Day, Safe Motherhood Day, Women's Day and during Breast Feeding Week. During these events, mobile HCT clinics will be present to provide on-the-spot voluntary counseling, testing and receipt of results. Post-test counseling will include how to stay HIV negative, motivation to accept PMTCT services, effective 'spousal communication' and partner testing at the static T & C sites. If positive, referrals will be made to adult ART centers and other counseling and support services for non-pregnant women and for pregnant women to the project facilities.

1.9 Outreach services to nearby PHCs and private clinics

Visits to PHCs and private health clinics in a 20 km radius of the focal health facilities will also be carried out by health care providers in order to provide PMTCT in terms of HIV testing and if found to be HIV positive, provision of ARV prophylaxis drugs to such individuals. Follow-up will be carried out to offer ARV prophylaxis to babies born to HIV positive mothers.

1.10 Quarterly network meetings of PLA support group
PLA support groups of year two will liase to form coalitions with other PLA support groups in the LGA and/or neighbouring LGAs that promote psychosocial and emotional support, to share experiences and to strategize ways of reducing stigma and motivate members to disclose their status.

1.11 Project Review Meeting
At the end of year 2, a stakeholder meeting will be held in each LGA to review the project through the last year of implementation. Joint discussions will plan the way forward in order to reach the goal and objectives of the project by bringing all the key persons involved in project implementation and reviewing where the project stands in terms of deliverables.

Monitoring and Evaluation:
Pathfinder International had strengthened its internal M&E system in COP09 by integrating its database with the National District Health Information System (DHIS) software for electronic data capture and GIS application, data quality and data use for improvement of service delivery. Data managers of Pathfinder International including the Edo state focal person for the project were trained by on its importance and use. On this project, the Country M&E Specialist will continue to ensure consistent and continuous reporting and monitor each step of the way and expand to include the additional facilities while at the same time ensuring quality data through continuous on-site technical support and data quality assurance checks at all levels of data collection, collation, use and reporting. Data information and analysis will be shared with facility managers, the LGA M&E officer, SACA and SASCP.

Code Objective/Key Indicator Target Year 3
Objective 1: Prevent new HIV infections and provide quality, comprehensive care to HIV+ pregnant women and mothers.
P1.1.D Number of pregnant women with known HIV status( includes women who were tested for HIV and received their results) 3384
P1.2.D Number of HIV-positive pregnant women who received antiretroviral to reduce risk of mother-to-child transmission 70
P1.1.N Percent of pregnant women who were tested for HIV and know their results. 90
P1.2.N Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission 85

If additional funds are granted, the M& E system will be strengthened within this technical area ( Budget amount estimate: $35,000.00)

For effective management of health and resources, government at all levels must have interest in supporting and ensuring that health data and information are available as a public good for all stakeholders to utilize. Availability of accurate, reliable, timely and relevant health information is the most fundamental step towards informed public health action. Over the years, planning monitoring and evaluation of health services and programmes have been hampered by dearth of reliable data. National Health Management Information System (NHMIS) is to provide reliable, relevant and timely information to health system's policy makers, managers, professionals, and to the other sectors. Health workers need to have proper orientation on District Health Information System (DHIS) and be motivated to play their own roles in data collection, collation, analysis and dissemination.

Therefore, to help strengthen the M&E system towards meeting the national reporting needs, the capacity of health workers at state and LGA need to be enhanced through the activities proposed below.
1. A five-day 'Basic M& E and orientation to DHIS' Training for 24 health care workers (from the focal health facilities) including the LGA M&E officers on the use of DHIS software for electronic data capture is planned. This training will be delivered by a consultant and hold in Benin.
2. A three-day 'GIS application and data use' Training of the same group and health facility managers and PHC coordinators on GIS application, data quality and data use for improvement of service delivery. This will be delivered using PI in-house capacity and hold in Benin.

Additional performance indicator would then be :

Code Objective/Key Indicator Target Year 3
H2.3.D Number of health care workers who successfully completed an in-service training program (M&E) 24

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 10125** | **Mechanism Name: USAID Track 2.0 PPP** |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Cooperative Agreement |
| Prime Partner Name: TBD | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: Yes | Global Fund / Multilateral Engagement: No |

| Total Funding: Redacted | |
|---|---|
| **Funding Source** | **Funding Amount** |
| Redacted | Redacted |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## Key Issues

(No data provided.)

## Budget Code Information

| **Mechanism ID:** | **10125** | | |
|---|---|---|---|
| **Mechanism Name:** | **USAID Track 2.0 PPP** | | |
| **Prime Partner Name:** | **TBD** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Prevention | HMIN | Redacted | Redacted |
| **Narrative:** | | | |
| None | | | |

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 10133** | **Mechanism Name: USAID Heartland Alliance** |
|---|---|

| | |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Heartland Alliance | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 1,507,000** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 1,507,000 |

## Sub Partner Name(s)

| | | |
|---|---|---|
| Alliance Rights Nigeria (ARN) | Howard Brown | Male Attitude Network (MAN) |
| Pure Professionals (PP) | TBD | The Independent Project (TIP) |

## Overview Narrative

USAID Nigeria has a new award which will provide integrated HIV prevention programming for a targeted most-at-risk population of men who have sex with men (MSM). The proposed program will build and strengthen institutional and technical capacity of five local MSM organizations in the FCT, Lagos, Cross Rivers, Rivers and Kano states to deliver high-quality comprehensive AB prevention programs and services targeting Men having Sex with Men (MSM). Lagos and FCT will be targeted to start programs in COP 09 with expansion to Rivers, Kano and Cross River state planned for later years. Nigeria with national prevalence of 3.4% (FMOH 2007) and prevalence exceeding 5% in some states has a concentrated epidemic. HIV/AIDS prevalence of 3.7%, 3.5%, 3.1% amongst transport workers, police force and armed forces and with prevalence of over 30% among female sex workers (IBBSS 2007), reveals unequal distribution among different population subgroups. The highest prevalence amongst high risk groups including MSMs at 13.5% emphasizes the need to target this particular group with HIV sensitization programs, prevention messages, and linkages to care and treatment. IBBSS 2007 revealed that half of the MSM surveyed could not correctly identify ways to prevent sexual transmission of HIV. Over 70% used oil based lubricants. Multiple sexual partnerships (insertive and receptive) are common among MSM while over 50% engaged in transactional sex. MSM were not more likely to have used condom at last transactional anal sex with a man (58%) compared to a non commercial sex partner (53%). Only 34% of reporting MSM have ever been tested for HIV in Nigeria. The proposed program will deliver HIV services as well as undertake multiple level capacity development approach to simultaneously respond to unmet need for prevention, community based care and support HIV services to MSM in Nigeria. Past efforts have worked through rather with MSM grassroots organizations and services were

provided under umbrella of most at risk population. Heartland Alliance iwill focus on MSM populations with a minimum of three interventions in the 5 states mentioned above.

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## Key Issues

Addressing male norms and behaviors

Increasing gender equity in HIV/AIDS activities and services

## Budget Code Information

| Mechanism ID: | 10133 | | |
|---|---|---|---|
| Mechanism Name: | USAID Heartland Alliance | | |
| Prime Partner Name: | Heartland Alliance | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Care | HBHC | 410,000 | |

**Narrative:**

This activity also links with prevention programs. USAID Nigeria is negotiating a new award which will provide integrated HIV prevention programming for a targeted most-at-risk population of men who have sex with men (MSM). As is the practice when making new awards, OGAC Intervention strategies will aim at reducing number of sexual partners, promoting consistent condom use in all sexual acts, encouraging the use of water based lubricants, providing adequate treatment of STIs and offering sex education. Specific activities will entail building the capacity of indigenous MSM organizations to provide high quality prevention programming that will bring about effective behavior change as it relates to reduction of multiple sexual partners and transactional sex as well as with messages promoting fidelity, encouraging partner reduction through risk reduction messages and personal risk perceptions skills; utilization of Peer Outreach & Community Mobilization activities, establishing Condom/lubricant outlets, Community Centers, Online – outreach and web resources, conducting trainings/Events and IEC materials development. Activities will also focus on male and female partners of MSM who are at high risk owing to contextual factors, with messages refined for each group. Activities to prevent transactional sex or

protect MSM involved in transactional sexual relationships will focus on skills based HIV education for vulnerable young women and young men with broad based community care and support activities that facilitate access to treatment and adherence counseling services for MSM. These interventions will be reinforced with mass media activities that highlight importance of mutual fidelity, risk behavior reduction and safe sexual practices. The program will concentrate activities in areas that will be identified through secondary analysis of national behavioral data generated through the project SEARCH and NARHS PLUS survey. The MARP prevention program will build capacity of local MSM networks to provide the minimum package intervention for the MSM population groups. Technically this will entail familiarizing the organizations with the minimum package modules and adopting a program approach that ensures delivery of the package as stated by the National Prevention Plan. The project anticipates reaching 28,000 MSM with AB messages and services and 22,000 MSM with community and facility services including adherence and prevention with positive services for identified positive MSM utilizing minimum package interventions that provide comprehensive balanced prevention interventions. 17 outreach coordinators and 70 Peer educators will be trained in COP 09 to MSM population in Lagos and FCT. Heartland Alliance will document and disseminate best practices; successful and innovative approaches with lessons learned and share these with their implementing agencies as well as other partners within the PEPFAR program in Nigeria. In COP 09, particular interest on lessons learned will focus on effective approaches for improving organizational and technical capacity of local lesbian, gay, bisexual, transsexual/men who have sex with men organizations. Implementation will be through local organizations whose capacities will have been built by the prime and have been identified to have capacity for rapid scale up. Within the initial 6 months of implementation, capacity-building for provision of prevention (AB) services for the groups will be carried out followed by development of IEC materials for MSM. The overall programmatic intervention will be in line with national priority plan and national prevention plan. CONTRIBUTIONS TO OVERALL PROGRAM AREA The programs and activities implemented will fill critical gap in the reach of HIV interventions into epidemiologically important population to better address gaps in coverage and to better address specific behaviors within underserved populations. This MARP prevention program, delivered through implementing agencies whose capacity has been built, will contribute to strengthening and expanding the capacity of the GON's response to the HIV/AIDS epidemic and increasing the prospects of meeting the Emergency Plan's goal of preventing 1,145,545 new infections. LINKS TO OTHER ACTIVITIES The AB and C/OP activities implemented under the proposed activity will be linked with care and support activities, as well as with the other prevention partners. POPULATIONS BEING TARGETED: Populations targeted in these activities will include MSM and their partners (male and female). KEY LEGISLATIVE ISSUES ADDRESSED: Key legislative issues will address increasing equity and access to information and services for MSM. EMPHASIS AREAS: The service delivery component will focus on information, education, and communication in the community and will build linkages with other sectors and initiatives.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Prevention | HVAB | 223,500 | |

**Narrative:**

Intervention strategies will aim at reducing number of sexual partners, promoting consistent condom use in all sexual acts, encouraging the use of water based lubricants, providing adequate treatment of STIs and offering sex education. Specific activities will entail building the capacity of indigenous MSM organizations to provide high quality prevention programming that will bring about effective behavior change as it relates to reduction of multiple sexual partners and transactional sex as well as with messages promoting fidelity, encouraging partner reduction through risk reduction messages and personal risk perceptions skills; utilization of Peer Outreach & Community Mobilization activities, establishing Condom/lubricant outlets, Community Centers, Online – outreach and web resources, conducting trainings/Events and IEC materials development. Activities will also focus on male and female partners of MSM who are at high risk owing to contextual factors, with messages refined for each group. Activities to prevent transactional sex or protect MSM involved in transactional sexual relationships will focus on skills based HIV education for vulnerable young women and young men with broad based community care and support activities that facilitate access to treatment and adherence counseling services for MSM. These interventions will be reinforced with mass media activities that highlight importance of mutual fidelity, risk behavior reduction and safe sexual practices. The program will concentrate activities in areas that will be identified through secondary analysis of national behavioral data generated through the project SEARCH and NARHS PLUS survey. The MARP prevention program will build capacity of local MSM networks to provide the minimum package intervention for the MSM population groups. Technically this will entail familiarizing the organizations with the minimum package modules and adopting a program approach that ensures delivery of the package as stated by the National Prevention Plan. The project anticipates reaching 28,000 MSM with AB messages and services and 22,000 MSM with community and facility services including adherence and prevention with positive services for identified positive MSM utilizing minimum package interventions that provide comprehensive balanced prevention interventions. 17 outreach coordinators and 70 Peer educators will be trained in COP 09 to MSM population in Lagos and FCT. Heartland Alliance will document and disseminate best practices; successful and innovative approaches with lessons learned and share these with their implementing agencies as well as other partners within the PEPFAR program in Nigeria. In COP 09, particular interest on lessons learned will focus on effective approaches for improving organizational and technical capacity of local lesbian, gay, bisexual, transsexual/men who have sex with men organizations. Implementation will be through local organizations whose capacities will have been built by the prime and have been identified to have capacity for rapid scale up. Within the initial 6 months of implementation, capacity-building for provision of prevention (AB) services for the groups will be carried out followed by development of IEC materials for MSM. The overall programmatic intervention will be in line with national priority plan and national prevention plan. CONTRIBUTIONS TO OVERALL

PROGRAM AREA The programs and activities implemented will fill critical gap in the reach of HIV interventions into epidemiologically important population to better address gaps in coverage and to better address specific behaviors within underserved populations. This MARP prevention program, delivered through implementing agencies whose capacity has been built, will contribute to strengthening and expanding the capacity of the GON's response to the HIV/AIDS epidemic and increasing the prospects of meeting the Emergency Plan's goal of preventing 1,145,545 new infections. LINKS TO OTHER ACTIVITIES The AB and C/OP activities implemented under the proposed activity will be linked with care and support activities, as well as with the other prevention partners. POPULATIONS BEING TARGETED: Populations targeted in these activities will include MSM and their partners (male and female). KEY LEGISLATIVE ISSUES ADDRESSED: Key legislative issues will address increasing equity and access to information and services for MSM. EMPHASIS AREAS: The service delivery component will focus on information, education, and communication in the community and will build linkages with other sectors and initiatives.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVOP | 873,500 | |

**Narrative:**

USAID Nigeria is negotiating a new award which will provide integrated HIV prevention programming for a targeted most-at-risk population of men who have sex with men (MSM). As is the practice when making new awards, OGAC will be informed when the award is ready, and the partner(s) and targets will be uploaded into COPRS. The proposed program will build and strengthen institutional and technical capacity of five local MSM organizations in the FCT, Lagos, Cross Rivers, Rivers and Kano states to deliver high-quality comprehensive AB prevention programs and services targeting Men having Sex with Men (MSM). Lagos and FCT will be targeted to start programs in COP 09 with expansion to Rivers, Kano and Cross River state planned for later years. Nigeria with national prevalence of 3.4% (FMOH 2007) and prevalence exceeding 5% in some states has a concentrated epidemic. HIV/AIDS prevalence of 3.7%, 3.5%, 3.1% amongst transport workers, police force and armed forces and with prevalence of over 30% among female sex workers (IBBSS 2007), reveals unequal distribution among different population subgroups. The highest prevalence amongst high risk groups including MSMs at 13.5% emphasizes the need to target this particular group with HIV sensitization programs, prevention messages, and linkages to care and treatment. IBBSS 2007 revealed that half of the MSM surveyed could not correctly identify ways to prevent sexual transmission of HIV. Over 70% used oil based lubricants. Multiple sexual partnerships (insertive and receptive) are common among MSM while over 50% engaged in transactional sex. MSM were not more likely to have used condom at last transactional anal sex with a man (58%) compared to a non commercial sex partner (53%). Only 34% of reporting MSM have ever been tested for HIV in Nigeria. The proposed program will deliver HIV services as well

as undertake multiple level capacity development approach to simultaneously respond to unmet need for prevention, community based care and support HIV services to MSM in Nigeria. Past efforts have worked through rather with MSM Intervention strategies will aim at reducing number of sexual partners, promoting consistent condom use in all sexual acts, encouraging the use of water based lubricants, providing adequate treatment of STIs and offering sex education. Specific activities will entail building the capacity of indigenous MSM organizations to provide high quality prevention programming that will bring about effective behavior change as it relates to reduction of multiple sexual partners and transactional sex as well as with messages promoting fidelity, encouraging partner reduction through risk reduction messages and personal risk perceptions skills; utilization of Peer Outreach & Community Mobilization activities, establishing Condom/lubricant outlets, Community Centers, Online – outreach and web resources, conducting trainings/Events and IEC materials development. Activities will also focus on male and female partners of MSM who are at high risk owing to contextual factors, with messages refined for each group. Activities to prevent transactional sex or protect MSM involved in transactional sexual relationships will focus on skills based HIV education for vulnerable young women and young men with broad based community care and support activities that facilitate access to treatment and adherence counseling services for MSM. These interventions will be reinforced with mass media activities that highlight importance of mutual fidelity, risk behavior reduction and safe sexual practices. The program will concentrate activities in areas that will be identified through secondary analysis of national behavioral data generated through the project SEARCH and NARHS PLUS survey. The MARP prevention program will build capacity of local MSM networks to provide the minimum package intervention for the MSM population groups. Technically this will entail familiarizing the organizations with the minimum package modules and adopting a program approach that ensures delivery of the package as stated by the National Prevention Plan. The project anticipates reaching 28,000 MSM with AB messages and services and 22,000 MSM with community and facility services including adherence and prevention with positive services for identified positive MSM utilizing minimum package interventions that provide comprehensive balanced prevention interventions. 17 outreach coordinators and 70 Peer educators will be trained in COP 09 to MSM population in Lagos and FCT. Heartland Alliance will document and disseminate best practices; successful and innovative approaches with lessons learned and share these with their implementing agencies as well as other partners within the PEPFAR program in Nigeria. In COP 09, particular interest on lessons learned will focus on effective approaches for improving organizational and technical capacity of local lesbian, gay, bisexual, transsexual/men who have sex with men organizations. Implementation will be through local organizations whose capacities will have been built by the prime and have been identified to have capacity for rapid scale up. Within the initial 6 months of implementation, capacity-building for provision of prevention (AB) services for the groups will be carried out followed by development of IEC materials for MSM. The overall programmatic intervention will be in line with national priority plan and national prevention plan. CONTRIBUTIONS TO OVERALL PROGRAM AREA The programs and activities implemented will fill critical gap in the reach of HIV

| |
|---|
| interventions into epidemiologically important population to better address gaps in coverage and to better address specific behaviors within underserved populations. This MARP prevention program, delivered through implementing agencies whose capacity has been built, will contribute to strengthening and expanding the capacity of the GON's response to the HIV/AIDS epidemic and increasing the prospects of meeting the Emergency Plan's goal of preventing 1,145,545 new infections. LINKS TO OTHER ACTIVITIES The AB and C/OP activities implemented under the proposed activity will be linked with care and support activities, as well as with the other prevention partners. POPULATIONS BEING TARGETED: Populations targeted in these activities will include MSM and their partners (male and female). KEY LEGISLATIVE ISSUES ADDRESSED: Key legislative issues will address increasing equity and access to information and services for MSM. EMPHASIS AREAS: The service delivery component will focus on information, education, and communication in the community and will build linkages with other sectors and initiatives. |

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 10170** | **Mechanism Name: USAID Track 2.0 CSN** |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Catholic Secretariat of Nigeria | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 445,000** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 445,000 |

## Sub Partner Name(s)

| | | |
|---|---|---|
| CALABAR ECCLESTIASTICAL PROVINCE SUCCOUR PROJECT | CATHOLIC ARCDIOCESE OF ONITSHA SUCCOUR PROJECT | Catholic Archdiocese of Abuja |
| Catholic Archdiocese of Calabar | Catholic Archdiocese of Kano | Catholic Archdiocese of Lagos |
| Catholic Diocese of Abakaliki | Catholic Diocese of Awka | Catholic Diocese of Bauchi |

| | | |
|---|---|---|
| Catholic Diocese of Ijebu-Ode | Catholic Diocese of Jalingo | CATHOLIC DIOCESE OF LOKOJA SUCCOUR PROJECT |
| Catholic Diocese of Nnewi | CATHOLIC DIOCESE OF NSUKKA SUCCOUR PROJECT | Catholic Diocese of Ogoja |
| JOS ECCLESTIASTICAL PROVINCE SUCCOUR PROJECT | KADUNA ECCLESTIASTICAL PROVINCE SUCCOUR PROJECT | LAGOS ECCLESTIASTICAL PROVINCE SUCCOUR PROJECT |
| ONITSHA ECCLESTIASTICAL PROVINCE SUCCOUR PROJECT | | |

## Overview Narrative

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Economic Strengthening | 111,250 |
| Human Resources for Health | 44,500 |

## Key Issues

Impact/End-of-Program Evaluation

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **10170** |
| **Mechanism Name:** | **USAID Track 2.0 CSN** |
| **Prime Partner Name:** | **Catholic Secretariat of Nigeria** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HKID | 300,000 | |
| **Narrative:** | | | |
| None | | | |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVAB | 145,000 | |
| **Narrative:** | | | |
| None | | | |

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 10171** | **Mechanism Name: USAID Track 2.0 GECHAA** |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Cooperative Agreement |
| Prime Partner Name: GECHAAN/The New Tommorrow's Project | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 860,000** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 860,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Education | 260,000 |
| Food and Nutrition: Commodities | 50,000 |
| Human Resources for Health | 130,000 |

## Key Issues

Addressing male norms and behaviors

Increasing gender equity in HIV/AIDS activities and services

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **10171** |
| **Mechanism Name:** | **USAID Track 2.0 GECHAA** |
| **Prime Partner Name:** | **GECHAAN/The New Tommorrow's Project** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HKID | 675,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVAB | 185,000 | |

**Narrative:**

None

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| | |
|---|---|
| **Mechanism ID: 10172** | **Mechanism Name: USAID Track 2.0 ProHealth** |
| Funding Agency: U.S. Agency for International Development | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Pro-Health International | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

**Total Funding: 1,472,389**

| Funding Source | Funding Amount |
|---|---|
| GHCS (State) | 1,472,389 |

## Sub Partner Name(s)

| | | |
|---|---|---|
| Neighbor Care Outreach | | |

## Overview Narrative

HARPIN will carry out sexual prevention (AB/C&OP) and PMTCT programming in the Niger Delta and build the Financial and Management capacity of Pro-Health and other organizations. The objectives of the HIV/AIDS Reduction Program In the Niger Delta (HARPIN) program are to increase the knowledge of prevention of HIV transmission by 10% in target communities, to increase HCT uptake by 10% among the people of Cross Rivers and Rivers state over a 3 year period, to reduce stigma and discrimination associated with HIV/AIDS by 10%, and also to build the financial and management systems capacity of Pro Health International (PHI) and its partners to provide more effective HIV/AIDS programming. The above objectives will be achieved by providing Peer Education using a minimum of three (3) intervention packages to reach in and out of school youth within the ages of 15 and 24. In addition, there will be a Peer led intervention for People Living with HIV/AIDS using a combination of three (3) minimum packages as a means of reducing transmission. Also, a PMTCT program will be carried out to address cross generational transmission of the virus from mother to child.

The abstinence and be-faithful (AB) program area will target in-school and out-of-school youths with peer education on HIV/AIDS and reproductive health. Following training of trainers on Peer Education with use of UNICEF/SFH manuals, youths will be carefully selected and trained as peer educators who will reach out to their peers with HIV prevention messaging. This will be reinforced with small group discussions and formation of health clubs or Community-based organizations. This combination of interventions will make up the minimum package for youth. Existing Community Based Organizations will also be collaborated with for continual program implementation and sustainability.

The HARPIN Condoms and Other Prevention program will target PLWHAs with peer education and emphasis on prevention with positives. This program area is designed to identify and reduce HIV/AIDS stigma and discrimination in the Niger-Delta. HARPIN will collaborate and network with PLWHA support groups and other CBOs to carry out these activities. They will be reached using a Peer Education approach. In addition, stigma reduction activities will be carried out as a means of providing an enabling environment for sustainable behavior change.

HARPIN Prevention of Mother-to-Child Transmission of HIV will target pregnant women. Women in reproductive age groups and their male partners will be secondary targets. The PMTCT program will be based on the WHO four pronged approach. This thematic area is designed to identify pregnant women who are HIV positive (through HCT) and prevent mother-to-child transmission through ARV prophylaxis, proper infant feeding and family planning. Other activities include provision of general health education, nutrition and adherence counseling and health promotions. HARPIN PMTCT program is facility-based (Primary Healthcare Facilities), but with a strong community-based component especially in collaboration with TBAs (to refer their clients for HCT). HARPIN will collaborate with trained HCWs, PLWHA lay counselors, volunteers with strong stakeholders' advocacy for program implementation and sustainability. Early infant diagnosis will aid the early detection of positive infants and subsequent treatment.

HARPIN strategic plan will involve the use of combination prevention intervetnions which will target the individual, the individual's community and the socio-cultural/socio-economic milieu for both sexual prevention and PMTCT.

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Child Survival Activities
Safe Motherhood
Family Planning

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **10172** |
| **Mechanism Name:** | **USAID Track 2.0 ProHealth** |
| **Prime Partner Name:** | **Pro-Health International** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVAB | 839,290 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVOP | 492,750 | |

**Narrative:**

The Condoms & Other Prevention program is a peer led program which will target high risk/highly vulnerable populations identified by the NARHS Plus with HIV prevention and behavior change interventions in line with the National Prevention Plan. These target populations include PLWHA, Uniformed services men (Nigeria Police Force) and widows. The overall approach for these target cohorts focuses on reaching the individual with Prevention messages aimed at sustainable behavior change, addressing community norms and practices, and creating the appropriate socio-economic/socio-cultural milieu for sustainable behavior change.

Using the 'Prevention with Positives' approach, capacity building of the PLWHA will target individual behavior to reduce new infections, re-infection and promote positive and healthy lifestyle. These behavioral changes include delayed sexual debut, secondary abstinence, partner reduction, mutual fidelity for married couples, self stigma reduction, correct and consistent use of condoms, non-sexual risk reduction and positive/healthy lifestyle. The socio-economic milieu will be targeted through economic strengthening to reduce the economic vulnerability of individuals. The community framework will be targeted using stigma and discrimination reduction strategies. These strategies will address socio-cultural norms and practices in the community that fuel sexual transmission of HIV within PLWHA and even to the uninfected population.Training of Trainers will provide a capacity platform for the trainers to gain the requisite knowledge and skills for training support group Peer Educators. A yearly retraining will provide program staff the opportunity of being current on innovations and advances in Behaviour Change Communication especially as it concerns community based 'Prevention With Positives'. Volunteer PETs will be trained concurrently as a means of building a pool of trained personnel to avoid burnout. Volunteer training will also aid in building local technical capacity for future program implementation. Advocacy and Roll Out will be achieved through community mapping techniques, mobilization of PLWHAs, visits to stakeholders, advocacy meetings, PLWHA tracing and necessary approvals from respective authorities. Using a Peer led approach, Training of PLWHA Peer Educators will be carried out for 2-3 members of each support group using an adapted CDC PWP manual. Best practice strategies like use of audio visual materials and other interactive learning techniques will facilitate a greater knowledge gain. Peer Education for PLWHAs will be Support Group based and form the fulcrum activity for the PWP program. Picture codes and other message sensitive IEC materials will be provided with the reaching of PLWHAs to increase the transfer of knowledge from Peer Educator to their Peers. Peers and Peer Educators will have access to the Toll Free Telephony backup. Incentives will be provided to outstanding support

groups.
Widows will be targeted with messages that will encourage Abstinence or Being Faithful based on the preference of the widow to either remain single or be re-married. The behavoural objectives will include secondary abstinence, partner reduction, mutual fidelity, avoidance of risky behaviours and improved self-esteem. Community structures including women associations and groups will be targeted using advocacy and community mobilization techniques in reducing the stigma and discrimination often associated with widowhood. Wife inheritance, widow disinheritance and other harmful socio-cultural practices will be targeted using advocacy tools in a bid to address the socio-cultural milieu of the widows. Partnerships will be fostered with FIDA and other legal frameworks involved in providing legal support to widows as a means of addressing the rights issues associated with widowhood. Capacity building in small scale businesses with the provision of skills aquisition and micro-credit will aid the economic vulnerability that is prevalent with widows.

Due to the high level of the Stigma and Discrimination in the South South Region, a multi-level approach will be adopted. This will include:
• Intrapersonal Level
• Interpersonal Level
• Organizational/Institutional Level
• Community Level and
• Governmental/Structural Level.
At the intrapersonal level, internalization of stigma results in low self esteem and self isolation. Formation of support groups has been identified as a strong factor in the reduction of intrapersonal stigma. These support groups through their various activities will improve PLWHA's identity and self esteem, their coping skills as well as their social integration.
Interventions at the interpersonal level aim at modifying the affected persons' environment. These interventions deal with the impact of social support and social networks on health status and behaviours. They aim to establish relationships between members of the person's interpersonal environment in order to have them share ways to restore or promote their health. Using Community Based Rehabilitation Strategies like engaging PLWHAs in Economic Strengthening Activities will help to rehabilitate delinquent PLWHAs, equalize their opportunities within the community, and provide a sound basis for social integration. Also, providing linkages to palliative care and support services provides a basis for the improvement of the health status of the individual PLWHA, thus improving the likelihood of social integration.
Interventions at the organization/institutional level aim at organizational change to modify health and stigma related aspects of an organization. The institutionalization of Workplace Programs that improve the conditions of PLWHAs in the workplace is a best practice that will help in reducing stigma. Components of workplace programs include winning the support of the owners and managers of the

organizations thus creating a trustful environment; advocacy and mobilization of personnel for anti-stigma activities; creation and enforcement of policies that improve the working conditions of PLWHA e.g health benefits, job security for PLWHA, mainstreaming of HCT and ARVs into benefits; education on PLWHAs workers rights, formation of support groups within the organization etc. In addition, greater involvement of PLWHAs (GIPA) is another strategy that will reduce workplace stigma.
Community Level interventions seek to reduce stigma within specific community groups. Some of the specific community groups that will be targeted in the HARPIN program will include religious communities, educational communities like secondary schools, tribal/ethnic communities etc. The primary focus will be to provide sensitization and improve knowledge about HIV/AIDS thereby providing facts that counter false assumptions on which stigma is based. Using the 'contact' strategy, HARPIN will reduce stigma and discrimination by airing actual testimonials by PLWHAs as TV commercials. Alongside, anti-stigma activities will be mainstreamed into all other HARPIN activities as a means of leveraging on already available structures and resources. Advocacy visits will be carried out to key gatekeepers and influencers who will in turn influence their respective communities to imbibe non-stigmatizing and non-discriminatory acts against PLWHA.
Governmental and structural interventions to reduce stigma and discrimination against PLWHA will focus on the strengthening of the role of SACA within the states. Legal and policy interventions will provide sensitization visits to legislative, legal and law enforcement bodies.
All of these will form composite stigma and discrimination reduction strategy that will further address the unacceptably high rate of stigma and discrimination against PLWHA in the Niger Delta. Therefore, the three interventions for the C&OP program include Peer Education(fulcrum activitiy), Stigma reduction ( provides an enabling environment for sustainable behavior change) and IGA which addresses the socio-economic milieu by interupting the vicious cycle of poverty and increased risk of transmission.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | MTCT | 140,349 | |

**Narrative:**

None

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| Mechanism ID: 10174 | Mechanism Name: USAID Sesame Street |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Cooperative Agreement |

| Prime Partner Name: Sesame Street Workshop | |
|---|---|
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 400,000** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 400,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Education | 400,000 |

## Key Issues

(No data provided.)

## Budget Code Information

| **Mechanism ID:** | **10174** | | |
|---|---|---|---|
| **Mechanism Name:** | **USAID Sesame Street** | | |
| **Prime Partner Name:** | **Sesame Street Workshop** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Care | HKID | 400,000 | |
| **Narrative:** | | | |
| None | | | |

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 10176** | **Mechanism Name: USAID Hope WW Nigeria** |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Hope Worldwide Nigeria | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 2,225,000** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 2,225,000 |

## Sub Partner Name(s)

| | | |
|---|---|---|
| COMMUNITY OF WOMEN LIVING WITH HIV/AIDS (NCW+) | COUNSELING FOR YOUTHS AND TEENAGERS ON HIV/AIDS IN NIGERIA (COYATOHAN), LAGOS | INITIATIVE FOR PEOPLES GOOD HEALTH (IPGH) UGHEP. |
| Integrated Development Initiative | INTERNATIONAL CHURCH OF CHRIST, LAGOS (ICOC) | Living Hope Care |
| NEIGHBOURHOOD CARE ORGANISATION (NCO), CALABAR | POSITIVE LIVING NIGERIA, LAGOS (PLON) | |

## Overview Narrative

The HOPE Worldwide Nigeria (HWWN) Assistance and Care to Children Orphaned and at Risk (ACCORD) Project is a three-year USAID-funded project with a goal to bring compassionate relief and support to communities, families, and children affected by the HIV/AIDS epidemic. Hence, the objectives of the project include the following - Strengthen the capacity of HWWN to manage and scale up programs in her organization and partner CSOs, Increase comprehensive and integrated care and support for Orphaned and Vulnerable Children (OVC), Increase the capacity of affected families to care for and support OVC, Mobilize and strengthen community based OVC responses.

HWWN is working in partnership to build the capacity of 8 indigenous non-governmental organizations in five states (Cross River, Osun, Oyo, Lagos and Delta State) and Federal Capital Territory (FCT) to provide quality service to OVC. The International Church of Christ (ICOC) a partner and a multiplier organization on the project is working in Lagos, Oyo, Delta state and the FCT. The project is providing the 6 plus one USG OVC program components (Psychosocial support, basic health care, nutrition, education, protection and shelter with economic empowerment) to total of 8616 orphaned and vulnerable children. All children enrolled into the project receives psychosocial and health care services while the other services such as nutrition, education, protection, shelter and economic empowerment are provided based on need assessment using a standardized tool – the CSI. The capacity of caregivers is being strengthened to care for and support OVC through trainings, linkages to services within the communities and economic empowerment while communities where the project is present are mobilized and equipped through the initiation of Child Care Committees and training of community members and volunteers to ensure that support to OVC is sustained.

HWWN collaborates with the Federal Ministry of Women Affairs, National Population Council, Education and Primary Health Care Departments through working with their State counterpart and other governance structure like the Local government for the enrolled children to access services such as birth certificates, health care, education etc.

HWWN also partners with USAID COMPASS, SESAME STREET and MARKETS programs to leverage education and nutritional support for OVC and their caregivers.

In COP10, HOPE worldwide Nigeria (HWWN) will also continue the implementation of AB programs in 5 States namely, Cross River, Lagos, Osun, Oyo and Delta States. The target population will be 12500 young people and adolescents of age 10-18 years old who will be provided access to abstinence skills and other information that will assist them in making informed, less risky sexual choices to prevent new HIV infection. Under this program, Orphans and Vulnerable Children who fall within the age bracket will benefit by learning skills to prevent HIV and Sexually Transmitted Infections and be trained as peer educators. The activities that will be implemented will enhance self esteem of the target audience and help them acquire life skills. This effort will be delivered in partnership through capacity strengthening of the following Implementing Agencies (IAs); Initiative for People's Good Health (IPG- Ugep Cross River State), Positive Development Foundation (PDF- Calabar, Cross River State), Neighborhood Care Outreach (NCO- Calabar South, Cross River State), Integrated Development Initiative (IDI- Ikom, Cross River State), Counseling for Youths And Teenagers On HIV/AIDS in Nigeria (COYATOHAN- Ojo, Lagos), Living Hope Care (LIHOC- Ilesa, Osun state), Community of Women Living with HIV/AIDS (NCW+ Amuwo Odofin, Lagos), Positive Life Organization of Nigeria (PLON- Yaba, Lagos), and The International Church of Christ (ICOC- Lagos, Delta & Oyo), a multiplier organization. capacity building of the IAs to provide quality service delivery to the target population.

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## Key Issues

Addressing male norms and behaviors

Increasing women's access to income and productive resources

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **10176** |
| **Mechanism Name:** | **USAID Hope WW Nigeria** |
| **Prime Partner Name:** | **Hope Worldwide Nigeria** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HKID | 2,000,000 | |

**Narrative:**

In COP09, the Assistance and Care for Children Orphaned and at Risk (ACCORD) program continued to build the capacity of the following indigenous Implementing Agencies (IAs) in organizational service delivery to provide care and support to OVC in 6 states in Nigeria including FCT - Initiative for People's Good Health (IPG- Ugep Cross River State), Neighborhood Care Outreach (NCO- Calabar South, Cross River State), Integrated Development Initiative (IDI- Ikom, Cross River State), Counseling for Youths And Teenagers On HIV/AIDS in Nigeria (COYATOHAN or COY- Ojo Lagos), Living Hope Care (LIHOC- Ilesa, Osun state), Community of Women Living with HIV/AIDS (NCW+ Amuwo Odofin, Lagos), Positive Life Organization of Nigeria (PLON- Yaba, Lagos). The International Church of Christ (ICOC) is also part of this program as a multiplier organization.

In accordance with the guiding principle of PEPFAR which is building local and host-nation capacity to provide quality services and sustain national programs, HWWN, under ACCORD in COP09, is building its and her IAs Organizational Capacity with support from a technical partner, whose services would be procured during this period. HWWN partners'capacity would be developed in the following areas - Financial Management, Small Grants Administration, Project Management, Procurement and Store Management. In addition, the technical partner would assist HWWN partners to develop organizational policies, process and procedure.

In COP09, HWWN through ICOC (a multiplier IA) increases number of sites from 4 to 6 to include Abuja and Delta State. A total of 6832 OVC would be reached with the six plus one services according to PEPFAR & GoN guidelines.
All IAs are provided with specific refresher training to provide services to OVC - Psychosocial support, structured group therapy, monitoring and evaluation, data quality and data assurance, financial management and report writing trainings.
In COP10, HWWN will continue to provide OVC services according to National Guidelines in Lagos, Oyo, Osun, Cross River and Delta States. A total of 8616 (2057 new) OVC in the 5 States plus FCT will be provided basic minimum services - Psychosocial support and Health Service. Nutrition, education, protection services with economic empowerment will also be provided based on needs. More children orphaned and vulnerable within the communities where the program is domiciled will be identified and the Child Status Index will be used to collect baseline information on these new enrollees to ensure that the children needs are prioritized for service provision. Existing children would also be assessed again for possible change in needs and outcome of the program on them and their household..
The three resource centers established in Lagos (Surulere, Agege) and Ibadan (Mokola) by ICOC in COP08 will continue to provide information on sexuality, reproductive health, and life skills to the children in the communities where they are domiciled. These centers will be further strengthened by the HWWN AB program to provide information on Sexual Abstinence and other modes of prevention of STI &HIV/AIDS. IAs service providers including volunteers directly working with the children will be trained on AB program as trainer of trainers to step down this training to all 10-18 year old OVC as peer health educators. The trained peer educators OVC would be providing information on AB in their respective communities and schools.
Newly identified parents/caregivers will be co-opted into already existing caregiver's forums in the different communities. In COP10 a total of 1312 (513 New) caregivers will be trained on provision of care (PSS) to their ward including training on parenting, AB, gardening, succession planning and will writing. These sessions will be taught by trained providers from within and outside the organizations. To deal with the issue of gender violence, male caregivers will be included under the Men as Partners activities of the AB program as well. In COP 10, sustainability will be taken further by ensuring that more caregivers/parents are supported with income generating activities in the form of training, seed or booster stocks to empower them continue providing food and other support to their ward with education when the project closes out.
In COP09, kids clubs were established to provide children life skills and afford children an opportunity to play and interact with their peers. In COP10, the kids clubs will continue to hold while new ones are established where needed and existing ones strengthened to further provide Psychosocial support to all children in the program. The clubs will also serve as coordinating points where OVC can receive the other core services and trainings e.g Reproductive health and Abstinence trainings. ACCORD will through her partners increase OVC enrolment in school through partnerships with state ministries and

local education authorities. Short term direct assistance to subsidize school related costs such as books, uniforms, exam registrations, school bags and sandals will be provided to selected OVC based on needs assessment using the Child Status Index. Support will also be solicited from the Communities to provide children heading household and/or older OVC with free/subsidized vocational training. Caregivers and OVC will receive skill acquisition training in trades of their choice. Start up grant/materials/stock based on assessments conducted will be provided to some of them and the rest referred for employment.
With support from the Society for Family Health SFH, households with OVC less than 5 years and HIV positive children under the program will receive Basic prevention kits comprising a bucket with spigot, LLITN and water guard for the prevention of malaria and diarrhea. Children requiring medical care will also be referred to primary health care facilities in their communities where drugs to treat minor ailments will be provided. As most of the identified households are in rural communities, caregivers will receive training surrounding safe water storage, proper hand washing techniques and hygiene while HIV related cases for both children and their caregivers will be referred to the nearest ARV/PMTCT treatment centre. The ACCORD program will also continue to provide assistance to families in critical need by paying their medical bills.
Therapeutic and supplementary feeding of malnourished children particularly the under fives, based on assessment conducted following WHO guidelines, will be done in partnership with the primary health care facilities where food demonstrations classes will also hold. The feeding program will target malnourished children with priority given to infants of HIV positive mothers and under fives. HWWN will also leverage MARKETS' Family Nutritional Support Program (FNSP) which will target the immediate nutritional needs of the most vulnerable children. Through family economic empowerement program, HWWN will address the long-term livelihood support needs of OVC and their caregivers. The IAs especially will embark on community advocacy and solicit community support to improve vulnerable household food security.
Article 7 of the Convention on the Rights of the Child establishes the right of every child to a name and nationality. In many countries including Nigeria, birth registration is not accessible to large portions of the population especially to people in hard to reach areas. HWWN and her implementing agencies will continue advocacy to the National Population Commission, UNICEF, Federal and State Ministry of Women Affairs to access free birth registrations for all unregistered children enrolled into the program.
It is anticipated that 60% of the programs total beneficiaries will be girls and the remaining 40% boys.
In COP09, HWWN is providing technical assistance and field support to Cross River State MoWA to conduct a baseline assessment of all OVC providing NGOs, CBOs and FBOs in the State. In COP10 HWWN will continue to work closely with stakeholders including the Local Government and States' OVC desk officers plus the OVC steering committee to improve OVC program through provision of technical assistance, supporting monitoring and evaluation of OVC programs in the States. HWWN will continue networking and referral linkages with other OVC serving organization within the States - collaborate with the Federal Ministry of Women Affairs, National Population Council, Education and Primary Health Care

Departments through working with their State counterpart and other governance structure like the Local government for the enrolled children to access services such as birth certificates, health care, education etc.
HWWN wll also partners with other USAID Implementing Partners (e.g. SESAME STREET and MARKETS) programs to leverage education and nutritional support for OVC and their caregivers.
HWWN will continue to benefit from the LMS project implemented by MSH on Strategic and Sustainability Planning, Human Resource Management, Leadership and Governance as part of her Organizational Capacity Development.
HWWN will provide refresher trainings and continuous mentoring on monitoring and evaluation to IAs to further strengthen the data collection, collation and analysis skills of these different implementing agencies. All IAs will be retrained on the use of the CSI to evaluate the needs, outcome/impact of the program on individual beneficiaries and communities as a whole. Efforts will be directed to quality assurance and service delivery improvement through regular field visits, mentoring, supportive supervision and charts review with immediate feedback on areas of weaknesses and follow- up planning plus supportive supervisory implementation of corrective measures to ensure all round quality.
CONTRIBUTIONS TO OVERALL PROGRAM AREA
This activity contributes to the USG's PEPFAR Strategy of providing care to OVC and is consistent with the Nigerian National Plan of Action on OVC.
LINKS TO OTHER ACTIVITIES
This activity is linked to AB, HCT, Pediatric Care &Support, and Treatment. Through the kids club and the caregivers forum, abstinence as a prevention method information will be provided to children and their caregivers encouraging them to reduce or not indulge in risky sexual behaviors and giving life skills that enable the young people to say no to sex and 'zip-up'. Care givers and their wards would be referred for counseling and testing especially if caregiver is not the biological parent of her ward and cause of death of wards parent are unestablished. Referral for treatment, care and support at the nearest treatment centre would be done in cases of new cases of HIV infection. HWWN IAs will leverage existing USAID funded Economic Growth programs to provide wrap-around nutritional and income generating support for OVC in the programs.
POPULATION BEING TARGETED
This activity target population include OVC and their Caregivers, with the communities and support groups as indirect beneficiaries as HWWN advocates and mobilize communities through the Child Care Forum members to respond to the needs of OVC in their communities.
EMPHASIS AREAS
This activity emphasis is on Community base organization capacity development to provide sustainable services to the less priviledge within their community Wrap-Around that will primarily provide nutrition and IGA support for OVC. Local organization capacity development is another major emphasis area. Community mobilization and participation, development of network/linkages/referral system, and

| information, education and communication will also be addressed. | | | |
|---|---|---|---|
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Prevention | HVAB | 225,000 | |
| **Narrative:** | | | |
| None | | | |

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 10243** | **Mechanism Name: HHS/CDC Track 2.0 ProHealth** |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Pro-Health CDC | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 50,000** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 50,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

The goal of the program is to increase primary prevention of HIV infection through expanding HCT services among the people of Nasarawa and Plateau States.

1. Increasing HCT outlets in Plateau and Nasarawa states.
2. Increasing the number of people who access HCT services and receive their results in Plateau and Nasarawa states.
3. Strengthening the capacity of the local health care providers and PHI to provide HCT in communities

within these states
4. Building the capacity of local organizations to collect, analyze, disseminate and use HIV/AIDS related data.

The program targets the general population of Bassa Local Government Area, Plateau State as everyone is at risk in the HIV/AIDS epidemic. The program shall be gender sensitive and shall also attend to the needs of children when required by providing pediatric counseling as is stipulated in the national algorithm. Special attention shall be accorded to high risk populations like the prisoners, commercial sex workers, and partners/clients of commercial sex workers. Health workers and other indigenes of Bassa LGA in Plateau state will have their capacity built to ensure sustainability and eventual transfer of ownership of the program to the community.

As a contribution to systems strengthening, the program will build the capacity of SI staff within and among communities in Plateau state and enhance the capacity of five local organizations to collect, analyze, disseminate and use HIV/AIDS-related data. Some of the identified organizations with stringent needs include are Plateaus AIDS Network (PLANET); Youth Adolescent Reflection and Action Center (YARAC); Widows Comfort Outreach Ministry (WICOM); Calvary Ministries (CAPRO); and Society for Women & AIDS in Africa (SWAAN).

The program intends increase gender equity in HCT activities and services. Both men and women groups from the community in Plateau State will be mobilized by PHI to participate in the HCT service uptake. These will include market women's group, farmers' group and other gender-based groups in the community. Advocacy will be directed towards community leaders, women groups and men groups on the need for equal opportunities for women and men to participate in HIV/AIDS related activities and programs. PHI will also advocate for the eradication of harmful practices and prejudice against women especially those that encourage the spread of HIV/AIDS.

To ensure that the quality of data is maintained, quality assurance and continuous quality improvement through periodic site visits and assessments of the program will be carried out. Data collection will be done on site regularly and will be collated monthly. Data collated will be reported periodically to CDC, GON, state and local government according to CDC and GON requirements.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 4,000 |

## Key Issues

Increasing gender equity in HIV/AIDS activities and services

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **10243** |
| **Mechanism Name:** | **HHS/CDC Track 2.0 ProHealth** |
| **Prime Partner Name:** | **Pro-Health CDC** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HVCT | 25,000 | |
| **Narrative:** | | | |
| None | | | |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Other | HVSI | 25,000 | |
| **Narrative:** | | | |
| None | | | |

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 10263** | **Mechanism Name: HHS/CDC Track 2.0 ASM** |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: American Society for Microbiology | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 450,000** | |
|---|---|
| **Funding Source** | **Funding Amount** |

| | |
|---|---|
| GHCS (State) | 450,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAY

This is a continuing activity with funding initiated in late COP07. ASM has the capacity to support the PEPFAR program by ensuring that laboratories possess the necessary organizational and technical infrastructure to provide quality laboratory testing and results in support of HIV prevention, care, and treatment programs, especially for tuberculosis (TB) and opportunistic infections (OI). ASM can provide technical assistance through carefully chosen experts from among ASM's more than 5,000 clinical laboratory microbiologists and immunologists worldwide. Plans are to continue to strengthen a strong cadre of local Nigerian microbiologists in order to ensure sustainability and an ongoing, standardized transfer of skills. ASM has also within its staff a monitoring and evaluation (M&E) expert, who assists ASM, as well as, local Nigerian M&E and technical experts with identifying microbiology-specific quality and technical indicators to introduce in the national M&E system.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 450,000 |

## Key Issues

TB

## Budget Code Information

| **Mechanism ID:** | **10263** | | |
|---|---|---|---|
| **Mechanism Name:** | **HHS/CDC Track 2.0 ASM** | | |
| **Prime Partner Name:** | **American Society for Microbiology** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Treatment | HLAB | 450,000 | |

**Narrative:**

ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAY - ASM will continue to focus on improving the quality and capacity of TB and OI diagnosis in Nigeria. The following activities will support this goal: 1) improvement of training for simple OI diagnosis (microscopy); 2) development of a comprehensive, integrated quality management system for basic microbiology, 3) review and improvements to the basic microbiology curriculum (and SOP's) currently used in Nigeria, 3) assisting via onsite mentoring and guidance with providing technical support for development of a proficiency program for OIs to assist with accreditation processes; 4) offering technical assistance for QMS implementation for TB culture moving towards accreditation. ASM will continue to work closely with PEPFAR-Nigeria Lab Technical Working Group (LTWG) to ensure that these activities are coordinated with the (Government of Nigeria) GON and those organizations currently supporting TB and OI diagnosis and treatment in Nigeria (including, UMD-ACTION, Harvard-APIN, German Leprosy Group, GHAIN, Netherlands Leprosy Group, Damien Foundation of Belgium (DFB) and WHO. ASM will work through the LTWG to ensure that activities and deliverables are developed and implemented in a harmonized fashion.

EMPHASIS AREAS: The major emphasis of this activity is local organizational and human capacity development in quality assurance and quality improvement of laboratory testing.

POPULATIONS BEING TARGETED: ASM will develop/improve training programs provided to laboratorians working in clinical health care facilities for improved diagnosis of TB and OIs. ASM will also improve the infrastructure of laboratories where these individuals currently work.

REACHING THE VISION: This activity will enable ASM to reach its vision and long-term strategy of building resource-limited countries' ability to better diagnose infectious diseases through quality-assured laboratory procedures. The main emphasis is in transferring knowledge to Nigerian laboratorians thus human capacity development via training and mentoring in order to ensure that the activity is sustained over the years. ASM's activities also contribute to narrowing the gender gap in Nigeria by offering knowledge transfer opportunities to both female and male Nigerian laboratorians.

LINKS TO OTHER USG RESOURCES/DONOR SUPPORT: While there is no direct link to other USG resources and donor support, ASM places great emphasis on gathering information on what other donors are doing, in order to prevent duplicating efforts and act more in a leveraging capacity.

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 10328** | **Mechanism Name: HHS/CDC Track 2.0 PFD** |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Partners for Development | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 1,068,357** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 1,068,357 |

## Sub Partner Name(s)

| | | |
|---|---|---|
| Daughters of Charity, Ikot Ekpene | Daughters of Charity, Warri South | |

## Overview Narrative

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Economic Strengthening | 20,000 |
| Gender: Reducing Violence and Coercion | 20,000 |

## Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Safe Motherhood
Workplace Programs
Family Planning

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **10328** |
| **Mechanism Name:** | **HHS/CDC Track 2.0 PFD** |
| **Prime Partner Name:** | **Partners for Development** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HBHC | 93,625 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HKID | 85,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HTXS | 222,750 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HVCT | 25,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | PDCS | 14,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | PDTX | 20,625 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Other | HVSI | 60,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVAB | 101,366 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVOP | 92,952 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | MTCT | 80,139 | |

**Narrative:**

Partners for Development (PFD) and their faith-based organization (FBO) sub-partner the Daughters of Charity (DC) implement the PMTCT component of their CDC funded project entitled ""Counseling, Care and Antiretroviral Mentoring Program" or CAMP, the name of PFD's CDC-funded project. In COP 09 PFD and DC worked in two sites located in Delta and Akwa Ibom states providing PMTCT services through a combination of satellite PHC facilities. Satellite PHC facilities in Benue and Bauchi states were also added in COP 09.

In COP 10, PFD will continue to provide PMTCT services to the same target population and plans to reach 2000 pregnant women. Utilizing a network model with primary health care outposts linked to secondary "hub sites" that provide more complex PMTCT care and lab testing, pregnant women receive PMTCT counseling & testing and receive their results. A total of 2 PMTCT hub sites will be supported linked to at least 10 satellite sites. In Akwa Ibom and Delta states, PMTCT stand alone points of service in the network are linked to adult and pediatric ARV care through utilization of a PMTCT network. Using the referral SOP, HIV+ pregnant women who require HAART are linked to an ARV point of service.

Particular emphasis is placed on the involvement of community health workers who are the primary source of care for women in the pre and post-partum period and are integral to a program that seeks to engage women where they seek care. This program will work closely with the care and support team to maximally engage community based PMTCT and ARV linkages. In addition to receiving PMTCT services, each HIV+ pregnant woman will be referred to OVC services in order to facilitate care for all of her affected children. In Benue and Bauchi states, satellite PHC facilities are mentored by PFD staff and assisted by local NGOs.

Opt-out HCT with same day test results will be provided to all women presenting for ANC and untested women presenting for labor and delivery. All women are provided pre-test counseling services on prevention of HIV infection including the risks of MTCT. Partner testing is offered as part of counseling through referral to on-site HCT centers. A step down training of couple counseling and a prevention for positives package will be utilized in all sites. This will provide an opportunity to interrupt heterosexual transmission, especially in discordant couples. Master trainers for HCT will train labor and delivery staff in the use of HIV rapid tests for women who present at delivery without antenatal care.

As a result of these PMTCT HCT activities, an anticipated 2000 HIV+ pregnant women will be tested and an anticipated 200 identified as HIV+ and provided with a complete course of ARV prophylaxis . HIV+ women will have access to supported lab services including CD4 counts without charge. This will be available on-site or within the network through specimen transport. Women requiring HAART for their own health care are linked to a network ARV service provision point. For the anticipated 2/3 of women not requiring HAART, the current national PMTCT guidelines recommended short course ARV option will be provided which includes ZDV from 28 weeks, ZDV/3TC from 34/36weeks and intra-partum NVP, and a 7 day ZDV/3TC post-partum tail. All HIV+ women will be linked post-partum to an HIV/ARV point of service, which will utilize a family centered care delivery model whenever feasible, co-locating adult and pediatric care and providing a linkage to family planning services.

HIV+ women will be counseled pre- and post-natally regarding exclusive breast feeding with early cessation or exclusive BMS if AFASS using the National infant feeding curriculum. Couples counseling or family member disclosure will be utilized to facilitate support for infant feeding choices. As part of OVC programming, we would provide safe nutritional supplements as well as water guard, bed nets and other home based care items. HIV+ women will be linked to support groups in their communities which will provide both education and ongoing support around infant feeding choices and prevention for positives. This will ensure that HIV+ women remain in care throughout pregnancy, receive ARV prophylaxis, are supported in their infant feeding choice, access EID, and are linked to HIV care post-partum, thereby reducing loss to follow-up throughout the PMTCT cascade.

Infant prophylaxis will consist of single dose NVP with ZDV for 6 weeks in accordance with Nigerian National PMTCT Guidelines. Cotrimoxazole suspension is provided to all exposed infants pending a negative virologic diagnosis. Testing of infants will be carried out using dried blood spot (DBS) specimen collection. We will actively participate in the national early infant diagnosis initiative by providing infant for DBS testing from 6weeks of age. A systematic coordinated approach to program linkage will be operationalized at the site level and program level including linkages to adult and pediatric ART services, OVC services and basic care and support. Quality monitoring will be undertaken through site visits using an existing assessment tool and routine monitoring and evaluation indicators.

PFD will train 5 HCWs from 2 sites including community-based health workers in the provision of PMTCT services and infant feeding counseling. The national PMTCT training curriculum, national infant feeding curriculum and new national training tools will be utilized.

CONTRIBUTIONS TO OVERALL PROGRAM AREA
This activity will provide counseling & testing services to 2000 pregnant women, and provide ARV prophylaxis to 200 mother and infants pairs. This will contribute to the PEPFAR country specific goals of preventing 1,145,545 new HIV infections in Nigeria by 2009.

LINKS TO OTHER ACTIVITIES
This activity is linked to care and support, OVC services, ARV services, laboratory infrastructure, sexual prevention, and SI. Prevention for positives counseling will be integrated within PMTCT care for HIV+ women. The basic package of care provided to all HIV+ patients will be available to HIV+ pregnant women. Women requiring HAART for their own health care will be linked to ARV services. Our lab staff will ensure that HIV testing provided within the PMTCT context is of high quality by incorporating PMTCT sites into the laboratory QA program.

POPULATIONS BEING TARGETED
This activity targets pregnant women who will be offered HCT, HIV+ pregnant women for ARV prophylaxis and infant feeding counseling, and exposed infants for prophylaxis and EID.

KEY LEGISLATIVE ISSUES ADDRESSED
This activity is related to issues of gender equity since treatment will be provided to women and will promote male involvement in PMTCT programming.

EMPHASIS AREAS
The major emphasis area is training as most supported personnel are technical experts. A secondary emphasis area is commodity procurement as ARVs for prophylaxis and laboratory reagents for infant

diagnosis will be procured. Another secondary emphasis area is network/ referral systems as networks of care will be supported which are critical to ensuring quality of care at the PHC level, identifying women in need of HAART, and ensuring access to HAART within the network. In addition, partners and PABAs will be identified for linkage to care and support services.

MONITORING AND EVALUATION
CAMP clinics will track the number and proportion of women attending antenatal care each year who receive PMTCT services and the number of HIV+ women receiving antiretroviral prophylaxis. Quality of PMTCT sites will be monitored through indicators such as reduction in waiting time experienced by participants, the percentage of participants who complete their treatment, and the number of HIV+ women who undertake peer education activities in their communities about the benefits of VCT.

In COP10, under 'PEPFAR Nigeria's accelerated PMTCT plan', PFD, will strengthen its support to PMTCT service delivery by implementing activities that further improve the coverage and quality of PMTCT services. These activities will be directed towards increasing utilization of PMTCT services at existing service outlets through demand creation in collaboration with community resources and ensuring the upgrade of existing supported PHCs offering stand alone HIV counseling and testing to render at least minimal package of PMTCT services. In order to leverage resources, priority will be given to PHCs located in the selected focal states with presence of other donor agencies and in local government areas already earmarked for HSS support through GFATM. Where new sites are envisioned, those that are used for national ANC sero-sentinel surveys but yet to commence PMTCT services as well as PHCs located in communities with high HIV prevalence rates above the National average will be given priority.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HLAB | 188,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HTXD | 84,900 | |

**Narrative:**

None

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 10625** | **Mechanism Name: HHS/CDC Columbia Univ SPH** |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: International Center for AIDS Care and Treatment Programs, Columbia University | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 25,769,304** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 25,769,304 |

## Sub Partner Name(s)

| | | |
|---|---|---|
| ARFH, IBADAN (Managing NGO) | Ashaka Cement Clinic | BDSH KADUNA |
| CACA OGOJA | Care for Life | Care for Life, Gombe |
| CHAD, GOMBE | Citizen Empowerment Project, Kogi | CMH, Ogoja |
| DOMSOJ, OGOJA | ECUMENICAL CENTER, BENUE | Fantsuam Foundation Kafanchan |
| GADDS, Gombe | GAGH, Kaduna | GAMUNAN, GOMBE |
| GAWON FOUNDATION, MANCHOK | General Hospital Adikpo | General Hospital Akpabuyo |
| General Hospital Bajoga | General Hospital Etim Ekpo | General Hospital Etinan |
| General Hospital Gambo Sawaba Zaria | General Hospital Gwantu | General Hospital Idah |
| General Hospital Ikot Ekpene | General Hospital Kafanchan | General Hospital Kaltungo |
| General Hospital Kwoi | General Hospital Makarfi | General Hospital North Bank, Benue |
| General Hospital Ogoja | General Hospital Okene | General Hospital Saminaka |
| General Hospital SANKERA | General Hospital Vandekya | General Hospital Zambuk |
| G-HAC, OGOJA | Grace and Light, Ogoja | Holley Memorial Hospital Ochadamu |

| | | |
|---|---|---|
| Jireh Foundation | KWHO, Kaltungo | Nongu U Kristu U Sudan hen Tiv (NKST) Mkar, Gboko |
| POHSAC, SAMINAKA | POSITIVE HEALTH INITIATIVE, AKS | POSITIVE MEDIA, BENUE |
| REDEMPTION SUPPORT GROUP, AKS | Rekindle Hope | RUWDI, OGOJA |
| State Specialist Hospital, Gombe | Support Health and Education for Development | TBD |
| Tulsi Chanrai Foundation | Women Alive Foundation in Nigeria, Etinan | YDMH KADUNA |
| Youth Challenge, Kaduna | | |

## Overview Narrative

ICAP's main goal is to work in partnership with the government of Nigeria (GON) and local organizations at all levels to support the delivery of high-quality, sustainable, comprehensive HIV/AIDS prevention, care and treatment services using a family centered approach. ICAP works with the USG, other donors and implementing partners, GoN (Federal, State and Local), faith based, non-governmental and community based organizations and other for profit partners across the six states of Akwa-Ibom, Benue, Cross River, Gombe, Kaduna and Kogi targeting a combined population of 22,727,346 using a multi-disciplinary approach to support 30 hospital networks across six states of Nigeria in mostly geographically contiguous locations.

Comprehensive services provided is focused on-site implementation assistance to strengthen systems including HCT to most at risk populations, ART clinics (adult and pediatric) management, support for drugs, equipment and supply chain management, repairs of dilapidated infrastructure, medical records, referral linkages, patient follow-up, integration of prevention into care and treatment (C&Tx), involvement of PLWHA including OVCs, access to laboratory services and ARVs including first/second line regimens for adults and children using national protocols and guidelines. ICAP also strengthens linkages with entry points including: HCT, ANC, pMTCT, child welfare/under-5 clinics, TB clinics, OPDs, inpatient wards, family planning and palliative care services to enhance service uptake and improve quality of services. ICAP will also continue with the implementation of innovative WATCh (Where Are The Children) strategies piloted in COP09 to increase pediatric enrolment and improve child survival. Working closely with national TB/Leprosy Control Program and state/LGA TB control programs, ICAP support sites to provide services to TB/HIV co-infected patients through point of service laboratory support and strengthening of referrals and linkages at the facility/community levels to C&Tx sites. ICAP has also continued to foster, strengthen and expand community linkages, participation and involvement in all the

sites it is presently supporting and is actively putting in place sustainable structures for program continuity at all levels. ICAP supports prevention activities (including condom distribution) at community level through capacity building for CBOs, HCWs and PHEs to ensure that the prevention minimum package is delivered to MARPS and the general population. ICAP will also support states/LGAs by providing the framework to ensure safer and more rational use of ARVs and OI medicines.

In COP10, ICAP will continue to focus on improving access to and quality of care, and program sustainability through the implementation of robust strategies in partnership with all tiers of Government. A major thrust will be through health systems strengthening and human capacity development of policy makers, state officials, providers and community members. ICAP will continue to expand its health systems strengthening plans across these states by continually motivating the states to adapt and establish a chronic care system that will ensure continuity and comprehensive care not only for HIV but to other chronic illnesses as a whole. ICAP will establish QA/QI teams with state/LGA officials who will jointly monitor program progress with state officials and administer the Model of care and Standards of Care assessment tools, including systemic approach to ensure quarterly CD4 monitoring for early enrolment, quality care and identification of treatment failure. ICAP will leverage resources from other health care services and maximize linkages to ensure quality of care to mothers and their children. ICAP will continue to build the capacity of state facility lab personnel with emphasis on quality assurance/management, providing individual on the job trainings to improve service delivery. For sustainability, state quality officers will be trained alongside Regional Lab Advisors to supervise and conduct regular lab audits in preparation for national and international accreditations. Due to the human resource challenge across ICAP supported sites, ICAP will continue to engage the service of post NYSC health providers on a transitional basis and advocate for employment and appropriate remuneration of HCWs to the governments. ICAP will facilitate the institution of innovative procurement and infrastructure repair procedures, gender mainstreaming and public-private partnerships. For sustainability, use of regional stores will be enhanced and capacity of state governments on forecasting, quantification and procurement planning and storage strengthened. LMIS and inventory control systems will be strengthened with emphasis on automation of inventory control and decentralization of logistics systems to lower level facilities. ICAP will also leverage on IPs' resources to maximize treatment costs (SCMS, partnership with Roll Back Malaria etc.) and establish linkages with community pharmacies to expand community based palliative care and referrals.

With the paradigm shift to cost effectiveness, sustainability and local ownership, ICAP M&E will focus on strengthening data quality by implementing a robust standard of care monitoring and contributing to achieving the "three ones" strategy of GoN. Attaining these fundamental goals will involve training, mentoring, joint supportive supervision and logistic support to GoN at all levels

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Construction/Renovation | 154,616 |
| Education | 146,885 |
| Food and Nutrition: Commodities | 258,853 |
| Human Resources for Health | 3,605,126 |
| Water | 154,616 |

## Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Malaria (PMI)
Mobile Population
Safe Motherhood
TB
Workplace Programs
Family Planning

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **10625** |
| **Mechanism Name:** | **HHS/CDC Columbia Univ SPH** |
| **Prime Partner Name:** | **International Center for AIDS Care and Treatment Programs, Columbia University** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HBHC | 4,071,412 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Care | HKID | 1,515,000 | |

**Narrative:**

ACTIVITY UNCHANGED FROM FY2009
ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS:

In COP09, ICAP supported OVC services as follows: appropriately identifying OVC who are not receiving services; providing a holistic family centered approach to care of OVC; providing educational support; services for adolescent OVC (including creating exit strategy at 18 and appropriate prevention message with reproductive health services); providing nutritional assessments and support; providing health care services for HIV infected and affected children; and providing enhanced psychosocial support at both facility and community levels. ICAP further assisted 30 secondary hospitals and 24 CBOs in Kaduna, Benue, Akwa Ibom, Kogi, Gombe and Cross River States to support 6559 HIV-infected and affected children (OVC) to access health care, and other related services at the hospitals, their referral networks, including building community coalitions to boost services in surrounding communities.

In COP10, OVC services will be provided for 7,215 new children and adolescents and 74 caregivers. These OVC will include HIV positive and HIV-negative children of PLWHA or HIV affected orphans. ICAP will also continue to support 24 CBOs/FBOs/NGOs to provide community OVC services in the same states

ICAP family-focused approach is applied not only at the facility level but also at the community and home levels through care services. Community based programming leads to identification of OVC through awareness campaigns, support groups, and community-based HCT. OVC are also identified through provider initiated counseling and testing of children accessing care in health facilities following national norms regarding counseling and consent of minors. Once OVC have been identified, ICAP's OVC program focuses on providing an appropriate balance of services in the facility, community and home settings.

ICAP OVC programming has several key elements: appropriately identifying OVC who are not receiving services; providing a holistic family centered approach to care of OVC and adolescents; providing educational support; nutritional assessments and intervention; providing health care services for HIV infected and affected children; providing psychosocial support at both facility and community levels and activating linkages to economic strengthening activities.

In COP10, ICAP will continue to implement strategies to increase enrolments of OVC and uptake of services. Some of these include: chart reviews of adult PLWHA on treatment to identify children not enrolled and reached with services; weekly reporting systems for OVC tracked and enrolled into care and

treatment, provision of basic care kits (BCK) targeted at OVC and their care givers. ICAP will continue to provide nutritional support to OVC and work with the GON in partnership with MARKETS - a USG IP to leverage resources for providing therapeutic and supplementary foods respectively for OVC diagnosed with malnutrition. Through leveraging resources in COP09 with MARKETS; nutritional support was provided to OVC and caregivers with Richfil - a locally processed family cereal, in Cross River State. MARKETS also conducted a TOT and have sponsored two CBOs in Cross River State to train up to 300 OVC Caregivers on IGAs. In COP10, ICAP will continue to leverage on this collaboration to support OVC and their caregivers on nutrition and economic strengthening. ICAP will also explore linkages to other community-based food and microfinance programs through supported CBOs to promote sustainability and household food security. Economic strengthening opportunities for female OVC caregivers will be prioritized. ICAP will continue to facilitate the establishment of community driven "food bank" initiatives in comprehensive facilities to provide nutritional support to OVC. Food Banks will be supported to build capacities in food drives and stock management; reporting mechanism for OVC beneficiaries of the food banks, will also be strengthened the. Partnerships will be explored to help expand and sustain these innovative food banks to continue to serve OVC and their adult family members. The possibility of linking severely malnourished children to time-limited feeding programs will be explored where availability of and proximity to such programs allow. ICAP will continue to identify and leverage state and local government support mechanisms to further ensure the sustainability and ownership of these initiatives.

Health care services for OVC will continue to emphasize high quality of service delivery, reaching all tracked OVC with clinical services including de-worming with anti-helminthics, malnutrition screening and intervention, ongoing monitoring of growth and development. OVC services will be extended and integrated into identified adolescent clinics to be supported by ICAP. Other areas of emphases will be linkage to immunization, malaria treatment, screening and referrals for TB when indicated, cotrimoxazole prophylaxis (CPT) following national guidelines, diagnosis and management of common and life threatening childhood illnesses As a way of ensuring preventive care at the home level, basic care kits comprising of LLITNs, soap for effective hygiene, water guard and water cans procured from SFH (another USG supported IP) will be distributed to all clients. ICAP will also continue to work through local partners to provide educational support (e.g., school levies, uniforms, school bags and writing materials) to most in-need children following selection criteria locally adapted by the OVC CCC (OVC Community Care Coalition), with guidance from the national OVC Vulnerability Index. Through ICAP support, some of these CBO partners will also continue to provide peer education programming at primary and secondary schools and through targeted outreach activities to reach in- and out- of school adolescents.

ICAP enables the implementation of advocacy and social mobilization, psychosocial support, home based care (HBC), and educational support for OVC and their households through its support and capacity building of local NGOs, CBOs and FBOs, The psychosocial support provided to OVC and their

care givers, is multifaceted and comprehensive; it includes counseling on stigma and discrimination, disclosure, grief, and recreational activities. OVC services are also integrated into community HBC programs. Networking with community organizations and other implementing partners enables leveraging of resources and enhances service delivery and sustainability.

ICAP will also continue to build capacities of these local community and faith based organizations such as Fantsuam Foundation, Tulsi Chanrai Foundation (TCF), GAWON Foundation, Catholic Archdiocese of Ogoja (CACA), Grassroots HIV/AIDS Counselors, ARFH, other CBOs and PLWHA groups to provide family-focused OVC services. These NGOs/CBOs/FBOs provide home based primary care, psychosocial support, nutritional support and links for OVC to health facilities for basic health care needs by providing transport and other support.
Training and supportive supervision of health care cadres and CBOs/FBOs members, will be a vital element in ICAP's COP10 strategies. Health care workers in all 30 hospitals will continue to be trained on OVC to enable them to identify HIV-infected and non infected children, to link them into Care and treatment as appropriate. Social workers/ nurses focal persons for OVC will continue to be identified in all comprehensive sites. Onsite clinical mentoring will enhance quality of OVC care and management skills for program sustainability. OVC flow chart, posters, and detailed SOPs will be provided to the sites to support quality improvement and facilitate the delivery of optimal Care and support services for services.

In COP10, ICAP will provide training for additional 194 care providers including, counselors, and community/HBC providers using GON National guidelines, OVC National Plan of Action and SOPs. In addition ICAP and local partners will set up a monitoring system using the nationally approved tools that allows the monitoring of services provided directly by ICAP and/or by referral from ICAP to other organizations.

CONTRIBUTIONS TO OVERALL PROGRAM AREA:
ICAP, in partnership with other organizations, will provide training and scale up of OVC services that will enhance the delivery of quality services to 7, 125 OVC and their caregivers enrolled in core programs such as health, educational support, psychosocial support, and food and nutrition. All these activities will improve the lives of OVC reached in line with the national plan of action on OVC and the National Strategic Framework, and will contribute to meeting PEPFAR goals.

LINKS TO OTHER ACTIVITIES:
This activity relates to activities in ART (XXXX), Lab (XXXX), Palliative Care (XXXX), TB/HIV (XXXX), AB (XXXX), and SI (5541.09). HIV-exposed and infected children will be placed on prophylactic cotrimoxazole (CTX) following National guidelines. Household members of OVC will be referred for HCT

(5550.09) and children of women enrolled in PMTCT (XXXX) will be offered HCT as well as referred for OVC services. Policy makers and key decision makers in the health and education sectors will be reached by advocacy efforts.

POPULATIONS BEING TARGETED:
This activity targets infants, young children, in- and out of school adolescents and other at-risk children in HIV infected and affected families. It also targets the households, including caregivers of OVC. The entry point for OVC in the general population will be ICAP supported sites and partner organizations. Health and allied care providers in clinical and community settings will be trained to provide services to OVC. Community and facility based volunteers, traditional birth attendants and support group programs, will be used to increase access to care and support especially to the underserved.

EMPHASIS AREAS
ICAP's area of emphasis will be Community-based services for HIV-infected/affected children (0-17 years), Direct and Supplemental Services, Wraparounds (food, nutrition, IGA, water, and education) and Commodities (water guard, bed nets, etc.). Efforts will continue on improving and sustaining networks, linkages and referral systems as well as capacity development and food/nutrition support. In addition, ICAP will advocate equal access to education and improved legal and social services such as the protection of inheritance rights for women and children, especially for female children, and increased gender equity in HIV/AIDS programming. ICAP will advocate for increased access to income and productive resources for HIV infected and affected women and care givers. This activity will foster necessary policy changes and ensure a favorable environment for OVC programming. In COP10, ICAP support will continue to enhance equity and gender approaches that lessen vulnerability of female OVC by increasing their access to education, care and other support services. Increasing involvement of men in caring for OVC will also be emphasized.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HTXS | 6,983,775 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HVCT | 100,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Care | PDCS | 625,000 | |

**Narrative:**

ACTIVITY UNCHANGED FROM FY2009
ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS:
In COP09, ICAP has expanded support to a total of 30 health facility networks in the six high-prevalence states of Gombe, Akwa Ibom, Cross river, Kaduna, Benue and Kogi. By the end of COP09, ART will have been provided to a cumulative of 3200 children (including 536 new).

During COP 10 ICAP will strategically focus on reaching HIV positive children needing care and treatment (C&Tx) through various innovative approaches which include: support of pediatric HIV diagnosis; enhanced pediatric case finding and referral to care and treatment; ensuring comprehensive C&Tx services, including ART, for HIV-exposed infants (HEI) and HIV-infected infants and children; and providing enhanced psychosocial support at both facility and community levels. Following National Palliative Care Guidance and USG PC policy, ICAP-supported sites will provide a basic package of care services, including basic care kits, prevention with positives counseling for parents, clinical care (nursing care, growth monitoring, under 5 immunization services, neuro-developmental screening and monitoring; pain management, OI and STI treatment and prophylaxis, nutritional assessment and support, lab-baseline hematology, chemistry and CD4 percentage and follow up, OI and STI diagnosis- psychosocial support, provision of Cotrimoxazole, home based care, and active linkages between hospitals, health centers, and communities.

ICAP family-focused model of care is an optimal platform for pediatric case-finding and referrals. ICAP uses adult care and treatment venues as additional entry points for pediatric services, utilizing a genealogy form that ensures that HIV-positive adults are asked about the HIV status of their children at each visit. In COP 10, targeted testing will be done using skilled CBOs to ensure that children of adult in care and treatment are tested and linked to care.

In COP10 ICAP support for pediatric diagnosis will continue to include: enhancing linkages between PMTCT programs and those supporting OVC and ART services; supporting EID via dried blood spot (DBS) testing; initiating and expanding routine opt-out pediatric testing at inpatient and outpatient wards (including OPDs, casualty wards, well baby immunization clinics, child welfare venues, and adolescent/youth-friendly clinics) following national norms regarding counseling and consent of minors; and providing training, supplies, and laboratory support for HIV testing. DBS is collected from ICAP supported Nationally approved EID sites; ICAP will continue to partner with Clinton Foundation to ensure regular supply of DBS materials to all sites and shipment of samples /collection of results to and from National PCR labs.

In COP09, several challenges were identified as limiting pediatric uptake of care and treatment services. These include: poor linkage between PMTCT and services for HEI;  poor uptake of PICT for children of HIV infected adults in ICAP-supported C&Tx programs, OVC programs and within points of medical services for children especially sick children; also there was a lack of segregation of pediatric care data into exposed and infected status which is responsible for lack of determination of proportion of HIV infected children receiving HAART among others. A "WATCh"("Where are the Children") task force was initiated to put in place mechanisms that will identify innovative strategies to reach the children within the shortest timeframe and bring them into much needed C&Tx. The overall aim of the WATCh strategies is to develop systems to improve identification; enrollment and retention into care of HEI and infected children into care and treatment, including treatment with HAART. These interventions will be further expanded upon in COP10 and include: strengthening linkages between antenatal care, maternity and Exposed Infants, ollow up clinics, strengthening the tracking and follow up of HEI, strengthening universal "low hanging" PICT for children of HIV infected adults in C&Tx, OVC , and hospitalized children. This will involve having a minimum of 2 point of service testing for children in all comprehensive sites (in the Pediatric wards and immunization clinics). ICAP will continue to ensure monthly reporting of PICT performed on children of HIV infected adults in care and health services care points (reporting by categories and use of # of admissions would also help evaluate coverage). ICAP will further ensure that strategic approaches including chart reviews and monthly M&E reporting are used to determine program-level performance monitoring of HAART initiation among eligible HIV-infected children on a monthly basis. Also regular chart reviews will be conducted on records of HEIs and HIV-infected children to ensure  that all DBS positive Infants are linked to treatment appropriately.
ICAP will also ensure that Pediatric clients (both HIV exposed and infected) have priority for defaulter tracking. To further ensure that the children of adult in care and treatment are tested and the positive linked to care and treatment, ICAP will use skilled CBOs for targeted testing and to provide escort services of HIV positive children to comprehensive sites.

Enrolment into care and treatment
In COP10, 3,060 HIV-infected infants and children will be enrolled in care, and carefully staged, both at baseline and at subsequent follow up visits. Following clinical and immunologic staging, those not yet eligible for ART will receive clinical services including ongoing monitoring, charting and plotting of growth and development, screening and prophylaxis (IPT) for TB when indicated, cotrimoxazole prophylaxis (CPT) following national guidelines, and diagnosis and management of opportunistic infections as needed. Ready-to-Use-Therapeutic Feeding" (RUTF) using criteria agreed upon by the USG in-country and GON team will be provided at facility and community level via referrals where possible.
Parents/caregivers of HIV-infected children (regardless of children' HIV status) will receive a standardized "preventive care package" including basic care kits, ITN water guard, water vessel, ORS, soap and

gloves. Infants and children who are eligible for ART will receive appropriate first and/or second-line therapy accompanied by careful monitoring for toxicity and efficacy and by intensive adherence support. To improve retention in care for children ICAP will continue to advocate for communal support of transport reimbursement/food items for indigent children as well as link caregivers to IGA (income generating activities) in all the comprehensive sites

Decentralization of pediatric care and treatment services
In COP10 ICAP will continue to build capacities of pilot comprehensive PHCs to link to referring hospitals to support HIV/AIDS programs and provide onsite ART refills and follow up for stable patients, at the PHC level. Experienced nurses and community health officers identified in high volume pilot PHCs will be further trained to deliver quality focused pediatric C&Tx services including conduct nutritional assessments and monitor growth and development, provide drug refills based on a symptom checklists, provide CTX and micronutrients, psycho-social and disclosure support, and referral to the comprehensive treatment sites as needed. ICAP will work with local State primary health care agencies to develop/adapt job aids and SOPs for providing HIV care and treatment at the PHC. Pediatric ART services in COP 10 will include having a minimum package of care for infected children at all ICAP sites. This minimum package of care for infected children will include: follow up schedule, WHO staging, growth and development monitoring, TB screening at every visit, CD4 baseline and repeat every 3 months, DBS testing, CTX prophylaxis, immunization, Multivitamins, anti-helminthics, antibiotics (Ampiclox, Co-trimoxazole, and erythromycin), ITN and antimalarials for treatment, basic care kits, baseline investigations and nutritional assessment, food supplement, infant feeding counseling and confirmatory HIV test at 18 months.
This minimum package of care for HIV infected children in the PMTCT-only sites is in line with the decentralization of pediatric ART services to smaller sites (PMTCT only) and will bring ARV treatment, care and support services closer to families and communities. This will require building the capacity of the health care workers at the primary and secondary sites to scale up pediatric ART services at these sites. In the PMTCT only sites where there is no CD4 machine, ICAP will continue to support CD4 sample logging using the same channel of sample logging with the PMTCT, TB and Adult ART services.

Human Capacity Development
Training and supportive supervision of health care cadres will be a vital element in ICAP's COP10 program. Clinicians at all 30 hospitals will be assisted to identify HIV-infected children, to enroll them in C&Tx, to perform appropriate clinical and laboratory staging of these children, and to provide comprehensive care and support, including the prompt initiation of ART for eligible children. ICAP will also train PHCs staff to encourage task shifting in the care of HIV positive children. ICAP will conduct pediatric ART trainings, ongoing CME and QA activities for 232 clinicians and allied health care providers (including 100 for ART and 132 for Palliative care) who will support pediatric C&Tx. ICAP trainings will

reinforce the need for opt-out testing for pediatric inpatients, pediatric TB patients, adolescent patients and children suffering from malnutrition and common illnesses which are also warning signs of HIV infection. Trainings will also focus on second line and regimen changes for children who are already on ARVs. Additional training and support will enhance the specialized counseling, patient education, and linkages required in early infant diagnosis programs. Adherence trainings and support services will be provided at each site. This will facilitate adherence assessment and support including group counseling, disclosure counseling, patient/family/caregivers education, appointment diary system, referral linkages, patient follow-up, provision of support tools (dosage guides, reminders etc.), linkages to community-based adherence support and retention in care programs.

Clinical Systems Mentoring and Quality of Care
Onsite clinical mentoring will enhance quality of care and build site-level clinical and management skills for program sustainability. ART reference tools will include pocket guides, dosing cards, posters, and detailed SOPs. ICAP will support quality improvement/quality assurance mechanisms to facilitate the delivery of optimal C&Tx services. ICAP will also facilitate and actively support onsite standardized HMIS using GON forms and provide onsite assistance with data management and M&E to guide quality improvement measures.

Harmonization of Activities
In COP10, ICAP will continue to work closely with other PEPFAR IPs and GON to ensure compliance with National policies, curricula and guidelines, and continue to participate in the USG Clinical Working Group to address emerging treatment-related topics and further promote harmonization with other IPs and the GON.

Community Linkages
In COP10 ICAP will continue to work closely with its 24 NGO/CBO/FBO partners to promote community involvement, provide HIV prevention activities and linkages to wraparound activities, and facilitate adherence among HIV positive community members. ICAP will continue to strengthen/establish children support groups as part of the psychosocial support.

ICAP will also continue to provide nutritional support through partner CBOs to all 3,790 (?) HIV + children on ART. Support will include provision of RUTF as needed and other nutritional support. ICAP will also expand its successful Peer Health Educator program, enhancing targeted family counseling and testing, defaulter tracking, and inter/intra-facility linkages. ICAP will continue to ensure that HEI and HIV-infected infants and children are linked into OVC services. Prevention for positives messaging will include a balanced ABC approach messaging for adolescents infected with HIV. All HIV positive infected children/adolescents will be linked to home based care and support, community and social services for

referrals for food and education assistance, economic empowerment, and other wraparound services.

CONTRIBUTIONS TO OVERALL PROGRAM AREA:
One of the pioneers of family-focused multidisciplinary HIV/AIDS treatment in resource-limited settings, ICAP will be providing in COP010, ART services to 589 HIV infected children, contributing to the GON/PEPFAR targets for Nigeria. ICAP will build the skills of at least 232 care providers thus contributing to national sustainability plans.

LINKS TO OTHER ACTIVITIES:
This activity relates to HBHC (XXX), OVC (XXX), HCT (XXX), PMTCT (XXX), HVOP (XXX), TB/HIV (XXX), AB (XXX), and SI (XXX). As expansion of ART services is prioritized to rural areas, ICAP will strengthen referral channels and network mechanisms. Children on ART will be linked to home based care and community and social services. TB/HIV linkages will be strengthened where ART and TB DOTS sites are co-located, and co-location of new ARV sites will be actively promoted in TB DOTS stand-alone sites. All HIV infected children will be screened for TB using the National algorithm while all children infected with TB will be offered HIV testing. Children will be also linked to other child survival programs. ICAP will also provide onsite assistance with data management and M&E to guide quality improvement.

TARGET POPULATIONS:
HIV positive children, will be provided access to pediatric ART services. Health care providers in secondary and primary health facilities will be trained to deliver quality ART services.

EMPHASIS AREAS:
Emphasis areas are quality assurance/improvement and supportive supervision. ICAP personnel including national and international experts will provide skill and competency-based trainings, CME, and ongoing clinical mentoring to enable onsite staff to provide quality ARV services to children infected with HIV. Emphasis areas also include training, human resources issues, referral networks, infrastructure support, linkages to other sectors and initiatives. Services will also focus on addressing the needs of women, infants and children to reduce gender inequalities and increase access to ART services among these vulnerable groups. ARV services will facilitate linkages into community and support groups for nutritional support and other wrap around services. ICAP will strengthen the integration of HIV Pediatric packages into existing MCH and child survival services. This will be achieved through: decentralization of care of HEIs and integration of HEIs clinics into existing MCH services in PHCs.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | PDTX | 495,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Other | HVSI | 900,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HMBL | 40,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HMIN | 75,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVAB | 101,366 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVOP | 1,059,658 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | MTCT | 4,935,679 | |

**Narrative:**

ACTIVITY UNCHANGED FROM FY2009
ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS:
In COP10, ICAP will continue to work in the six states of Kaduna, Cross River, Benue, Kogi, Akwa Ibom and Gombe.

A total of 107 existing Government of Nigeria (GoN) mission and private health facilities will continue to receive support to provide PMTCT services and community outreach activities through 30 hospital networks and 77 PHCs.

ICAP will train health care workers (HCWs), support infrastructure, purchase equipment and supplies, monitor, evaluate and provide supportive supervision to the sites. Efforts will be made to facilitate the public health approach in taking PMTCT services to PHCs and community levels as essential steps towards universal access and the shared goal of eliminating peri natal transmission.. In COP10, ICAP will work to increase uptake of PMTCT services, including routine antenatal care and facility-based deliveries. ICAP will support PMTCT activities through: HCT for all pregnant women (ANC, labour and postpartum period); ARV interventions dispensed in ANC and maternity for HIV+ women; integrated group counseling into other health services attended by pregnant women and women of childbearing age; provision of services for well/or sick children (Immunization clinic), linkages to family planning and sexually transmitted infections (STIs) clinics; and promote integration of HAART in MCH and at PHCs using trained locum/mobile doctors, to provide 'one shop' services; and reduce delays in initiating HAART at comprehensive sites. Pregnant women, especially HIV-positive mothers, will be supported to deliver in health facilities through the provision of the national safe motherhood program delivery kits ("mama kits"). Mothers-2-Mothers (M2M) support groups will be established and/or strengthened at comprehensive and high volume PHC sites to increase facility-based delivery and reduce the number of women lost to follow up. ICAP will support and train mentor mothers who will spearhead these M2M support groups at PMTCT sites. Mentor mothers will conduct peer counseling to newly diagnosed HIV+ pregnant women, adherence counseling to women on ARV prophylaxis or HAART, provide information on minimum package of care for exposed infants and support defaulter tracking for positive mother-baby pairs. The use of ART for PMTCT will follow the National PMTCT guidelines. ICAP will provide support for psychosocial and adherence issues and for mothers infant feeding choices through appropriate infant feeding counseling. HAART eligible women will be enrolled at the nearest comprehensive site by referral and linkages. Health facilities will be supported to provide basic laboratory services and, if not available on site, will be linked to a laboratory network model in which CD4 testing can be performed by logging samples through specimen transport systems supported with motorbikes. ICAP will provide support for CD4 capability to high volume PHCs . ICAP will expand the use of hand held haemoglobinometers to all the PHCs to monitor women who are on AZT. Exposed infants will be actively linked to pediatric care and treatment through under-5 cards issued in labor and delivery. Women who test negative will receive prevention counseling and appropriate support to remain so.

ICAP will emphasize group counseling and opt-out testing with same day results at ANC, labor and postpartum service delivery points. Partners, households and children will be linked into HCT. ICAP will actively promote community-based PMTCT services through CBOs, to provide "doorstep" counseling

services to pregnant women, their partners and other household members. Clients will be counseled on the beneficial effect of couple/partner HCT/disclosure on adherence to infant feeding choice. Eligible HIV-infected women will be assessed and linked into care and treatment services including ART and cotrimoxazole prophylaxis (CTX). Other activities are enhanced pediatric care including CTX from 6 weeks of age and promotion of best practices for infant feeding, nutritional support and linkages to family planning services. In addition to receiving PMTCT services, each woman will be referred to OVC services upon HIV diagnosis to facilitate care to all of her affected children. ICAP will actively encourage male circumcision as a preventive measure especially in Kaduna and Gombe states.

Identification and follow-up of HIV-infected and exposed children living within the community will be a priority with CBOs/FBOs assisting with adherence issues and defaulter tracking. ICAP will continue to implement a basic minimum package of care services to exposed infants at PMTCT/HCT-only sites. This would ensure that exposed infants are linked into care and prevent loss to follow up. Minimum package include: simplified Exposed Infant registers for data capturing, prophylactic ARV syrups (NVP and AZT) within exposed infant/immunization clinic, growth monitoring, nutritional assessment/infant feeding counseling, child survival strategies counseling DBS at 6wks, HIV C&T services at immunization clinics and for women with unknown HIV status. To implement these services at the PHC level, ICAP will develop minimum training package adapted from the National pediatrics and PMTCT training manuals to train PHC staff. ICAP will advocate to the National Primary Health Care Agency on the inclusion of HIV/AIDS information on road to health charts to help identify HEIs.

ICAP and its sub-partners will train 715 HCWs, using GON curricula, to provide an enhanced package of quality MCH services to HIV+ women. The training will focus on prevention messaging (including balanced ABC messaging),on STI screening/treatment, cervical cancer screening, safer sex, malaria prophylaxis, minimum package of care for exposed infants including child survival strategies, use of ITNs and safe water. It is estimated that about 15% of babies born to HIV-positive women will become HIV infected through breastfeeding. To reduce this risk, ICAP will empower providers to give unbiased infant feeding counseling to mothers based on WHO/GoN recommendations (exclusive breastfeeding, use of BMS based on AFASS criteria). ICAP will support govt efforts through zonal training of trainers on HIV and infant feeding, infant feeding meetings and reprinting of finalized Infant National guidelines. Additional health care providers will be trained to educate and assist mothers make appropriate infant feeding options and discourage "mixed feeding" practices..

Home deliveries remain a very strong preference among many communities in Nigeria as 2/3rds of pregnant women either deliver with birth attendants or in their homes (DHS: 2005, Piper CJ; 1997). In order to reduce the number of HIV positive mothers and their exposed infants lost after home deliveries, ICAP will support GoN to develop a National TBA curriculum to enhance their quality of service at the

grass root level. ICAP will also support community sensitization, organization and capacity building of xxx TBAs across communities surrounding PMTCT sites in the six ICAP- supported states. TBAs will be trained on basic HIV prevention and infection control, safe motherhood, HIV counseling and testing information especially to pregnant women and their partners; and for referral support of newly delivered mothers and their babies for follow up care. Retired midwives and health care providers will be identified to monitor effective identification and referrals of pregnant women, newly delivered mothers and their exposed infants to nearby PMTCT sites for enrolment into care. TBAs will be involved in "Men Taking Action" activities to enhance community support.

ICAP will address the critical challenge of limited/lack of male partner involvement in PMTCT services and will strengthen male involvement through gender transformative activities. Through 'Men taking Action' MTA , ICAP will work with CBOs to increase service uptake, promote positive male norms and behaviors, especially as it relates to discordant couples, and help reduce stigma and discrimination through community based activities. These activities include community education and behavioral change communication (EBCC),"Mobile" outreach VCT at male-friendly HIV/AIDS events, use of trained community leaders/gate keepers to conduct EBCC and deliver accurate messages related to PMTCT and VCT to male partners of pregnant women attending ANC and to men in the general community. At the end of the sessions, men will be encouraged to undergo rapid HIV testing with HIV+ male partners' appropriate referrals for TB and CD4 screening to nearby health facilities, and linkage into care. ICAP will also encourage facility managers to make their MCH men friendly for HCT and utilizing mainly male counselors where feasible.

ICAP will work in close partnership with GoN on HIV early infant diagnosis (EID), offering HIV infant diagnosis testing in line with the National EID initiative from 6 weeks of age using DBS. HIV positive infants will be enrolled and linked to appropriate care and treatment. ICAP will support GON at training HCWs on EID at PHCs and in the finalization of EID training curriculum. A joint USG/GON/ICAP team will provide ongoing M&E and supportive supervision activities and contribute to the national PMTCT program's M&E efforts. ICAP is also earmarking USD125, 000 for procurement of goods and supplies through the SCMS mechanism

CONTRIBUTIONS TO OVERALL PROGRAM GOAL:
ICAP and its sub-partners target states with some of the highest seroprevalence rates in Nigeria. Providing services at the primary and secondary levels assists the GON in achieving its goal of decentralizing PMTCT services beyond the secondary care level. ICAP will significantly contribute to an increase in PMTCT services by supporting 107 existing secondary and primary health care facilities government, mission and private health facilities and also indirectly supporting GON ministries/programs in their rapid scale-up plans for PMTCT.

ICAP will strengthen national and state PMTCT programs by: support of capacity building of master trainers for PMTCT services; production of GON approved infant feeding support tools; support adaptation of IMAI Document for HCWs at the PHCs,printing of national PMTCT registers; support of regular coordination meetings in collaboration with other partners at all government levels. ICAP will also strengthen the programmatic skills of partner CBOs/FBOs in line with GON sustainability plans.

LINKS TO OTHER ACTIVITIES:
This activity is related to activities in ARV services, Basic Care and Support, OVC, counseling and testing, SI, Lab, and Sexual Prevention. Provider-initiated opt-out HCT will be offered to all pregnant women at ANC, and to their partners. Women presenting in labor will have rapid HIV tests and receive single dose NVP if positive. Infants born to HIV-infected women will access ART (single dose NVP and ZDV) and CTX prophylaxis. Infant PCR HIV testing via DBS will be conducted with HIV positive infants linked to appropriate OVC care and treatment services. PC linkages will enable HIV+ women and family members access to support groups. Pregnant women will be linked into FP services. Partner counseling/communication will be promoted through sexual prevention activities. M&E activities at PMTCT sites will contribute to the national PMTCT program's M&E efforts using national PMTCT MIS.

POPULATIONS BEING ADDRESSED:
Pregnant women, postpartum mothers, their partners and household members including HIV exposed infants and HIV infected children will be targeted and supported so that they have full access to HCT at multiple entry points of care. HIV infected women will be provided with PMTCT/PMTCT plus services, while HIV infected infants and children, and infected partners, will access care and treatment services, including OVC services. Uninfected women will be supported to remain HIV negative. CBOs, FBOs, TBAs, support groups, and men will also be targeted so that they participate fully in community based PMTCT services. Healthcare providers will be trained on providing services while the management skills of GON policy makers and implementers at all levels will be also improved.

EMPHASIS AREAS:
Emphasis will be on training, increasing gender equity in HIV/AIDS programs, human capacity development and SI.
Equipping women with IGAs, communication skills and legal Aid counseling, will promote gender equity in HIV/AIDS programs and increase access to services by the vulnerable groups of women and children. Emphasis will also be on primary prevention of HIV infection and prevention of unintended pregnancies among women living with HIV. HCT services will be integrated in RH/FP services while all PMTCT clients will be referred to access RH/FP services post-delivery. The health status of HIV+ women will be further enhanced by actively screening them for TB and cervical cancers. Recognizing the impact of male

involvement on a woman's access to PMTCT and VCT services, ICAP will use MTA strategies to enhance partner testing, endorsement of infant feeding choices, and engagement in care.
From a public health view, tasks can be shifted from more specialized to less specialized HCWs. At comprehensive/ high volume PMTCT/HCT-only sites, "Mentor Mothers", will be trained to spearhead Mothers to Mothers (M2M) support groups. They will also be trained to participate in peer/adherence counseling, minimum package for HEIs and tracking of defaulting mother-infant pairs, thus further leveraging task-shifting. At the State government level, ToTs will build capacity of State and local government PMTCT Task Force and also provide an opportunity for task shifting and promote sustainability by engaging state personnel in clinical systems mentoring activities at sites.

In COP10, under 'PEPFAR Nigeria's accelerated PMTCT plan', ICAP, will strengthen its support to PMTCT service delivery by implementing activities that further improve the coverage and quality of PMTCT services. These activities will be directed towards increasing utilization of PMTCT services at existing service outlets through demand creation in collaboration with community resources and ensuring the upgrade of existing supported PHCs offering stand alone HIV counseling and testing to render at least minimal package of PMTCT services. In order to leverage resources, priority will be given to PHCs located in the selected focal states with presence of other donor agencies and in local government areas already earmarked for HSS support through GFATM. Where new sites are envisioned, those that are used for national ANC sero-sentinel surveys but yet to commence PMTCT services as well as PHCs located in communities with high HIV prevalence rates above the National average will be given priority.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HLAB | 2,538,000 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HTXD | 1,679,414 | |

**Narrative:**

None

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HVTB | 650,000 | |

**Narrative:**

None

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 10994** | **Mechanism Name: State Amb Self Help Fund** |
|---|---|
| Funding Agency: U.S. Department of State/Bureau of African Affairs | Procurement Type: Grant |
| Prime Partner Name: TBD | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: Yes | Global Fund / Multilateral Engagement: No |

| Total Funding: Redacted | |
|---|---|
| **Funding Source** | **Funding Amount** |
| Redacted | Redacted |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## Key Issues

(No data provided.)

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **10994** |
| **Mechanism Name:** | **State Amb Self Help Fund** |
| **Prime Partner Name:** | **TBD** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HKID | Redacted | Redacted |
| **Narrative:** | | | |
| None | | | |

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 12446** | **Mechanism Name: USAID TREATMENT FOLLOW ON.** |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Cooperative Agreement |
| Prime Partner Name: TBD | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: Yes | Global Fund / Multilateral Engagement: No |

| Total Funding: Redacted | |
|---|---|
| **Funding Source** | **Funding Amount** |
| Redacted | Redacted |

## Sub Partner Name(s)

| | | |
|---|---|---|
| TBD | | |

## Overview Narrative

The USAID Treatment follow on project will take on patients currently on Anti Retroviral therapy and who will be transitioning to the project from the close out of two USAID partners (GHAIN and CHAN) with the goal of maintaining these individuals on treatment in line with PEPFAR and Government of Nigeria guidelines. The partner (TBD) will provide comprehensive ART services to identified patients through the established treatment sites in all target states in collaboration with the GON.

Consolidating on the strengths of the previous projects, the partners will strengthen appropriate HIV services at PHC facilities through a decentralized, integrated disease management approach at the state

and LGA level, consistent with national/ district health management policies/regulations. The partner will engage relevant stakeholders to increase access not only for HIV/AIDS but also for sexual and reproductive health and TB services in Nigeria. This project will promote compliance with Care and Treatment National guidelines, the integration of prevention into care and treatment services, the promotion of adherence and treatment education, clinical monitoring, management of OIs and related laboratory services within available funding and GON policies. All patients on ART will be monitored every month for adherence and detection of any adverse drug reactions. Cotrimoxazole prophylaxis will be provided to all HIV positive patients with CD4 counts of less than 350 in line with the national clinical guidelines. TB screening will also be done using a structured symptom checklist. The partner will support the task shift of ARV refills from comprehensive to PHC facilities, following national policies and guidelines. The partners will pay particular attention to improving non ART patient retention by strengthening patient tracking, community engagement and prevention with positives. This group of care patients will be enrolled for ongoing psycho-social, medical and psychological care, prophylaxis and prevention with positives package and will have their CD4 levels and clinical picture assessed every 3-6 months or as appropriate to determine progress and eligibility for ART. The implementing partners will initiate the diagnosis and management of STIs using WHO syndromic management protocols. The partners will support the integration of HIV/AIDS services with other services such as Reproductive health (RH), Malaria in Pregnancy and Food and nutrition services for HIV positive individuals. The partners will also cater to the clinical needs of Pediatric ART patients inherited from GHAIN and CHAN with the aim of optimizing the quality of life of such children.

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Malaria (PMI)
Child Survival Activities
Mobile Population
Safe Motherhood
TB
Family Planning

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **12446** |
| **Mechanism Name:** | **USAID TREATMENT FOLLOW ON.** |
| **Prime Partner Name:** | **TBD** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HBHC | Redacted | Redacted |

**Narrative:**

In COP10, community home-based care will be implemented through the engagement of community health workers and volunteers who will conduct home visits and provide nursing and psychosocial care services to clients in addition to providing hands-on training for family care givers. The partners will also train family members using national palliative care guidelines on proper hygiene and sanitation, PwP, and support for treatment adherence in the home. The follow on partners will advocate to the local and state governments to support facility teams with funds to track defaulting clients, procure reagents for diagnosis of OIs so that other patients can benefit from the wide range of tests available, take responsibility for the procurement of a certain percentage of commodities such as basic care kits and laboratory reagents.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HTXS | Redacted | Redacted |

**Narrative:**

The implementing partners (IPs) following on from the GHAIN and CHAN projects will train healthcare workers to provide ART services to clients both old and newly initiating ART in COP 10. The partners will focus on building the capacities of facility based multi disciplinary teams to provide comprehensive adult care and treatment services through a family centred approach and in partnership with CBOs facilitate the referral of patients and families in need to relevant resources in the community. The training will also emphasize the need to address gender disparities in access to and use of health and HIV/AIDS Services. Additional trainings in management of STIs using WHO syndromic management protocols, integrated service delivery models, advanced ART care and quality assurance will be conducted.

In COP10, these partners will strengthen the capacity of clinicians to further evaluate patients in long term care for failure and initiate second line therapy, provide clinical care to Treatment Experienced patients referred from other treatment sites and refer clients for higher level care. Laboratory services will

include capacity for CD4 evaluation and patient monitoring while adherence counseling services will continue to be provided at the health facility by trained pharmacists and persons living with HIV/AIDS (PLWHAs) who work as ART aides. Patients enrolled in care or treatment will be offered on-going counseling, diagnosis of opportunistic infections (OIs), prophylaxis and treatment of HIV/AIDS-related complications including malaria and diarrhea. TB screening will be done using a structured symptom checklist. These patients will also be enrolled into the facility and community-based family support groups for continuous psychosocial support and education. All enrolled patients will be provided with a basic home care kit consisting of insecticide treated bed nets (ITNs), Water Guard, calamine lotion, and Gentian Violet and condoms as part of the prevention package.

The partners will support the policy of task-shifting and will continue to advocate for this with local authorities and hospital directors while providing the needed mentoring and support supervision. Health facilities will be assisted to use task shifting as one mechanism for rationalizing the deployment of available human resources, based on the realities at each facility.

The partners will implement a series of tasks to assure high quality services and will liaise with the national ART TWG and HIVQUAL working group to adapt the quality indicators to the projects; adult Care and treatment services. State and facility based multidisciplinary teams will be trained and supported to inaugurate Quality Assurance teams which will conduct periodic clinical audits. Continuous quality improvement will be the focus of ongoing professional development efforts.

The implementing partners will also participate with other stakeholders in the National ART task team meetings as well as USG Clinical and ART technical working group meetings.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HVCT | Redacted | Redacted |

**Narrative:**

The implementing partners will provide HIV Counseling and Testing (HCT) according to standard best practices in all supported sites. In particular, pediatrics, couples and HCT services to index cases of care and support will be strengthened.

With the strategic shift in HCT focus, partners will build the capacity of collaborating health facilities to implement Provider Initiated Testing and Counseling (PITC). While at the community levels, partners will collaborate with local NGOs and FBOs to implement targeted HCT services for MARPs and for couples including for premarital HCT. The linkages of HCT clients to other prevention services, including Prevention with Positives; care and support and treatment services will be strengthened through well

coordinated two-way referral mechanism.

Strong close collaboration with the government, especially at the states and local government level to strengthen HCT program coordination and monitoring and evaluation will be of particular focus.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | PDCS | Redacted | Redacted |

**Narrative:**

In COP10, the implementing partners (IPs) will health workers and volunteers to provide pediatric HIV services including provider initiated counseling and testing to children and their family members, enrollment of HIV positive children, adolescents and their family members into care, clinical staging,CD4 evaluation, assessment for Antiretroviral therapy (ART) eligibility and provision of ARVs for eligible pediatric patients, screening for and treatment of opportunistic infections like TB, provision of prophylactic treatment of Opportunistic infections, parent-child follow up, growth monitoring, immunization, nutrition supplementation and provision of Basic Care package (ITN, water guard and water vessel). Referral for higher level of care when necessary and for other social or community based support programs will be provided.

The partners will ensure follow up of children and their care givers, promotion of hygiene and good sanitation and linking families to community based resources. Care givers will attend and participate in Peer Support Group meetings with their children. The partners will provide capacity building for adolescents on disclosure, adolescent reproductive health and positive living. Pediatric adherence counseling services as well as management of acute infections will also be provided.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | PDTX | Redacted | Redacted |

**Narrative:**

The partners will support identified HIV exposed and positive children with facility-based clinical care and support. This support will be provided through the supported public and private comprehensive ART sites. During COP10, The partners will continue supporting health facility-based care for HIV-exposed children with the aim of extending and optimizing quality of life for HIV-infected children and their families. In line with the PEPFAR guidance on targets for COP 10, the partner will prioritize serving patients enrolled in previous years and minimize enrolling new children into care. The partner will adhere to National Standard Treatment and PEPFAR guidelines.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Prevention | MTCT | Redacted | Redacted |

**Narrative:**

PMTCT intervention in COP 10 will target the primary prevention of HIV in pregnancy, before delivery and post partum stages. "Opt-out" testing and counseling with same-day test results will be provided to all pregnant women presenting at antenatal care (ANC) or labor and delivery (L&D) wards. All pregnant women will be provided post-test counseling services on prevention of HIV infection, including the risks of MTCT and their partners will be encouraged to access counseling and testing services. All positive pregnant women will have CD4 tests conducted to determine placement on ARV prophylaxis or HAART for their own health.

Pregnant women, who qualify for HAART based on their health, will receive triple therapy, while those who do not qualify, will get AZT from 28 weeks or Combivir from 34 -36 weeks, sdNVP during labor and a 7 day tail of AZT and 3TC in accordance with the national guidelines. Women presenting in labor will receive sdNVP and the 7 day tail of AZT and 3TC. Infants will receive sdNVP at birth and AZT for 6 weeks. Co-trimoxazole (CTX) prophylaxis for all HIV exposed children from the age of six weeks until proven HIV negative will be routine across sites.

HIV positive pregnant women identified in the PMTCT program will be linked into care as well as infants and children identified. Infant follow-up care linked with PMTCT activities will include nutritional counseling and support, growth monitoring, co-trimoxazole prophylaxis, HIV testing, and other care services.

In COP10, the identified implementing partners will improve coverage and quality of PMTCT service outlets and will provide training for HCWs on PMTCT, ensure the supply of PMTCT commodities to their sites, provide supportive mentoring and supervision to staff at service outlets. The IPs will provide support to select state governments in order to build their capacity to better plan, implement, supervise and evaluate PMTCT activities in the identified focal states and also will support the accelerated PMTCT Plan in COP10.

IPs will focus on integration of services into maternal and child health as well as other reproductive health, immunization and other healthcare delivery services within facilities in all states. Infant feeding messages will be incorporated into counseling for PMTCT to include information on proper and effective weaning of infants using the recommended WHO guideline. EID will be carried out using DBS at the secondary and primary level in line with the national EID scale up plan.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Treatment | HLAB | Redacted | Redacted |

**Narrative:**

The implementing partners will provide Laboratory services for HIV/AIDS diagnosis, disease staging and treatment monitoring, these services will also be provided for index cases of care and support. The partnering health facilities will further be supported to develop capacity for the quality diagnosis of opportunistic infections including but not limited to TB, Cryptococcus, Pnuemocystic jiroveci pneumonia (PJP), and other fungal, parasitic and bacterial infections.

As the strategic focus in the next 5 years is to support the health system develop and sustain Quality Management Systems (QMS) in all Labs as a key strategy for sustained quality health care system, the implementing partners will support appropriate capacity development necessary to implement quality laboratory management systems and achieve National and/or International Accreditation.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HVTB | Redacted | Redacted |

**Narrative:**

In COP10, the implementing partners will strengthen TB/HIV collaborative activities; provide TB screening among HIV positive patients and referrals for TB treatment. Provide CTX to TB co-infected patients. Provide CT for TB patients, strengthen TB lab diagnosis. Logistics systems and capacity building for HCW. Support TB programs to provide quality TB and TB HIV services for TB patients. Build capacity of NGOs to create awareness for TB and train treatment supporters to encourage adherence. Provide support to the national and state TB programs to provide programmatic support for the MDRB TB service.

Strengthen community TB care by developing capacity of NGOs for awareness, treatment support and provision of TB treatment. Strengthen advocacy and social mobilization for TB HIV joint collaborative activity

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| Mechanism ID: 12447 | Mechanism Name: SAVE the Children |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Cooperative Agreement |

| Prime Partner Name: Save the Children UK | |
|---|---|
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 1,210,000** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 1,210,000 |

## Sub Partner Name(s)

| | | |
|---|---|---|
| Association for Reproductive and Family Health | | |

## Overview Narrative

Links for Children is a five-year project to improve services and support to OVC in four states: Kaduna, Kwara, Niger and Bauchi. The project will expand access to treatment services, and care and support for 23,120 orphans and vulnerable children; and training on care and support for 4,320 caregivers and 384 Child Protection Committee members. In COP 2010, project activities will focus on care and support for 1,200 OVC and training of 480 caregivers and 192 CPC members in two states, Kaduna and Bauchi, while establishing a presence in Kwara and Niger. This project will focus on one technical area of support: Support to OVC.

Key Project Outcome Indicators at end of COP 2010: 1) ARFH and 24 CSO partners (6 in each state) have completed an organizational assessment and development plan; 2) Initial baseline information will be compiled on all 3 project objectives. 3) 1,200 children will receive support in areas of education, economic, psychosocial, or protection; and 480 caregivers and 192 CPC members will receive training. 4) One training for state government agencies will be conducted in two states.

This Budget Code will include one cross-cutting program under Economic Strengthening, which will comprise the facilitation of Village Savings and Loan Groups for caregivers and HIV-affected households. This component will begin in Year 2, so is not included in the COP 2010 plan.

Save the Children will provide overall programmatic and administrative management, establishing a sub-grant with ARFH to implement activites in Bauchi and expanding to additional states in subsequent years. A Project Steering Committee (PSC) will give guidance on overall strategic direction and organizational arrangements.

There will be Project Manager and two Deputy Project Managers, one managing the SC state teams, and the other managing the ARHF state teams. An OVC Advisor will ensure overall technical quality; a Monitoring and Evaluation Advisor will manage all M&E systems; an Organisational Development Advisor will handle organizational assessments and development plans for ARFH and the CSO partners; and a Village Savings and Loan Advisor (starting in 2011) will coordinate this component. Technical Support includes a Health & HIV Advisors from SC and ARFH. An SC Grants Coordinator supports the management of project funds. An ARFH Finance Manager will manage the ARFH sub-grant.

The Project's State teams will be led by a State Team Leader. Four Project Officers in each State will guide the CSO facilitators and 3 support staff will support the offices.

The Performance Monitoring and Evaluation systems will assure a balance between systems that are sophisticated enough to help determine the success of the project and its impact on children, and systems that are user-friendly enough for the communities and individuals that are using them. The project is developing tools to capture valid and reliable data which can be used by community volunteers and CSO facilitators with basic literacy skills. A key component will be the Child Status Index (CSI), which will be used to assess the progress of children and families over time. Other tools developed for OVC programs in the Nigeria context and through SC's global experience will be used to complement the CSI. The project will also provide extensive training staff, partners, and communities in use of the M&E systems.

The Child Protection Committees-CPCs will serve as the basic team of service providers, along with CSO facilitators and project staff. The CPCs conduct a household survey in the community, during which each household is visited and assessed using the CSI tool. The household registers compiled from this survey serve as the "Baseline Assessment" for the household and community on which progress is measured. For each family documented on the register, a simple "case file" will be created and updated on a quarterly basis after home visits. The information from updated case files and household registers will be used to prepare progress reports for each community, and summarized for each state.

At the household and community level, caregivers and other household members will receive training to build skills in caring for their children appropriately in the context of what is already considered socio-culturally appropriate. Local leaders form an integral part of the committee formation and are asked to support all subsequent events. The community grants provided for the CPCs are implemented through a matching system, under which the CPCs are asked to raise portions of the grant's value. They are also linked with local government structures through advocacy visits.

Links for Children will match SC's expertise in using child-focused approaches with ARFH's expertise in providing sexual and reproductive health services to young people. Using a structured organizational development plan, ARFH will be able to meet the requirements to become a prime recipient of PEPFAR funding at the project's end. In the first year, ARFH will receive a sub-grant from SC to manage project activities in Bauchi. This will expand in Year 2 to include a second state, along with plans for subsequent transfer of additional states in the remaining years.

At state level, Save the Children has worked in partnership with 4 organizations since 2006: JNI, CAN, FOMWAN, and NRCS. The project will add two organizations with more experience in HIV/AIDS and OVC: AONN and NEPWHAN. Save the Children will not provide a specific sub-grant to each of these organizations; but the project will directly fund the field activities planned by the CSOs and CPCs. An organizational assessment and OD plan will be done for each CSO partner. By the project's end, at least two CSOs in each state will have successfully obtained funding to implement HIV & OVC projects, independent of this project. The project will also engage relevant government agencies in each state to further develop their OVC action plans through training, advocacy, and technical support.

At the community level, the CPC model demonstrates concrete results to the entire community of involving women and girls in problem-solving conversations and decision making processes. The process of bringing men, women, boys, and girls together to discuss issues of power, privilege, diversity, and exclusion in situations affecting their daily lives, helps address issues of gender roles and norms in a realistic, structured, and sustainable manner. In the area of economic empowerment, Village Savings and Loan activities have multiplier effects across individual, household, and community levels. Opportunities for participants include services to enhance small scale investments and asset building. All services provided in this project will ensure that age-appropriate and gender-appropriate interventions are provided, in particular focusing on improving access to services for older children in areas of sexual and reproductive health, HIV and STI prevention, and other life skills.

Legal protection for OVC will include such activities as birth registration and working with legal organizations addressing such issues as inheritance and property rights. CPCs will identify those households where children are required to work in hazardous labour to support their families; and work with the families to enable their children to attend school, while exploring alternative means for supporting the family. The project will work with communities to develop locally managed response systems that can link with the formal legal systems, but which also build trust and confidence for victims to report incidents in a supportive and confidential environment.

Extensive training is provided to all project staff, CSO facilitators, and CPCs, which includes a wide range of topics: child development, child protection and participation; gender equity, roles, and expectations;

diversity and exclusion; power, privilege, and discrimination; HIV/AIDS and other health/nutrition issues; M&E and reporting; and basic family assessment and psychosocial support. This will equip the staff and volunteers with skills to provide (or refer) age and gender-appropriate support and services for each child in each household, depending on the individual situation.

Each CSO facilitator works with the communities and CPCs through a mentoring system in which they are matched with project staff for purposes of mentoring and role modelling. Over time, the CSOs take on more responsibility for support to communities, while staff assume a monitoring and oversight role. CPC members do not receive any remuneration for the work that they do, as they are elected representatives of the community. CSO facilitators receive small monthly stipends to cover their local transport costs and other incidentals. By the end of the project, at least two CSOs in each state will have obtained small grants to support their work with CPCs and OVCs in the local communities independent of this project.

The project will use a community engagement model of Child Protection Committees that has proven effective in mobilizing communities in a sustained and relevant manner, and which has demonstrated significant success in Nigeria for reaching OVC and HIV-affected families. By supporting these groups, which also comprise children, to engage directly with families affected by HIV, the project will increase the number of OVC and families able to access testing, PMTCT, treatment, prevention, and care and support services. Through home visits, information will be provided on other key health and nutrition areas, such as maximizing the nutritional potential of local foods; breastfeeding and infant feeding practices; basic sanitation, water storage, and cleanliness practices; and other basic preventive health practices, such as malaria prevention, routine immunization, ORS solution for diarrhoea, etc.

A child-focused approach with child participation is fundamental to all work undertaken by Save the Children. SC has developed child participation models that have proven to be very effective, most recently in the development of the National Plan of Action for OVC. Child participation is built into the structure of this project, starting from the community level, where the Child Protection Committees are comprised of equal groups of men, women, boys, and girls.

The CPCs will work with other local structures to develop solutions for children and families that provide support through large-scale interventions. In Kwara and Kaduna States, the project will take advantage of SC's involvement in ESSPIN, a 6 year DFID-funded Education Program, to work with school authorities and School-Based Management Committees, to develop broad-based sustainable solutions to improve the access of large numbers of vulnerable children to basic education services

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## Key Issues

Increasing gender equity in HIV/AIDS activities and services

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **12447** |
| **Mechanism Name:** | **SAVE the Children** |
| **Prime Partner Name:** | **Save the Children UK** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HKID | 1,210,000 | |

**Narrative:**

Links for Children is a five-year project to improve services and support to OVC in four states: Kaduna, Kwara, Niger and Bauchi. The project will expand access to treatment services, and care and support for 23,120 orphans and vulnerable children; and training on care and support for 4,320 caregivers and 384 Child Protection Committee members. In COP 2010, project activities will focus on care and support for 1,200 OVC and training of 480 caregivers and 192 CPC members in two states, Kaduna and Bauchi, while establishing a presence in Kwara and Niger. This project will focus on one technical area of support: Support to OVC.

Key Project Outcome Indicators at end of COP 2010: 1) ARFH and 24 CSO partners (6 in each state) have completed an organizational assessment and development plan; 2) Initial baseline information will be compiled on all 3 project objectives. 3) 1,200 children will receive support in areas of education, economic, psychosocial, or protection; and 480 caregivers and 192 CPC members will receive training. 4) One training for state government agencies will be conducted in two states.

This Budget Code will include one cross-cutting program under Economic Strengthening, which will comprise the facilitation of Village Savings and Loan Groups for caregivers and HIV-affected households. This component will begin in Year 2, so is not included in the COP 2010 plan.

Save the Children will provide overall programmatic and administrative management, establishing a sub-

grant with ARFH to implement activites in Bauchi and expanding to additional states in subsequent years. A Project Steering Committee (PSC) will give guidance on overall strategic direction and organizational arrangements.

There will be Project Manager and two Deputy Project Managers, one managing the SC state teams, and the other managing the ARHF state teams. An OVC Advisor will ensure overall technical quality; a Monitoring and Evaluation Advisor will manage all M&E systems; an Organisational Development Advisor will handle organizational assessments and development plans for ARFH and the CSO partners; and a Village Savings and Loan Advisor (starting in 2011) will coordinate this component. Technical Support includes a Health & HIV Advisors from SC and ARFH. An SC Grants Coordinator supports the management of project funds. An ARFH Finance Manager will manage the ARFH sub-grant.

The Project's State teams will be led by a State Team Leader. Four Project Officers in each State will guide the CSO facilitators and 3 support staff will support the offices.

The Performance Monitoring and Evaluation systems will assure a balance between systems that are sophisticated enough to help determine the success of the project and its impact on children, and systems that are user-friendly enough for the communities and individuals that are using them. The project is developing tools to capture valid and reliable data which can be used by community volunteers and CSO facilitators with basic literacy skills. A key component will be the Child Status Index (CSI), which will be used to assess the progress of children and families over time. Other tools developed for OVC programs in the Nigeria context and through SC's global experience will be used to complement the CSI. The project will also provide extensive training staff, partners, and communities in use of the M&E systems.

The Child Protection Committees-CPCs will serve as the basic team of service providers, along with CSO facilitators and project staff. The CPCs conduct a household survey in the community, during which each household is visited and assessed using the CSI tool. The household registers compiled from this survey serve as the "Baseline Assessment" for the household and community on which progress is measured. For each family documented on the register, a simple "case file" will be created and updated on a quarterly basis after home visits. The information from updated case files and household registers will be used to prepare progress reports for each community, and summarized for each state.

At the household and community level, caregivers and other household members will receive training to build skills in caring for their children appropriately in the context of what is already considered socio-culturally appropriate. Local leaders form an integral part of the committee formation and are asked to support all subsequent events. The community grants provided for the CPCs are implemented through a

matching system, under which the CPCs are asked to raise portions of the grant's value. They are also linked with local government structures through advocacy visits.

Links for Children will match SC's expertise in using child-focused approaches with ARFH's expertise in providing sexual and reproductive health services to young people. Using a structured organizational development plan, ARFH will be able to meet the requirements to become a prime recipient of PEPFAR funding at the project's end. In the first year, ARFH will receive a sub-grant from SC to manage project activities in Bauchi. This will expand in Year 2 to include a second state, along with plans for subsequent transfer of additional states in the remaining years.

At state level, Save the Children has worked in partnership with 4 organizations since 2006: JNI, CAN, FOMWAN, and NRCS. The project will add two organizations with more experience in HIV/AIDS and OVC: AONN and NEPWHAN. Save the Children will not provide a specific sub-grant to each of these organizations; but the project will directly fund the field activities planned by the CSOs and CPCs. An organizational assessment and OD plan will be done for each CSO partner. By the project's end, at least two CSOs in each state will have successfully obtained funding to implement HIV & OVC projects, independent of this project. The project will also engage relevant government agencies in each state to further develop their OVC action plans through training, advocacy, and technical support.

At the community level, the CPC model demonstrates concrete results to the entire community of involving women and girls in problem-solving conversations and decision making processes. The process of bringing men, women, boys, and girls together to discuss issues of power, privilege, diversity, and exclusion in situations affecting their daily lives, helps address issues of gender roles and norms in a realistic, structured, and sustainable manner. In the area of economic empowerment, Village Savings and Loan activities have multiplier effects across individual, household, and community levels. Opportunities for participants include services to enhance small scale investments and asset building. All services provided in this project will ensure that age-appropriate and gender-appropriate interventions are provided, in particular focusing on improving access to services for older children in areas of sexual and reproductive health, HIV and STI prevention, and other life skills.

Legal protection for OVC will include such activities as birth registration and working with legal organizations addressing such issues as inheritance and property rights. CPCs will identify those households where children are required to work in hazardous labour to support their families; and work with the families to enable their children to attend school, while exploring alternative means for supporting the family. The project will work with communities to develop locally managed response systems that can link with the formal legal systems, but which also build trust and confidence for victims to report incidents in a supportive and confidential environment.

Extensive training is provided to all project staff, CSO facilitators, and CPCs, which includes a wide range of topics: child development, child protection and participation; gender equity, roles, and expectations; diversity and exclusion; power, privilege, and discrimination; HIV/AIDS and other health/nutrition issues; M&E and reporting; and basic family assessment and psychosocial support. This will equip the staff and volunteers with skills to provide (or refer) age and gender-appropriate support and services for each child in each household, depending on the individual situation.

Each CSO facilitator works with the communities and CPCs through a mentoring system in which they are matched with project staff for purposes of mentoring and role modelling. Over time, the CSOs take on more responsibility for support to communities, while staff assume a monitoring and oversight role. CPC members do not receive any remuneration for the work that they do, as they are elected representatives of the community. CSO facilitators receive small monthly stipends to cover their local transport costs and other incidentals. By the end of the project, at least two CSOs in each state will have obtained small grants to support their work with CPCs and OVCs in the local communities independent of this project.

The project will use a community engagement model of Child Protection Committees that has proven effective in mobilizing communities in a sustained and relevant manner, and which has demonstrated significant success in Nigeria for reaching OVC and HIV-affected families. By supporting these groups, which also comprise children, to engage directly with families affected by HIV, the project will increase the number of OVC and families able to access testing, PMTCT, treatment, prevention, and care and support services. Through home visits, information will be provided on other key health and nutrition areas, such as maximizing the nutritional potential of local foods; breastfeeding and infant feeding practices; basic sanitation, water storage, and cleanliness practices; and other basic preventive health practices, such as malaria prevention, routine immunization, ORS solution for diarrhoea, etc.

A child-focused approach with child participation is fundamental to all work undertaken by Save the Children. SC has developed child participation models that have proven to be very effective, most recently in the development of the National Plan of Action for OVC. Child participation is built into the structure of this project, starting from the community level, where the Child Protection Committees are comprised of equal groups of men, women, boys, and girls.

The CPCs will work with other local structures to develop solutions for children and families that provide support through large-scale interventions. In Kwara and Kaduna States, the project will take advantage of SC's involvement in ESSPIN, a 6 year DFID-funded Education Program, to work with school authorities and School-Based Management Committees, to develop broad-based sustainable solutions to improve the access of large numbers of vulnerable children to basic education services

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 12448** | **Mechanism Name: USAID Track 2.0 Prevention Follow-on** |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Cooperative Agreement |
| Prime Partner Name: TBD | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: Yes | Global Fund / Multilateral Engagement: No |

| Total Funding: Redacted | |
|---|---|
| **Funding Source** | **Funding Amount** |
| Redacted | Redacted |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

This mechanism for follow on activities which will aim to ensure an increase and continuity of services, increase the quality of interventions and yield the proper mix among service delivery, systems strengthening and capacity building to the federal, state, local government and civil society. The new award will ensure a smooth transition from those partners whose projects are closing during FY10 and in subsequent years. It is envisioned that this implementing mechanism will consolidate management burden and geographically tailor the selected geographic regions and health systems strengthening where the activities are needed.

A large component of PEPFAR I and II is the prevention of millions of HIV infections. The USAID Nigeria HIV/AIDS-TB team along with its partners and the Government of Nigeria has made great achievements in obtaining this goal. Due to their efforts, Nigeria has seen a decrease in its HIV prevalence from 4.4 percent in 2005 to approximately 3.6 percent in 2007. While there has been overall achievement, there are signs that the current strategy may need to be strategically augmented as incidence in some regions has increased. There is evidence that drivers of the epidemic include: transactional sex, low risk

perception, high risk behavior and sexual networks amongst Most at Risk Persons (MARPS), multiple and concurrent partnerships, and poor sexually transmitted infection (STI) management. Current activities do not cover all driver activities that are needed.

The new mechanism will tailor its approach to ensure it is aligned with the goals of the National HIV/AIDS Prevention Plan which include:
(1) Developing a comprehensive package of interventions to promote abstinence, fidelity and related community and social norms;
(2) Developing a comprehensive prevention package of interventions for persons engaged in high-risk behaviors and promoting correct and consistent use of condoms as well as STI management;
(3) Implementing the minimum prevention package of interventions targeting the general population and MARPS guided by evidence from recent studies and taking into cognizance the drivers of the Nigerian epidemic;
(4) Continuing to build the capacity of Faith and Community Based Organizations to implement high-quality prevention programming;
(5) Integrating comprehensive prevention programming in care and treatment services including Prevention with Positives;
(6) Supporting evidenced-based programming within the national and USG prevention portfolios.

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Workplace Programs

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **12448** |
| **Mechanism Name:** | **USAID Track 2.0 Prevention Follow-on** |
| **Prime Partner Name:** | **TBD** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Other | OHSS | Redacted | Redacted |

**Narrative:**

The HSS prevention follow on will focus on stregthening delivery of HIV prevention services in health facilities non governmental organizations and communities. The follow on will build the capacity for human resource cadre skilled in the implementation of a Minimum Prevention Package Intervention in Nigeria. HIV prevention interventions and activties will be intergrated in clincal and community health services. The HSS prevention follow on will provide technical assistance to institutionalize prevention training curricula in training and health instituions.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVAB | Redacted | Redacted |

**Narrative:**

This mechanism for follow on activities which will aim to ensure an increase and continuity of services, increase the quality of interventions and yield the proper mix among service delivery, systems strengthening and capacity building to the federal, state, local government and civil society. The new award will ensure a smooth transition from those partners whose projects are closing during FY10 and in subsequent years. It is envisioned that this implementing mechanism will consolidate management burden and geographically tailor the selected geographic regions and health systems strengthening where the activities are needed.

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(4) Continuing to build the capacity of Faith and Community Based Organizations to implement high-quality prevention programming;
(5) Integrating comprehensive prevention programming in care and treatment services including Prevention with Positives;
(6) Supporting evidenced-based programming within the national and USG prevention portfolios.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVOP | Redacted | Redacted |

**Narrative:**

This mechanism for follow on activities which will aim to ensure an increase and continuity of services, increase the quality of interventions and yield the proper mix among service delivery, systems strengthening and capacity building to the federal, state, local government and civil society. The new award will ensure a smooth transition from those partners whose projects are closing during FY10 and in subsequent years. It is envisioned that this implementing mechanism will consolidate management burden and geographically tailor the selected geographic regions and health systems strengthening where the activities are needed.

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(5) Integrating comprehensive prevention programming in care and treatment services including Prevention with Positives;
(6) Supporting evidenced-based programming within the national and USG prevention portfolios.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HVTB | Redacted | Redacted |

**Narrative:**

Combating stigma and discrimination
Ilustrative strategies and activties are as follows:

• Capacity building for CBOs in ACSM and TB control at the community level. Establish TB support groups to ensure treatment adherence and success among patients and establishment of TB networks in the communities.
• Promote community mobilization to address the unique needs of rural settings in which access to modern information technology (print, electronic and internet access) is low, literacy levels- including the knowledge of HIV prevention measures – are low, and learning occurs via oral tradition in closely knit small groups often facilitated by community leaders. In such settings, new ideas will be disseminated in the form of story telling, folks songs and parables to aid comprehension.Community facilitators will be trained to to respond to concerns and make necessary clarifications. Facilitators will also be equipped with information to identify signs of adverse drug reactions, TB suspects, etc. and make necessary referrals.
• Production of community specific radio and TV jingles, pamphlets, brochure, etc to increase TB awareness at the community level.
• Integration of TB information into the Peer Education training for National Youth Service Corps Members. Review of training manual to include TB, TBHIV with particular reference to Infection Control in community settings, during HCT activities, etc.
• Review of HCT training guidelines to include infection control measures during HCT sessions, especially at the community level.

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 12449** | **Mechanism Name: Central Contraceptive Procurement** |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Contract |
| Prime Partner Name: Central Contraceptive Procurement | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 306,217** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 306,217 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

The purpose of the central contraceptive procurement(CCP) is to provide an efficient mechanism for consolidated USAID purchases of contraceptives, including condoms, based on transfer of all funds from USAID accounts that support contraceptive procurement to a single central procurement account at the begining of each operational year. CCP also administers the commodity Fund, which serves HIV/AIDS prevention activities worldwide. The CCP project also provides a mechanism for independent testing of the condoms purchased by USAID or donated to USAID programs.

In COP'10 two PEPFAR implementing partners funded through USAID( GHAIN and LMS ProACT) will be sourcing their male condoms requirements through this mechanism, this will enable them provide HIV prevention programs that promote changes in sexual behaviors other than abstinence or be faithful(OP), these efforts will contribute to USAID/Nigeria's strategic objective (SO) 14- reduced impact of HIV/AIDS in selected states, and feeds into one of the four intermediate results( IRS) under SO 14: Increased use of quality HIV/AID and TB prevention services and intervention.

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## Key Issues

(No data provided.)

## Budget Code Information

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|---|---|
| **Mechanism ID:** | **12449** |
| **Mechanism Name:** | **Central Contraceptive Procurement** |
| **Prime Partner Name:** | **Central Contraceptive Procurement** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVOP | 306,217 | |

**Narrative:**

The central contraceptive project was estabilised to provide an efficient central contraceptive procurement mechanism for all USAID programs that responds to the request for contraceptives(including male condoms). Funds are transferred annually to this project through field support and from each USAID accounts that support contraceptive procurement. GH/PRH directs the use of these funds through a series of procurement contracts to provide contraceptive supplies for USAID programs worldwide.This project consolidates the procurement actions, but leaves responsibility for the estimation of condoms needs in the USAID offices that support the use of this commodity. In COP 10 USAID Nigeria will be pooling the procurements of male condoms for GHAIN and LMS ProACT projects respectively ( funded through USAID), 9 million pieces of condoms will be procured, of this number, GHAIN will be receiving 8.5 million pieces of condoms and LMS ProACT 0.5 million pieces of condoms respectively. The figures were derived based on quantification exercise conducted by the IPs, taking into consideration their COP targets. These projects will be utilizing these condoms for their other sexual prevention programs, based on their respective targets. The CCP project will be responsible for the procurement, shipping , clearing and delivery to a central location in Abuja-Nigeria for the partners, under a door-to-door transportation plan, through a frieght forwarder that will be contracted by the CCP. Warehousing, Distribution, Inventory monitoring, logistics information management system (LMIS) for these condoms will be managed by the implementing partners(IPS).The IPS will ensure that these high quality condoms are delivered to the targeted clients which include the most at risk populations (MARPS), like the commercial sex workers (CSW), others who exchanage sex for money and/or other goods, those with multiple or concurrent sexual partners, men who have sex with men(MSM), transport sector workers and other occcupational migrant workers (OMW), these services will be provided according to the national

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| policies, guidelines and standards. IPs will be providing this services through service outlets supported by their projects and through implementation agencies (IAs) in some instances, they IPs will build the capicity of the service providers and IAs to ensure that the clients are reached with prevention messages and condoms in line with set standards.<br>Under this program area, the CCP and USAID Nigeria will be supporting the GHAIN and LMS ProACT to reach their prevention planned targets. |

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 12450** | **Mechanism Name: USAID Track 2.0 AIDSTAR OVC** |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Cooperative Agreement |
| Prime Partner Name: TBD | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: Yes | Global Fund / Multilateral Engagement: No |

| Total Funding: Redacted | |
|---|---|
| **Funding Source** | **Funding Amount** |
| Redacted | Redacted |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## Key Issues

Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Child Survival Activities

## Budget Code Information

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|---|---|
| **Mechanism ID:** | **12450** |
| **Mechanism Name:** | **USAID Track 2.0 AIDSTAR OVC** |
| **Prime Partner Name:** | **TBD** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HKID | Redacted | Redacted |

**Narrative:**

In COP09 AIDSTAR will maintain services to the 14,400 OVC reached in COP 08 and train an additional 2,000 Caregivers in Enugu, Imo, Delta, Akwa Ibom, Rivers, Bayelsa, Gombe and Taraba States. COP 08 Narrative ACTIVITY DESCRIPTION: This is a new activity and it links to AIDSTAR activities in AB prevention to ensure that all OVC get age-appropriate prevention messaging integrated into their general health care. An analysis of the current USG Nigeria OVC portfolio, conducted by the USG Nigeria's Orphans and Vulnerable Children (OVC) TWG and reinforced by recommendations from previous technical assistance (TA) assessments, identified a number of key programmatic gaps: current paucity of indigenous partners to take programs to scale; poor understanding of OVC definitions by implementing partners; inadequate monitoring and supervision; weak referral networks between facility-based and community-based partners; lack of coverage in high prevalence states; few programs addressing the needs of adolescent OVC, particularly females; and little programming for young married girls in Northern Nigeria who have increased vulnerability. In addition to these programmatic gaps, the analysis identified a number of contracting constraints, as the current in-country capacity for making awards to new partners is limited by the current capacity of indigenous, civil society organizations (CSOs) to respond to the USG solicitation and award standards. The analysis also showed that to achieve community-level service provision and comprehensive services, a partner is needed with the technical expertise and implementation capacity to not only envision, but also have the ability to rapidly develop a large-scale effort in a country as large, complex and challenging as Nigeria. Finally, the analysis noted that implementing partners should have the mandate and capacity to engage local partners to ensure that the program is implemented comprehensively at the grassroots level. Based on these recommendations,

the AIDS Support and Technical Resources (AIDSTAR) Indefinite Quantity Contract (IQC) mechanism has been selected as a new partner under COP08, due to the fact that AIDSTAR contractors have demonstrated technical capacity in a range of technical areas related to care and support addressing multifaceted needs of OVC and palliative care. These include pediatric home-based care, gender, stigma and discrimination, and program-related data collection and analysis. This partner will work closely with the inter-agency OVC TWG and will be overseen by the PEPFAR Nigeria Senior Management team to ensure that it is integrated within the broader USG OVC portfolio. The scope of work will be developed in conjunction with the OVC TWG, and targets and specific activities will be shared with O/GAC prior to award, as is USG/Nigeria's practice for TBD activities. The Nigeria OVC task order will use AIDSTAR to provide: 1. Long-term in-country support for coordination and scale-up of HIV/AIDS activities in support of USG/Nigeria OVC strategies. 2. Service delivery focusing on the multifaceted needs of OVC, including home-based care for infected children, gender issues related to the vulnerability of female OVC and heads of household, stigma and discrimination. Specifically AIDSTAR contractors will: a) Identify OVC: Activities will be designed to build provider understanding of who is eligible for OVC services, and work with communities and clinical service providers to identify all children that are eligible for services. The geographic area of focus for AIDSTAR activities will be in areas of Nigeria with HIV prevalence at or above the national average that are underserved, particularly in the Southeast, South-South, North East and North West regions. Community-based and faith-based organizations in particular will be targeted as sub-partners. b) Develop a holistic OVC service model: AIDSTAR contractors will understand and establish the standard level of care for each of the 6+1 services using standards and practices that have been developed with USG support and GON collaboration. All OVC will receive at least 3 of these services, one of which must be psychosocial support. These services will be delivered through a family-centered and community-based model that reaches out to all children in a family infected/affected by HIV/AIDS. c) Ensure a multi-program and multi-sectoral referral system: AIDSTAR contractors will collaborate and form linkages/referrals between existing clinical and community-based partners within the geographical area of focus. In some states, AIDSTAR contractors will serve as case managers that coordinate referrals for OVC to ensure comprehensiveness of services. Wherever possible, community partners will engage with and link to clinical service providers; refer clients for HCT, care, and treatment; accept client referrals; and use this as a starting point to engage families in order to assist all children infected with or affected by HIV/AIDS. d) Address girls vulnerability issues: AIDSTAR contractors will focus activities in key Northern and Southern states where increased vulnerabilities of female girls are common, and provide support for girls' continuation in, or return to, school as well as improve outreach and linkages with HIV-related health services, particularly outreach efforts by USG projects (ACQUIRE, ACCESS, and Pop Council). 3. Increase the technical capacity of Nigerian decision-makers and personnel to design and implement effective, evidence-based HIV/AIDS interventions. Specifically, AIDSTAR contractors will: a) link with State Ministries of Women's Affairs (SMOWA) in focus states to build technical capacity so that they can roll out national-level policies, strategies, guidelines, quality

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| assurance, and data collection systems; b) provide technical support to FMOWAs to plan, manage, monitor and evaluate OVC service provision; and c) contribute to OVC program M&E in collaboration with the USG SI team and PEPFAR IPs tasked with overall M&E and SI capacity building. 4. Document and disseminate successful innovative approaches and sustainable models, evidence-based best practices and lessons learned, and new approaches, tools and methodologies in HIV/AIDS OVC programming. This activity substantively contributes to the overall USG Nigeria's Five-Year Strategy and to the implementation of Nigeria's National Plan of Action on OVC by developing and strengthening the community based service delivery for affected children. The suggested targets are determined based on the current estimated cost per targets for a minimum package of OVC interventions. As this is an IQC mechanism, the prime partner and final targets will be vetted with O/GAC and uploaded into COPRS after final award negotiations. The programs and activities implemented will increase the reach of OVC underserved populations and geographic areas with fairly high HIV/AIDS prevalence in comparison with the national average. LINKS TO OTHER ACTIVITIES: The activities implemented under the AIDSTAR IQC will achieve set targets for OVC served and caregivers trained while also providing clear linkages between their own activities and the wider OVC portfolio as implemented by other IPs. Strong linkages with the LMS project will be developed as LMS focuses on institutional capacity building in the FMOWA, while AIDSTAR focuses on increasing technical capacity. The emphasis on dissemination of best practices will also help develop the sustainability and efficacy of the program. POPULATIONS BEING TARGETED: Populations targeted in these activities will include all OVC, with particular focus on the female adolescent OVC in the Northern and Southern parts of Nigeria. Also targeted are community members, traditional leaders, religious leaders, men and women who act as caregivers for OVC. EMPHASIS AREAS: Emphasis areas will include human capacity development. The service delivery component of this award will have a key focus on community mobilization/participation and local organization capacity development. Other emphasis areas are development of network/linkages/referral system; information, education and communication and linkages with other sectors and initiatives. |

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

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|---|---|
| **Mechanism ID: 12451** | **Mechanism Name: USAID Track 2.0 AIDSTAR Injection Safety** |
| Funding Agency: U.S. Agency for International Development | Procurement Type: Contract |
| Prime Partner Name: TBD | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |

| | |
|---|---|
| TBD: Yes | Global Fund / Multilateral Engagement: No |

| Total Funding: Redacted | |
|---|---|
| **Funding Source** | **Funding Amount** |
| Redacted | Redacted |
| Redacted | Redacted |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## Key Issues

Workplace Programs

## Budget Code Information

| **Mechanism ID:** | **12451** | | |
|---|---|---|---|
| **Mechanism Name:** | **USAID Track 2.0 AIDSTAR Injection Safety** | | |
| **Prime Partner Name:** | **TBD** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Prevention | HMIN | Redacted | Redacted |
| **Narrative:** | | | |
| Under the AIDSTAR IQC, the TBD partner (The Partner) had implemented Injection Safety (IS) programs in five states (Anambra, Edo, Cross River, Lagos, Kano) and the Federal Capital Territory (FCT) since 2004 and individual USG and GON health facilities across another fourteen states (Bauchi, Benue, | | | |

Nassarawa, Niger, Plateau, Kwara, Ogun, Borno, Delta, Enugu, Kaduna, Katsina, Kebbi and Oyo States) during the FY08. By the end of COP 08, The Partner would have trained total number of 25,226 health care workers and 10,743 waste handlers. In COP09, The Partner will be conducting injection safety activities primarily in the 5 focal states and FCT. Technical assistance will be provided to other PEPFAR IP supported sites through training of trainers, health workers, store keepers and waste handlers trainings including refresher trainings at initial sites and supportive supervision. In COP 09, IP will expand to 30 new sites in a total of 4 States.

The Partner will continue to implement the four major technical areas: human and institutional capacity building; behavioral change of healthcare personnel to promote safe injection practices and the communities to promote oral medication where possible; ensure availability of equipment and supplies; and appropriate healthcare waste management at the 789 previously supported health facilities. In addition The Partner will extend its activities to an approximated 30 public health facilities through ad hoc partnership with corresponding IPs and or Government of Nigeria. In COP09 the Partner will provide IS training to a total of 5,000 individuals using FMOH adapted WHOAFRO/JSI training curriculum. A training of trainers on supportive supervision will be provided for all IP injection safety staff to enable them consolidate the gains of the training and ensure behavioral change at implementing sites. All IP will be encouraged to advocate for and support infection prevention and committees at facility levels.

Advocacy and behavior change communication (BCC) efforts include periodic advocacy meetings with policy makers at all levels of healthcare management and dissemination of BCC materials, tools, job aids, posters and pamphlets to healthcare providers. The partner will also promote safe injection practices, and oral medication to reduce unnecessary demand for injections at community level through Community Based Organizations (CBOs) interventions and the mass media in collaboration with INTERNEWS/ENHANSE. Collaborative BCC and advocacy work will continue with national and local institutions/organizations such as NAFDAC, the National Orientation Agency (NOA) and local/community and religious organizations. NAFDAC is supporting injection safety through; media messaging to discourage the populace from demanding injections from their health providers, advocacy to pharmaceutical industries producing injectables in Nigeria to support local production of safety boxes and promoting nationwide use of auto disabled syringes. Community outreach activities are expected to foster community engagement on issues of health with emphasis on injection safety issues as it affects communities in Nigeria. In COP08, the Partner trained field staff of the NOA to deliver appropriate injection safety messaging to the grassroots. This activity will continue in COP09. The Partner will work to maintain grassroots coalitions and encourage those coalitions to advocate on issues of injection safety with focus on the reduction of the demand for unnecessary injections, ensuring the safety of all necessary injections and proper healthcare waste management to the relevant health authorities and government.

The Partner will continue to work towards commodity security. The Partner procures IS commodities such as injection devices and safety boxes through her sub-contractor; PATH (Program for Appropriate Technology). Commodities are stored at the Government Central Medical Store in Oshodi (Lagos) and distributed by USAID accredited courier distribution company SDV to the focal GON Stores. The Partner has a tracking system to collect data on consumption and stock levels along the supply chain.

The Partner will support healthcare waste management through provision of seed waste segregation commodities, building infectious waste pits and encouraging the building of incinerators for appropriate final disposal options in accordance with WHO standards such as encapsulation in rural areas. We will also support the repairs and construction of incinerators, running cost as well as maintenance whenever possible where applicable. The Partner would work through the Federal Ministry of Environment and the National Prevention Technical Working Group with other partners to map out the HCWM microplan for selected HF sites, adapt the national adopted HCWM Plan, policy and guideline at the lowest service delivery points. The Partner will procure safe IS commodities through SCMS for the USG partners in FY09. All IPs are encouraged to plan for sustainability of the program in their sites.

The Partner will continue to work with the Federal Ministry of Health (FMOH) and other major stakeholders (such as the Nursing and Midwifery Council of Nigeria and Medical and Dental Council of Nigeria). The Partner also works with training health institutions (such as Medical, Dental, Pharmacy, Nursing and Midwifery schools and Schools of health technology) to review, include and update safe injections issues in their various curricula. In addition, injection safety training is part of the continuous medical education taking place at supported sites mentioned above (old or new). Training package for new entrance health workers into the healthcare system has been developed. The package is used to capture newly employed health care workers after completion of site trainings.

The National Policy on Injection safety and Health care Waste Management will continue to be disseminated widely in COP09. The Partner will perform quarterly monitoring of all sites including the GON and USG supported sites using the previously used tools. State MOH and other PEPFAR IPs will participate at state level meetings to give feedback for service delivery quality improvement.
The MMIS project operated in five focal states (Kano, Edo, Cross Rivers, FCT, Anambra and Lagos) with a view of saturation of those states with injection safety activities, while also supporting other states where PEPFAR treatment facilities were located. The range of activities included; Capacity building, HCWM, Procurement and behavior change.
Based on the current funding available for injection safety, one major shift from the MMIS project would be a dramatic decrease in procurement of auto disable syringes. To bridge this commodity gap the new award will have to put in a considerable amount of effort towards the implementation of the policy by

NAFDAC that would move syringe use in country from standard disposable to auto disable. Another gap in the MMIS project which will be filled with the new award is the inclusion of phlebotomy services, which will include the revision of the National injection safety manual to include safe phlebotomy and some seed stock for demonstrations. The new component will also be looking at safe male circumcision practices in its community component.
In summary;
• Injection safety training will continue to be offered to treatment partner sites as well as other selected states with a view of saturation in some of them;
• Phlebotomy services will be offered with provision of seed stock;
• Safe male circumcision will be incorporate into the behavior change community component of injection safety;
• level of effort will be increased to advocate for NAFDAC to implement the shift from standard disposable to auto disposable syringes.

CONTRIBUTION TO OVERALL PROGRAM AREA.
As the Partner plans to extend coverage to some sites supported by other USG IPs; this integrated HIV/AIDS programming will improve collaboration amongst partners, will maximize the impact and will contribute to the prevention of 1,145,545 new HIV infections by 2010 and contribute towards the PEPFAR global achievement of the 2,7,10. This will also improve the equity in access to HIV prevention services to the communities most in need; both rural and urban by reducing the risk of transmission to the community as well as to health care workers. These activities would contribute substantively to NACA's National HIV Prevention Plan implementation; develop strong links between THE PARTNER services and other service provides such as PEPFAR IPs, National Primary Health care Development Agency (NPHCDA), UNICEF, the World Bank and WHO, other organizations working on HIV/AIDS issues, IS and healthcare waste management. Improved safety in the work environment and universal precaution among health providers will lead to higher quality of health services and reduction in stigma/discrimination towards PLWHA.

LINKS TO OTHER ACTIVITIES
This activity also relates to activities in HIV Counseling and Testing, Laboratory, Palliative Care, TB/HIV, ART Services and OVC. Health care workers involved in these programs will benefit from the training program in injection safety and the adoption of utilization of single syringe and needle, needle stick policy and PEP protocol, all of which will improve the safety for workers involved in these other programmatic activities.

POPULATIONS BEING TARGETED

Targeted population include healthcare workers at focal health facilities; doctors, nurses, pharmacists, laboratory scientists, phlebotomists, community health officers, environmental health officers, store keepers and waste handlers. Religious and community leaders, community-based organizations are also targeted within the communities. In addition, heads of service and administrators need to be aware of the policies put in place to control medical transmission of HIV. Government policy makers, line ministries and National AIDS control program staff are also targeted for advocacy to leverage policy decisions, national guidelines and sustainability issues. Furthermore, these activities will indirectly target the general population on the community outreach program, who will be provided with information on safer injection practices, which are designed to prevent transmission of HIV and promote oral medications.

KEY LEGISLATIVE ISSUES ADDRESSED

Stigma and discrimination also occur in healthcare settings, and this has been reported in Nigeria. As HIV/AIDS treatment and care programs have been expanded, the training of all levels of healthcare providers on universal precautions and the risks of medical transmission have helped reduce the stigma and discrimination that can occur in these settings due to fear of occupational hazard.

EMPHASIS AREAS

Through these activities, major emphasis is placed on training of staff and institutional capacity development. This program will provide the basis for a workplace program through professional medical associations that will ensure that all treatment and laboratory specimens are handled safely, with minimal risk to healthcare providers. Minor emphasis includes policy and guidelines, information, education and communication, commodities procurement and quality assurance, quality improvement and support supervision.

ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS:

The significant change in THE PARTNER activity from COP08 to COP09 is the expansion strategy within selected sites as directed by USG and GON with inclusion of phlebotomy activities; this will entail coverage of IS at sites supported by other USG Implementing Partners (IPs) in addition to sites supported by JSI/THE PARTNER only, such as Government of Nigeria (GON), faith based and other private health facilities. THE PARTNER' support to USG IPs will be lead in IS training and coordination of all USG sites while supply of safe injection commodities and waste management will cover only non USG sites after training completion (USG sites will be required to purchase through SCMS; safe IS commodities) THE PARTNER will also support the setting up of support supervision system at sites level.

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| Indicators<br><br>• 4.0 Number of service outlets provided with training in injection safety 30<br>• 4.1 Number of individuals trained in medical injection safety 5000 |

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 12452** | **Mechanism Name: TB/HIV Collaborative Activities** |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Umbrella Agreement |
| Prime Partner Name: World Health Organization | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 900,000** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 900,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS:
TB and HIV constitute major public health problems in Nigeria, a country with a population of about of about 140 million people (2006 census). Nigeria presently ranked 4th among the 22 high TB burden countries in the world and first in Africa with an estimated incidence of 311 of all forms of TB per 100, 000 populations per year and prevalence of 521 per 100, 000 populations per year (WHO Global TB Report 2009). The National Programme currently implements the WHO recommended Stop TB strategy, a total of 90,311 TB cases were notified in 2008, representing a case notification rate of about 61/100,000 population.

The high National HIV prevalence (4.6% in 2008 National HIV sentinel survey) further complicates the

burden of TB, the prevalence of HIV/AIDS among TB patients increased from 2.1% in 1991 to 19.1% in 2003 (National HIV sentinel survey), and now estimated to be 27% (WHO Global TB Report 2009) which indicates that the TB situation will continue to be HIV-driven. The estimated incidence of all forms of TB among HIV patients is 83/100,000 population translating to the fact that about 123,000 TB-HIV co-infected patients occurs annually in the country (WHO Global TB Report 2009).

The deadly interaction of TB and HIV affects millions of people in Nigeria, threatens public health, and stretches the already weak infrastructure of the health sector. HIV is the most powerful known risk factor for reactivation of latent tuberculosis infection to active disease. HIV also increases the risk of recurrent tuberculosis; the rise in tuberculosis cases in PLWHA poses an increased risk of tuberculosis to the wider community. TB on the other hand is the leading cause of morbidity and mortality among People Living with HIV/AIDS. About 62% (56,053) of the notified TB cases in 2008 were tested for HIV (2008 NTBLCP report), 15,301 (27.3%) of whom were HIV positive. The access to HCT among TB patients is still far below the universal access target hence the need for further expansion and sustenance of TB/HIV services.

The emergence of multi-drug resistant TB (MDR-TB) and extremely drug resistant (XDR-TB) further create threat which if not properly controlled may erode all the gains made over the years in TB and HIV control. MDR-TB accelerate the morbidity and mortality among HIV/MDR-TB co-infected patients faster that ordinary TB, the difficulties in achieving cure among MDR-TB cases and the burden to hospital services as well as the affected households makes MDR-TB a health issue that must be given priority attention especially among PLWHAs.

There are very few data for multi-drug resistant TB (MDR-TB) in Nigeria; WHO estimates of MDR-TB prevalence for 2009 is 1.8% among new smear positive cases and 9.4% among retreatment TB cases (WHO Global TB Report 2009). A total of 80 MDR-TB cases were notified from 3 laboratories (NIMR, UCH, and Zankli) from 2006 to 2008. The ongoing DRS may further create an extra pool of about 250 MDR-TB patients which will require second line drugs some of whom may also be HIV positive. Additional cases are also expected as the capacity in-country to diagnose MDR-TB increases. Currently there are no second line anti-TB drugs in the Programme for treating MDR-TB; the GLC few weeks ago gave an approval for the NTBLCP to access second line drugs for the initial cohort of 80 patients at a concessionary price(about 99% reduction price compare with those in the open market). It is becoming more and more imperative for the programme to provide 2nd line anti-TB drugs for treating the expected MDR-TB cases among PLWHAs and the general population in view of the public health importance and human right issues and to provide effective Logistic management system for second line anti-TB drugs

Goal and Objectives of COP 2010 grants:

In view of the above, the planned activities for COP 2010 are therefore linked to the goal of reducing the burden of TB/MDR-TB and HIV in dually affected populations and the three objectives of the National strategic framework for the implementation of TB/HIV collaborative activities which are to:
1. Establish mechanisms for coordination at all levels,
2. Reduce the burden of TB/MDR-TB in HIV patients and
3. Reduce the burden of HIV among TB/MDR-TB patients.

The key intervention areas for COP 2010 will be to:
1. Strengthen capacity at National, State, LGA and facility levels to effectively coordinate and manage TB/HIV collaborative activities
2. Scale up of patients centered TB/HIV collaborative activities and ensuring continuous support for existing services.
3. Strengthen MDR TB Control and Management.
4. Strengthen implementation of TB infection control measures

The summaries of key activities that will be supported by this grant are highlighted below under each strategic direction:

1. Strengthen capacity at National, State and LGA levels to effectively coordinate and manage TB/HIV collaborative activities.
Funds from COP 06 - 09 through TB CAP/WHO was used in establishing and ensuring functionality of TB/HIV working groups at National level and in 23 states, the COP 08 and 09 grants was also used in collaboration with Scientifico di Tradate, Italy to develop the skills of the national facilitators from NTBLCP and NASCP in building capacity for TB/HIV management and leadership in Nigeria. The COP 010 will therefore be used to provide continuous support for the quarterly meetings of the TB/HIV working groups at National and in 23 states and also at health facility level. Capacity of programme staff from NTBLCP, NASCP and the state on TB/HIV leadership and management will also be enhanced.

2. Scale up of patient centered TB/HIV collaborative activities to 42 additional DOTS centers in 21 LGAs and ensuring continuous support for the existing TB/HIV services in 23 states.
The COP 010 will be used to support FMOH in scaling up services to 42 additional DOTS centers from 21 LGAs in line with the NTBLCP & NASCP scale up plan and in close collaboration with the International Federation of anti-Leprosy Associations (ILEP) members and other collaborating partners. The goal of this activity is to increase access to TB/HIV services in the 23 states currently receiving support from FMOH with PEPFAR grants through WHO/TB CAP in the implementation of TB/HIV collaborative activities while maintaining activities in the existing centers. Provider initiated HIV testing and counseling services will be established in 42 additional DOTS centers. 84 general health workers from these facilities

will be trained to provide health care provider initiated testing and counseling for TB suspects and patients, the workers will also have the capacity to diagnose HIV in TB suspects, treat HIV positive persons with active TB, provide CPT and referral to ART clinics and care and support services. The national HCT training curriculum will be used for CT training. In addition 42 laboratory staff from the identified 21 TB microscopy centers will be trained on how to carry out HIV testing in line with the national HIV testing algorithm and provide supervision back up for GHWs involved in multi point HCT service deliveries at DOTS centers. Capacity of the State TBL Control officers and State HIV/AIDS Programme Coordinator (SAPC) will also be strengthened to support TB/HIV services. WHO and FMOH staff at National and zonal levels will be supported to provide technical assistance to national, state and local government in mentoring, supervision and coordination of TBHIV activities at all levels. In collaboration with the FMOH, joint monitoring and supervision will be conducted from all levels and FY 2010 funds will also be utilized as required for on-going revision, printing and dissemination of national TBHIV reporting and recording forms to track progress towards the set targets.

3. Strengthening the control and Management of MDR TB

The COP09 grant was used to support the review, finalization and printing of SOPs for management and control of MDR TB patients. The APA4 was used in supporting renovation of MDR TB wards in 2 referral hospitals while renovations of other wards are also been supported by other partners. The APA 5 funds will also be supporting the training of personnel from MDR-TB treatment centers on effective MDR-TB Management and continue functioning of the National MDR-TB committee. The availability of second line anti TB drugs in the National programme for use at these MDR-TB treatment facilities is still a major gap; the COP 2010 will therefore be used in filling this gap by supporting availability and also effective Logistic management system for second line anti-TB drugs. The standard regimen currently approved by the National guidelines (6 Km-Cs-Lev-Pto-Z/18 Lev-Cs-Pto-Z) entails treatment of MDR-TB for 24 months, the first 6 months of which patents will be in the hospital, resources will be provided to support logistic management for second line drugs.

4. Strengthen implementation of TB Infection control Measures.

Ensuring appropriate Infection control measures in health facilities is one of the major challenges in the scaling up of TB/HIV services nationwide, these activities becomes vital in view of the emerging threat of MDR-TB, the increasing burden (rates of morbidity and mortality) of TB among co-infected patients. WHO in collaboration with other implementing partners will support the FMOH to scale up implementation of appropriate TB infection control measures in health facilities especially those with ARVs and TB services. The TB-IC will be used as an entry point for strengthening other infection control measures in the facility. The activities to be supported include:

? Dissemination of the national guidelines and SOPs on TB infection control.

? Organize Training of National (National focal person for TB-IC), State, WHO/TB CAP and other partners' staff from TB and HIV/AIDS control Programme on TB infection control.
? Conduct of Facility assessment in 12 sites with ART/HIV and DOTS services.
? Development of Infection control plan in 12 health facilities with ART and DOTS services
? Capacity building for facility staff from the 12 Health facilities on TB Infection control measures and the developed plan.
? Support formation and regular meetings of TB-IC committees in the 12 health facilities.
? Basic renovation and upgrading at the health facilities (OPD, AFB laboratories, DOTS centers) to conform to good TB-IC measures.
? Procurement of 10 Binocular Olympus microscopes to enhance diagnosis of TB among PLWHAs.
? Quarterly Supervision and monitoring of TB/Infection control activities. This will be integrated into the existing supervisory structures. TB-IC IEC materials (e.g. on cough hygiene will be developed).

Target Populations:
The target populations for the COP 2010 activities include:
? HIV positive persons receiving treatment, care and support and HIV positive persons with active TB.
? HIV patients who hitherto had no access to TB screening and care.
? TB suspects and patients from TB/DOTS centers who represent a high-risk population for HIV/AIDS (TB is the commonest Opportunistic Infection (OI) among PLWHA in the country).
? MDR-TB patients co-infected with HIV.
? MDR-TB patients with HIV status unknown.
? Through implementation of good TB-IC practice, the Health facility staff, visitors and patients in health facilities are also part of the target groups for some of the planned activities.

Geographical coverage:
The COP 010 will be used to support implementation of TB/HIV collaborative activities in 42 DOTS facilities from 21 LGAs in 7 states from the existing 23 states (Ogun, Osun, Ondo, Ekiti, Adamawa, Taraba, Niger, Nassarawa, Plateau, Kogi, Benue, Kwara, A-Ibom, Rivers, Enugu, Ebonyi, Imo, Abia, Sokoto, Katsina, Kebbi, Zamfara and Bayelsa) and also provide support for the existing TB/HIV service services in the 23 states.

Monitoring and evaluation plans:
The review, printing and dissemination of the National TB/HIV reporting and recording formats will be supported with funds from COP 2010; this is to enhance availability of these formats and to ensure quality data capturing at all levels. The M&E plan of this support is in line with the National M&E plan. Monitoring

and supportive supervision activities will be enhanced at all levels through support for:
? Updating of monitoring and supervisory tools where necessary.
? Monthly supervision of health facilities providing TB/HIV services by the LGA supervisors.
? Quarterly supervision LGA and health facilities by the State TB and HIV/AIDS Programme managers (STBLCO &SACP).
? Quarterly supervision to states by the Zonal NPOs.
? Joint Quarterly supervision by FMOH, WHO and partners to states.
? Leveraging of resources from partners such as GFATM Round 5 TB grants for Quarterly meetings at the state and Zonal levels to collate analyze and provide feed back.

Contributions to Overall Program Area:
The COP 2010 activities will contribute to the goals of the Government of Nigeria towards reaching the Stop TB targets, MDG targets and the Emergency Plan targets of providing HIV care. By linking TB and HIV services, this activity contributes to the Federal Governments strategy to have DOTS clinics and ART sites in the same facility or close by with a very strong referral mechanism. This activity also offers both TB and HIV patients a longer life free of the morbidity and mortality caused by TB and HIV interactions, thus allowing dually infected patients to contribute positively to the economic development of the country thereby contributing to the poverty alleviation Programme of the Government.

Contribution to health system strengthening:
Planned activities supported with COP 2010 will contribute to strengthening quality of services provided at health facilities and capacity of service providers in providing such services. The support for facilities to implement appropriate TB-IC measures will be used as an entry point for strengthening other necessary general infection control measures for other conditions. The COP 2010 is also supporting procurement of equipments such as Microscopes which can be leverage in the facility for diagnosis of other disease conditions such as malaria.

Links to other USG resources and /or other donor support:
This activity is linked to ART, palliative care and community based care and support services which are funded with PEPFAR funds through other implementers. This activity is also linked to ART services supported with the Round 5 GFATM HIV/AIDS grants.
This activity will also leverage nutritional support in areas where organizations such as MTN foundation are providing such support. This activity is also linked to the strategic direction of the National TB and Leprosy Control Program (NTBLCP).

## Cross-Cutting Budget Attribution(s)

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|---|---|
| Construction/Renovation | 45,000 |
| Human Resources for Health | 459,000 |

## Key Issues

TB

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **12452** |
| **Mechanism Name:** | **TB/HIV Collaborative Activities** |
| **Prime Partner Name:** | **World Health Organization** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HVTB | 900,000 | |

**Narrative:**

The planned activities for COP 2010 by WHO are linked to the goal of reducing the burden of TB/MDR-TB and HIV among dually affected populations and the three objectives of the National TB/HIV strategic framework for implementation of TB/HIV collaborative activities which are:
? Establishing and strengthening mechanisms for coordination at all levels.
? Reducing the burden of TB/MDR-TB in HIV patients and
? Reducing the burden of HIV among TB/MDR-TB patients.

Emphasis are also place on the issue of TB infection control measures while scaling up services to prevent transmission of TB and MDR-TB and also on enhancing linkage of MDR-TB/HIV co-infected patients to second line anti-TB drugs.

The WHO/TB CAP will use COP 2010 to support the Federal Ministry of health (NTBLCP and NASCP) in the following key intervention areas in addition to ensuring continuous support for existing activities instituted with COP06 – COP 09 through WHO and TB CAP:
1. Strengthen capacity at National, State, LGA and facility levels to effectively coordinate and manage TB/HIV collaborative activities
2. Scaling up implementation of patients centered TB/HIV collaborative activities and ensuring continuous support for the existing centers in 23 states.

3. Strengthen MDR TB Control and Management.

The implementation of these key intervention areas will be in line with the existing National strategic framework for TB/HIV collaborative activities and will be guided by the following principles:
? National/State ownership and leadership of the strategies:
? Partnership and collaboration with communities and other stakeholders at all stages of Programme development and implementation to increase acceptability of interventions, expand access to services, and broker additional human resources for Programme implementation.
? Equitable access to patients centered TB/HIV/AIDS interventions.

The Key activities that will be supported by this grant are discussed below under each strategic intervention:

1. Strengthen capacity at National, State and LGA levels to effectively coordinate and manage TB/HIV collaborative activities.

The FMOH and SMOH were supported with funds from COP 06 - 09 through TB CAP/WHO in establishing and ensuring functionality of TB/HIV working groups at National level and in 23 states (Ogun, Osun, Ondo, Ekiti, Adamawa, Bayelsa, Taraba, Niger, Nassarawa, Plateau, Kogi, Benue, Kwara, A-Ibom, Rivers, Enugu, Ebonyi, Imo, Abia, Sokoto, Katsina, Kebbi, Zamfara). This groups among other achievements, has help in strengthen coordination of partners involved in the implementation of TB/HIV collaborative activities at National and state level. The COP 08 and 09 grants was also used in collaboration with Scientifico di Tradate, Italy to develop the skills of the national facilitators from NTBLCP and NASCP in building capacity for TB/HIV management and leadership in Nigeria. The COP 010 will be used to support the following activities under this strategic intervention:

? Quarterly meetings of the National TB/HIV working group.
? Quarterly meetings of State TB/HIV working groups in 23 states (Ogun, Osun, Ondo, Ekiti, Adamawa, Bayelsa, Taraba, Niger, Nassarawa, Plateau, Kogi, Benue, Kwara, A-Ibom, Rivers, Enugu, Ebonyi, Imo and Abia).
? Formation and monthly meetings of facility based TB/HIV coordinating committees.
? Capacity building for State TBL Control Officers, State TBL supervisors and State HIV/AIDS Programme Managers from 12 states on TB/HIV Leadership and management using the existing pool of facilitators.
? Capacity building for 2 newly recruited programme staffs each from NTBLCP and NASCP on TB/HIV leadership and management using the existing pool of facilitators.

2. Scale up of patient centered TB/HIV collaborative activities to 42 additional DOTS centers in 21 LGAs and ensuring continuous support for the existing centers in 23 states.

There are 2,742 DOTS centers as at end of 2008, about 18% (500) of which are currently providing TB/HIV services, the COP 010 will be used to support FMOH in scaling up services to 42 additional DOTS centers from 21 LGAs in 7 states (from the 23 supported states) in line with the NTBLCP & NASCP scale up plan and in close collaboration with the International Federation of anti-Leprosy Associations (ILEP) members and other collaborative partners. The goal of this activity is to increase access to TB/HIV services in the 23 states currently receiving support from FMOH with PEPFAR grants through WHO in the implementation of TB/HIV collaborative activities while maintaining activities in the existing centers. The COP 2010 will be used to support the following activities under this strategic intervention

? Selection of 42 DOTS facilities to provide HCT services for TB suspects and patients from 21 LGAs
? Training 84 GHWs (2 GHWs per facility from 42 facilities) on provision of health care provider initiated testing and counseling for TB suspects and patients. The workers at the end of this training will have the capacity to recommend HCT to all TB suspects and patients, diagnose HIV in TB suspects, treat HIV positive persons with active TB, provide CPT and referral to ART clinics and care and support services. The national HCT training curriculum will be used for CT training.
? Selection of 42 AFB laboratory staff from identified 21 AFB microscopy centers.
? Training of 42 AFB laboratory staff (2 Lab staff per lab from 21 laboratories in 21 LGAs) will be trained on how to carry out HIV testing in line with the national HIV testing algorithm and provide supervision back up for GHWs involved in multi point HCT service deliveries at DOTS centers. The national strategy for HIV counseling and testing that will be implemented in these sites adopts a total and comprehensive approach to client management.
? Production and dissemination of IEC materials to raise awareness about the availability of the TB/HIV services in the facilities and communities to increase service utilization.
? Re-orientation of State TBL Programme managers and the SAPC from 23 states on provision, monitoring and supervision of TB/HIV collaborative activities. This will enhance quality of services provided, improve supportive supervision and quality of data generated and reported by states.
? Quarterly joint monitoring and supervision of TBHIV activities at all levels, in collaboration with the FMOH, joint monitoring and supervision will be conducted from all levels
? Monthly supervision by LGAs supervisors of TB/HIV activities at facility level.
? Revision, printing and dissemination of national TBHIV reporting and recording forms to strengthen collection, collation and analysis of required data and indicators thus ensuring quality programme tracking of progress towards the set targets, objectives and goal.
? Leveraging/procurement of Cotrimoxazole for CPT among PLWHAs at DOTS centers.

? Leveraging/procurement of HIV test kits for rapid HIV testing of TB suspects and patients in line with National algorithm.
? Procurement of consumables for HIV testing
? Support salaries of WHO-TB-CAP staff at National level to provide technical assistance to national, state and local government in mentoring, supervision and monitoring of TB/HIV collaborative activities.
? Support participation of National, State and WHO/TB CAP staff at international conferences and
? Piloting of Patient centered TB/HIV services in 12 LGAs in 6 states for effective roll out of 6months RH containing regiment.

3. Strengthen control and Management of MDR TB

Provision of effective management of MDR-TB and MDR-TB/HIV is one of the key challenges to National TB and HIV programmes efforts at reaching the set National and global targets including the MDG. In order to address this challenge, the WHO/TB CAP with COP09 grant supported the review, finalization and printing of SOPs, Guidelines and operational plans for management and control of MDR TB in Nigeria. The APA4 was used also to support renovation of MDR TB wards in 2 referral hospitals while renovations of other wards are also been supported by other partners. The APA 5 funds will also be supporting the training of personnel from MDR-TB treatment centers on effective MDR-TB Management and continue functioning of the National MDR-TB committee. The availability of second line anti TB drugs in the National programme for use at these MDR-TB treatment facilities is still a major gap; the WHO in collaboration with other partners supported the FMOH in securing an approval for the procurement of 2nd line anti-TB drugs from GLC. COP 2010 will therefore be used in filling this gap by supporting effective Logistic management system for second line anti-TB drugs. The standard regimen currently approved by the National guidelines (6 Km-Cs-Lev-Pto-Z/18 Lev-Cs-Pto-Z) entails treatment of MDR-TB for 24 months, the first 6 months of which patents will be in the hospital, resources will be leverage from FMOH and partners to provide social support for MDR-TB patients. The COP 2010 will therefore be used to support the following activities:

? Quantitative assessment of drug requirements, management of procurement, distribution, assurance of drug quality and ensuring rational drug use of second line drugs in-country.
? Setting up an inventory management system to ensure a safety stock and optimal stock movement, and to provide an accurate source of information for drug demand forecasting
? Provision of Air-conditions to ensure appropriate storage of second line drugs as some of the second line drugs may require to be preserved at ambient or controlled temperature (25°C, air conditioned room) or in Refrigerator.
? Training of pharmacists and pharmacy technicians from MDR-TB treatment facilities on pharmacy best practice for second line drugs.
? Production of laminated drug charts for second line anti-TB drugs.

? Production of laminated charts on adverse effects of MDR-TB/ARVs co-treatment and their management.

4. Strengthen implementation of TB Infection control Measures.
The practice of appropriate TB Infection control (TB-IC) measures is key to reducing the burden of TB and MDR-TB among PLWHAs. Studies of recent have shown that nosocomial transmission of TB and MDR-TB is on the increase especially in congregate settings such as HIV service delivery centers where good infection control measures are not observed, the result of this has been fatal in some societies often resulting to a more severe Extremely Resistance TB(XDR-TB). The implementation of good TB-IC measures is becoming more important in view of the emerging threat of MDR-TB even among PLWHAs and the increasing burden (rates of morbidity and mortality) of TB/MDR-TB among co-infected patients in Nigeria. WHO in collaboration with other implementing partners will support the FMOH to scale up implementation of appropriate TB infection control measures in health facilities especially those with ARVs and TB services. The TB-IC will be used as an entry point for strengthening other infection control measures in the facility. The activities to be supported include:

? Dissemination of the national guidelines and SOPs on TB infection control.
? Organize Training of National (National focal person for TB-IC), State, WHO/TB CAP and other partners' staff from TB and HIV/AIDS control Programme on TB infection control.
? Conduct of Facility assessment in 12 sites with ART/HIV and DOTS services.
? Development of Infection control plan in 12 health facilities with ART and DOTS services
? Capacity building for facility staff from the 12 Health facilities on TB Infection control measures and the developed plan.
? Support formation and regular meetings of TB-IC committees in the 12 health facilities.
? Basic renovation and upgrading at the health facilities (OPD, AFB laboratories, DOTS centers) to conform to good TB-IC measures.
? Procurement of 10 Binocular Olympus microscopes to enhance diagnosis of TB among PLWHAs.
? Quarterly Supervision and monitoring of TB/Infection control activities. This will be integrated into the existing supervisory structures. TB-IC IEC materials (e.g. on cough hygiene will be developed).

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

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|---|---|
| **Mechanism ID: 12453** | **Mechanism Name: USAID Track 2.0 OVC Follow-on** |

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|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Cooperative Agreement |
| Prime Partner Name: TBD | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: Yes | Global Fund / Multilateral Engagement: No |

| Total Funding: Redacted | |
|---|---|
| **Funding Source** | **Funding Amount** |
| Redacted | Redacted |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

This mechanism for follow on activities will ensure an increase and continuity of services, increase the quality of interventions and yield the proper mix among service delivery, systems strengthening and capacity building to the federal, state, and local governments and civil society. The new award(s) will ensure a smooth transition from those partners whose projects are closing during FY10 and in subsequent years. It is envisioned that this implementing mechanism will consolidate management burden, be geographically tailored to selected geographic regions, and will strengthen local capacity to carry out these activities.

USAID/Nigeria HIV/AIDS team presently has an Orphans and Vulnerable Children (OVC) portfolio of nearly $39 million in Fiscal Year (FY) 09 to reach a target of 219,245 children. In FY2010, USAID/Nigeria plans to expand its OVC budget and will procure awards to work both in service delivery and systems strengthening. Currently USAID/Nigeria has 7 OVC bilateral partners and 2 Track 1.0 central partners that are scheduled to end in 2010. In 2011, USAID/Nigeria has 5 bilateral partners that will end. In addition to the above mentioned OVC awards, USAID/Nigeria has 8 new or continuing activities with OVC components. In FY2010, USAID/Nigeria will design follow on activities which will aim to reduce management burden, ensure an increase and continuity of services to current beneficiaries, increase the quality of interventions and yield the proper mix among service delivery, systems strengthening and capacity building to local Non Governmental Organizations and Faith Based Organizations.The new award will be in place by August 2010 to ensure a smooth transition from those partners whose projects are closing. In subsequent years these new awardee(s) will be responsible for taking over activities of partners that end in 2011. USAID Nigeria HIV/AIDS team is currently determining the appropriate mechanism to be awarded that will expand and diversify the OVC portfolio.

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## Key Issues

Increasing gender equity in HIV/AIDS activities and services

## Budget Code Information

| | | | |
|---|---|---|---|
| **Mechanism ID:** | **12453** | | |
| **Mechanism Name:** | **USAID Track 2.0 OVC Follow-on** | | |
| **Prime Partner Name:** | **TBD** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Care | HKID | Redacted | Redacted |

**Narrative:**

The strategic approach and scope of work for the new activities will complement existing programs, build on the success of PEPFAR I and be consistent with the future direction of HIV/AIDS programming in PEPFAR II. USAID/Nigeria is currently assessment the proper mix of activities requested in a future procurement(s) with respect to:

• Appropriate geographic distribution of services

• Inclusion of a wider range of services (referral systems, water and sanitation, food and nutrition)

• Improvements for target populations (under 5 years of age services, exiting of OVC programs for 18 year olds)

• Recommendations on new activities to fill gaps identified in the current portfolio, activities that should be strengthened and which activities might yield better cost efficiencies.

New activities will also include best practice approaches to integrate prevention activities into OVC programming. These activities could include:

• Increasing new and local implementing partner activity (i.e. Muslim faith base organizations)

• Establishing public-private partnerships.

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| These new activities will be in line with the OVC National Plan of Action, Standards and Practice National OVC M&E Plan, USG COP Technical Guidance, OVC technical assistance trip reports, the 2008 OVC situational analysis key findings, and other relevant documents such as regionalization strategies. |

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 12454** | **Mechanism Name: TBHIV follow on** |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Contract |
| Prime Partner Name: TBHIV FOLLOW ON | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 600,000** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 600,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

The deadly interaction of TB and HIV affects millions of people in Nigeria, threatens public health, and stretches the already weak health sector infrastructure. TB is the leading cause of morbidity and mortality among People Living with HIV/AIDS (PLWHA), and HIV is fuelling the epidemic of TB in Nigeria. About 32% of the notified TB cases in 2007 had access to HCT (2007 NTBLCP report), hence the need for further expansion and strengthening of TB/HIV services towards reaching the universal access of care for co-infected patients. The TBCAP program served to link the goal of reducing the burden of TB and HIV in dually affected populations and the three objectives of the WHO Interim Policy on Collaborative TB/HIV activities which are: establishing mechanisms for coordination at all levels; reducing the burden of TB in HIV patients; and reducing the burden of HIV among TB patients. In addition, the program placed emphasis on TB infection control measures while scaling up services to prevent transmission of TB. Another chief concern is MDR-TB, with a current estimated prevalence of 1.9% and 9.3% among new and re-treatment TB cases respectively (2008 WHO Global report). TB CAP provided technical assistance to

federal and state TB and HIV control programs to coordinate and scale up implementation of TB/HIV collaborative activities at the National level and in concert with state governments.
Due to the importance of these activities to the PEPFAR Nigeria TBHIV portfolio, it is seen as paramount importance to replace the ending TBCAP project with another of similar quality and capacity. This follow-on is designed to accomplish this goal.

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## Key Issues

(No data provided.)

## Budget Code Information

| | | | |
|---|---|---|---|
| **Mechanism ID:** | **12454** | | |
| **Mechanism Name:** | **TBHIV follow on** | | |
| **Prime Partner Name:** | **TBHIV FOLLOW ON** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Treatment | HVTB | 600,000 | |

**Narrative:**

The TBCAP follow on will have following key areas of intervention in COP 10 in order to build on the successes of the previous TBCAP program:

1. Strengthen capacity at National, State, LGA and facility levels to effectively coordinate and manage TB/HIV collaborative activities
2. Stregthen laboratory and programatic control for MDR TB
3. Stregthen the participation and invovlement of community and faith based organizations in the implementation of the TB/HIV activities
4. Strengthen implementation of the 3Is in Nigeria
5. In collaboration with the national TB training center in Zaria, stregthen Human resource capacity for TBHIV and TB control in Nigeria

Laboratory stregthening and programatic control for MDR TB and TBHIV will be a focus for the follow on

project. This will be done by clinical and programatic training and upragde of facilities for TBHIV and MDR TB service delivery. The TBHIV follow on will involve community and faith based organizations in the implementation of the TB/HIV activities. A system will be developed within selected states to involve Community and Faith Based Organizations (working in the field of HIV/AIDS) per state in TB case finding and case holding activities. A TOT will be developed to enable master trainers to train community volunteers

Implementation of the 3Is (TB infection control, Isoniazide preventive therapy and Intensive case findings) will be stregthened in Nigeria. National and state staff from TB and HIV/AIDS control Programmes will be continued trained on TB infection control. The training will be stepped down by training GHWs from Health facilities on TB Infection control to enable them to develop an IC plan for their respective facilities. DOTS staff in congregate settings such as Prisons and HIV Service Delivery Centers in the selected states will be trained to increase case finding in congregate settings.

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 12455** | **Mechanism Name: TBD** |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Contract |
| Prime Partner Name: TBD | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: Yes | Global Fund / Multilateral Engagement: No |

| Total Funding: Redacted | |
|---|---|
| **Funding Source** | **Funding Amount** |
| Redacted | Redacted |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

The National HIV and AIDS and Reproductive Health Survey (NARHS) is a nationally representative survey to provide information on key HIV/AIDS and reproductive health knowledge and behaviour related

issues. The survey includes a biological marker component (HIV testing) and is called NARHS Plus. The major objective of NARHS Plus is to obtain accurate HIV prevalence estimates and information on risk factors related to HIV infection at the national, zonal, and--to some extent--state levels. In addition, it aims to provide information on the situation of reproductive and sexual health in Nigeria, the variety of factors that influence reproductive and sexual health, and to provide data regarding the impact of ongoing Family Planning and HIV/ AIDS behaviour change interventions, and to yield insights into existing gaps that may require attention. This program is traditionally funded by USAID and implemented by the Society for Family Health (SFH). The last survey was conducted in 2007, and another round will be conducted in 2011.

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## Key Issues

(No data provided.)

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **12455** |
| **Mechanism Name:** | **TBD** |
| **Prime Partner Name:** | **TBD** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Other | HVSI | Redacted | Redacted |

**Narrative:**

As SFH will be closing by the end of 2010--and continued support for NARHS is deemed critical to the collection of actionable information regarding current trends in Nigeria's HIV epidemic--a new award will designed to support the 2011 round of the survey.

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| Mechanism ID: 12456 | Mechanism Name: DQAEval |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Contract |
| Prime Partner Name: DQAEval | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| Total Funding: 950,000 | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 950,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

DQAEval is a five year project designed to implement a comprehensive performance planning, monitoring, evaluation and reporting system to measure the performance of USAID/Nigeria's development activities. This system will enable USAID/Nigeria to fulfill its performance monitoring, evaluation, reporting and dissemination requirements as mandated in the ADS and other Agency policies and procedures. The system will also meet PEPFAR reporting requirements as defined by the Office of the Global AIDS Coordinator (OGAC) including the new generation indicators.

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## Key Issues

(No data provided.)

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **12456** |
| **Mechanism Name:** | **DQAEval** |

| Prime Partner Name: | DQAEval | | |
|---|---|---|---|
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Other | HVSI | 950,000 | |

**Narrative:**

The Contractor will provide the following services:

Performance Monitoring - The contractor shall work with the PEPFAR team to build and continuously review the Performance Management systems of implementing partners to ensure compliance with Agency guidelines. This contractor will coordinate gathering, analysis and where required, dissemination of data that demonstrate results being achieved by Mission programs. It will keep track of key data produced by GON counterparts, donors, academic institutions, regional and national data sources thereby promoting synergy and preventing duplication of efforts.

Evaluation - The contractor shall work with PEPFAR Team to set up an annual evaluation schedule for their activities; advise AOTRs/COTRs and implementing partners on the development of Statements of Work for Contract / Assistance instruments as they develop their monitoring and evaluation plans; ensure inclusion of key and appropriate evaluation questions; recommend methods to ensure effective and timely use of evaluations to facilitate corrective actions, and most importantly disseminate lessons learned.

Information Dissemination and Capacity Building for M&E - The Contractor shall assess quantitative progress towards achievements of program results; conduct workshops and seminars on monitoring and evaluation; prepare press releases, brochures and other written documentations to disseminate results; collate and widely disseminate data on composite indicators and indices used by PEPFAR implementing partners, including other donors and Government of Nigeria and provide capacity building workshops for USAID/Nigeria, implementing partners and government counterparts to improve knowledge of monitoring and evaluation.

Strengthen Performance Management and Evaluation Capacity of Nigerian Partner Institution - The contractor shall establish partnerships with a select group of Nigerian institutions that can provide capacity building in such areas as survey field operations, planning, programming, data entry and analysis, all geared towards improving and supporting the capacity of Nigerian research and data gathering institutions to conduct high-quality evaluative research. Additional Purchased Services (surveys, analyses, evaluations and assessments) - The contractor will work collaboratively with the PEPFAR team to identify key pieces of

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| analytic and/or survey work that will contribute to the team's decision making process, resolve development questions, guide resource allocation, enhance program impact and provide success stories, best practices and lessons learned.<br><br>This Contract will be managed by the USAID/Nigeria Program Office. USAID HIV/AIDS-TB team will have an activity manager assigned within the team that will work closely with the HIV/AIDS Team Leader and the COTR.<br><br>Links to other activities – Using the SI fund, DQAEval will provide comprehensive performance planning, monitoring and evaluation and reporting systems to the HIV/AIDS-TB team.<br><br>Populations targeted – the project will target the HIV/AIDS-TB team, implementing partners and state level M&E. |

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 12457** | **Mechanism Name: Accelerated PMTCT HSS** |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Cooperative Agreement |
| Prime Partner Name: TBD | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: Yes | Global Fund / Multilateral Engagement: No |

| Total Funding: Redacted | |
|---|---|
| **Funding Source** | **Funding Amount** |
| Redacted | Redacted |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

PMTCT service outlets have increased since inception in 2002, from six to at least 600 with most of them being PEPFAR-supported. PEPFAR support for PMTCT activities include training of HCWs on PMTCT,

supply of PMTCT commodities, supportive mentoring and supervision to staff at service outlets and so on. In spite of the efforts in PMTCT service delivery, coverage of pregnant women receiving HIV testing and counseling is only about 11%.

In COP10, Nigeria is one of a few countries to receive supplementary funding in order to stimulate a higher pace of PMTCT activities towards improving coverage and quality.REDACTED.  This amount will be programmed in April since the agency allocations are not defined as yet.

PMTCT as an HIV/AIDS intervention is a health sector response in Nigeria. The frail health system in Nigeria is a contributory factor, amongst others, to the challenges with achieving efficient outcomes in PMTCT. It has become necessary to address some of the constraints to PMTCT service delivery that are related to underlying weak health systems. A major thrust of PEPFAR Nigeria's plan to support the acceleration of PMTCT in Nigeria is to re-direct efforts towards sub-national levels in achieving wider PMTCT coverage.

PEPFAR Nigeria, through its IPs will provide support to selected state governments in order to build their capacity to better plan, implement, supervise and evaluate PMTCT activities in their states. This HSS support will be provided through 'Lead IPs'-  A Lead Implementing Partner in the context of the accelerated PMTCT plan is a PEPFAR-supported Implementing partner that takes a lead role in facilitating support to enhance the capacity of sub-national levels of government towards improving the coverage and quality of PMTCT.

Most PMTCT IPs will receive supplementary funding in order to increase the pace of PMTCT activities. Seventeen (17) states have been selected to be focal states for the purpose of the accelerated PMTCT Plan in COP10. The Activities of the Lead Ips as defined above will be concentrated in these selected states- Akwa Ibom, Cross River, Edo, Benue, Nassarawa, FCT, Niger, Kogi, Enugu, Anambra, Abia, Oyo, Ondo, Adamawa, Taraba, Sokoto and Kano.

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## Key Issues

(No data provided.)

## Budget Code Information

| | | | |
|---|---|---|---|
| **Mechanism ID:** | **12457** | | |
| **Mechanism Name:** | **Accelerated PMTCT HSS** | | |
| **Prime Partner Name:** | **TBD** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Other | OHSS | Redacted | Redacted |

**Narrative:**

REDACTED. This amount will be programmed in April since the agency allocations are not defined as yet. While the selection of implementing partners is still under review, the intended activities are outlined below:

HSS activities for improved PMTCT service delivery will include support for the extension of the technical capacity from the national to the sub-national level through the introduction of zonal PMTCT task teams working with state PMTCT committees. The zonal task teams will ensure that requisite mentoring on PMTCT service delivery is available at state level within states in the respective zones. Lead IPs will work with SACA and SASCP officials to facilitate the formation (where such a forum is absent) of state PMTCT committees and strengthening (where such a forum exists) of these state PMTCT committees. These state committees will receive support to establish baseline data prior to state acceleration activities, develop and implement state PMTCT scale up plans as appropriate. HSS for PMTCT is expected to result in more coordinated USG support at State and LGA levels, Scale up of PMTCT coverage (from 11% to 40%) and Monitoring and evaluation activities that are better institutionalized at the state level

Activities for Strategic Information for PMTCT will include the procurement of Computers/Printers to strength community level PMTCT monitoring , program evaluation of PMTCT-MIS and documentation of lessons learned, Training of M&E officers at service delivery points to monitor the NGIs and PMTCT monthly summary forms and quarterly M&E meetings with FMOH,SASCP, SACA and IPs to report monthly summary forms (ANC, Delivery, Child-Follow-up).

Agency-funded support activities are to include joint advocacy and support excercises for PEPFAR Nigeria, FMoH, UN, and LGA/State governments in order to further foster collaboration and knowledge sharing between key PMTCT stakeholders. These activities are ancillary to HSS activities described above, and are deemed crucial to the success of the accelerated plan. Support activities will also be aimed at facilitating the revision of PMTCT training materials and tools, their dissemination, and their

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| widespread adoption by service providers through support of conferences, national trainings, and other appropriate dissemination activities. Support to NASCP for scale-up activities and joint demand-creation activities are also planned.<br><br>(See submitted "Accelerated PMTCT Plan" for more detailed information on planned activities.) |

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 12458** | **Mechanism Name: LMS PICABU** |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Management Sciences for Health | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 2,636,000** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 2,636,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

LMS PICABU is a Leaders Associate award follow-on that is to start by May 1, 2010 to May 1, 2015. It is to be a five year project in capacity building program that wiln assist to to maintain and increase momentum in the development of national capacity, leadership, ownership and sustainability for the national HIV/AIDS response and the health sector system strengthening in Nigeria. The program will work towards development of a conitunum of indeginous organization including CSOs, professional medical associations and relevant government of Nigeria training institutions and a cadre of professionals to deliver technical assistance, training, mentoring and coaching that are responsive to the needs of the country and peculiarity in the health system challenges. LMS PICABU is Leaders Management and Sustainability Program- PEPFAR Integrated Capacity Buiding Program. The LMS Nigeria Capacity Building Project will continue to provide health systems strengthening to Nigerian Government Agencies

which set HIV/AIDS policies, guidelines and standards. Technical support will continue to the HIV/AIDS Division (HAD) and the National Tuberculosis and Leprosy Control Program (NTBLCP) of the Federal Ministry of Health.

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## Key Issues

(No data provided.)

## Budget Code Information

| | | | |
|---|---|---|---|
| **Mechanism ID:** | **12458** | | |
| **Mechanism Name:** | **LMS PICABU** | | |
| **Prime Partner Name:** | **Management Sciences for Health** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Other | OHSS | 2,300,000 | |

**Narrative:**

LMS will continue to build the capacity of various cadres of Nigerian health professionals through its PEPFAR Health Professional Fellowship Program. The Fellowship program will continue to develop innovative ways of delivering training on HIV/AIDS, professional skills and leadership and management. In order to achieve this goal, the activities listed below shall be carried out:

• Assist in reopening of the Collaborative Centers for the Management training of Health Professionals (doctors, nurses) by work with the HR Branch to review and update training curriculum and training faculties (infrastructure and equipment).
• Provide adequate assistance to ensure that the levels of Standard Operational Procedures (SOPs) in the collaborative centers are maintained at the highest level.
• Provide assistance in printing and distribution of the training modules for the collaborative centers
• Provide assistance in the continuation of nursing fellowships for pre-service training
• Capacity building activities for HRH Managers from both the National and state levels and with USG

implementing partners as a means of assisting in development and implementation of policies and practices that will address training, supervision, and retention of health care workers
• Strengthen the HR policies and practices such as recruitment, retention and distribution of HWs at the Federal and SMoH and other line ministries to support the establishment of national health system
• To support the development of a national and state HRD plan for HIV/AIDS, TB, OVC, M&E and other related areas

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVOP | 61,000 | |

**Narrative:**

LMS will continue to build the capacity Federal, State health ministries and IPs in areas of prevention with specific reference to PwP, COP and sexual prevention by targeting youths, general population and People living with HIV/AIDS. Activities to carry shall be as follows:

• Provide TA and support the development or improvement and implementation of a curricula for the PwP at the facility and community level
• Provide adequate assistance to ensure a proper linkages between the PwP curricula for the facility and community activities
• Provide TA on improving upon the existing training manuals for COP activities
• Provide TA for Federal, State ministries and IPs on the printing and distribution of training manuals related to PwP, COP and Sexual prevention
• Provide assistance in printing and distribution of the training modules for the PwP and COP activities
• Capacity building activities for Federal, State health ministries and IPs for proper implementation of the prevention minimum package
• Capacity building for Federal and state health ministries and IPs in health data management and Quality assurance

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HVTB | 275,000 | |

**Narrative:**

Activities under HVTB shall be as follows:

• TA to improve the NTBLCP organizational structure and management capacity
• Work with TB partners to support the implementation of the TB HRH plan developed in COP09
• Strengthen the M&E, supervision and referral systems

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| • Provide assistance to strengthen the logistics systems<br>• Provide TA and support to the Nigeria STOP TB Partnership to implement international standard of care for TB control building and promote civil society involvement.<br>Support TB and TB/HIV health fellowship for HCWs in collaboration with the Nigeria STOP TB partnership<br>• Implementation of data systems for management decision making |

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 12459** | **Mechanism Name: health Care Improvement Project** |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Contract |
| Prime Partner Name: University Research Corporation | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 600,000** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 600,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

The Nigerian Federal Ministry of Women's Affairs and Social Development (FMWASD) in coordination with PEPFAR/ Nigeria, has been engaged in the Initiative to improve quality for orphans and vulnerable children (OVC) services during the past years and has began efforts to improve quality through the development of an OVC National Plan of Action and National Guidelines and Standards of Practice for OVC. The Ministry has taken a leadership role in engaging its partners towards increased effective and efficient OVC programs within the country.

In July 2009, at the request of PEPFAR/Nigeria, the USAID-Health Care Improvement (HCI) project

provided technical assistance to FMWASD and its implementing partners towards developing standards to define quality care for OVC programs. This initiative was grounded in the FMWSD priority to clearly define what is "meant by serving a child and family" in pursuit of improved coordination and harmonization across implementing partners. Thus with the Ministry leadership, PEPFAR funded partners and UNICEF gathered during a five-day workshop to develop DRAFT quality standards for OVC programs. In addition to the Draft service standards, stakeholders committed themselves to the process of quality improvement for OVC Programming. Based on these results, USAID-HCI proposes to provide the following technical assistance to:

Objectives:

Support the country-leadership role in improving quality care for OVC Programs to mitigate the impact of HIV/AIDS on most vulnerable families and children.
Strengthen integration of OVC Standards of Care within a national strategy response.
Strengthen local partners and international partners' abilities to organize for improvement.
Create a community of shared learning across all OVC stakeholders.

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## Key Issues

(No data provided.)

## Budget Code Information

| | | | |
|---|---|---|---|
| **Mechanism ID:** | **12459** | | |
| **Mechanism Name:** | **health Care Improvement Project** | | |
| **Prime Partner Name:** | **University Research Corporation** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Care | HKID | 600,000 | |
| **Narrative:** | | | |
| Specific activities: | | | |

1. Support the country-leadership role in improving quality care for OVC Programs to mitigate the impact of HIV/AIDS on most vulnerable families and children.

One of the priorities of PEPFAR programming is to strengthen country-driven approach. The FMWASD has already taken the leadership in engaging all stakeholders towards improving quality as demonstrated during the efforts to develop draft-standards. It is thus essential to continue to provide support to the Ministry to continue its quality improvement efforts for OVC Programs. HCI proposes to identify a quality improvement advisor, embedded in the Ministry who can lead and coordinate efforts across all partners. The QI efforts will also reflect the PEPFAR priorities of ensuring that USG investments are programmed within a national strategy, in close collaboration with other donors, to ensure institutionalization and sustainability of the process.
Provide technical support (such as the secretariat) towards the establishment of a QI Task Force, chaired by the Ministry and regrouping major representatives of IPs and donors. By establishing a National QI Task Force, the Ministry will ensure the commitment and buy-in of its partners as the QI Task Force will develop clearly goals and objectives and work plan for the year.

2. Strengthen integration of OVC Standards of Care within a national strategy response
Provide technical support to complete the Draft Quality of Care Standards by vetting the DRAFT standards (July 2009 version) with other line Ministries (Ministry of Education, the Ministry of Labor, Ministry of Youth and Sports, Ministry of Agriculture, as identified by the QI Task Force) and local partners at the point of service delivery (local NGOs and CBOs) and other partners engaged in development programs and strategies to address children's needs. (experts in nutrition, HIV care and treatment, maternal health, child survival, early childhood development partners as example). The vetting process is an important step in the standards development process to 1) strengthen coordination and integration across Nigeria's institutions; 2) assure integration of best practices at the point of service delivery and ensure that standards reflect the context of the country; 3) strengthen and ensure the sustainability of the response to HIV/AIDS as institutions and local partners are involved in the improvement process all along.
Client-centered care is one of the key principles of quality care. HCI in collaboration with the QI Task Force will provide guidance in how best to include children's and family/guardians' voices. Based on experiences from other countries, where HCI has provided TA towards improvement of quality care, HCI will propose to organize several youth workshops (10-14yrs; 15-17yrs) and focus group discussions in different regions to capture as much as possible the realities and needs of different segments of children based on gender, location (regions, urban/rural), education, living arrangements (child-headed households for example). The process of seeking youth involvement will be led by the Ministry through a consultative process with the QI Task Force.

Once evidence is gathered on DRAFT standards, the QI Task Force with support from HCI will organize a review of the DRAFT standards to integrate findings and best organizational practices to improve quality of services. It would be expected that the set of Draft Standards are thus endorsed as a national policy guiding document.

3. Strengthen local partners and international partners' abilities to organize for improvement.
Once DRAFT standards are completed, HCI will provide TA to local implementing partners (at the point of service delivery) to gather evidence on the feasibility of the standards and if applying standards actually make a measurable difference in organizational practices. Evidence will be collected to document if applying standards lead to improved sustainable OVC Programming strategies such as increased community participation, increased retention of service providers/community-based volunteers/or workers; increased public and private partnership and commitment of resources; increased access to services, etc. In collaboration with the QI Task Force, HCI will provide TA to develop a set of quality indicators to document how applying standards and organizing for improvement actually improve the quality of care processes (strategies).
In addition to tracking evidence that applying standards is making difference in processes of care, HCI, in close collaboration with the Ministry and other partners tasked to improve monitoring and evaluation of OVC programs, will provide support to local NGOs and INGOs to measure if applying standards actually make a measurable difference in children's well-being.
To gather such evidence, HCI will provide support to local organizations to organize for improvement by applying the principles of science of improvement: 1) process analysis; 2) team work; 3) client-centered; 4) decision making grounded in data. In close collaboration with the Ministry and PEPFAR, the gathering of evidence will be organized through the improvement collaborative approach in two regions in Nigeria. The two regions are to be identified by the QI Task Force. One of the regions will be around Abuja (as the QI Advisor at the Ministry can provide support), and HCI proposes that the second region be where URC has already a project of improving quality of care to leverage resources and expertise. However, identifying regions and partners to be included in the "piloting of standards" will be done by the FMWASD and in close consultations with the QI Task Force.

Improvement Collaborative Overview
An improvement collaborative is an organized improvement effort of shared learning about how to improve an area of care by people providing the actual services. The goal of an improvement collaborative is to rapidly develop and test changes that allow programs to overcome obstacles toward consistent application of standards, by bringing together a number of teams to work on rapidly achieving significant improvements in processes, quality, and efficiency of those services.
Representatives of local government, local NGOs and their partners (CBOs and volunteers) are organized into QI teams to analyze what the standards describe as quality services and reflect on their

current practices with respect to the essential actions as described in the standards. The teams form the core of a collaborative. Teams meet individually on a regular basis to analyze, plan and test changes to improve services. Changes, grounded in data, that actually make a difference in quality of programs are shared regularly across representatives of the QI Teams through learning sessions.

Create a community of shared learning across all OVC stakeholders
The QI Advisor (embedded in the Ministry) will lead, organize and coordinate all QI efforts across the Ministries, donors and IPs. Thus at a national level, communication across partners involved in improvement of programs will be strengthened. It is expected that the QI Task Force will meet regularly (once a month at least) to lead the QI efforts.
One of the organization principles for an improvement collaborative is for partners involved in improvement to share changes in organizational practices that lead to measurable results (improved strategies and improved children's outcomes). HCI will support the organization of regular learning sessions (every three months) within the two regions where representatives of the collaborative (Regional MWASD representatives, representatives of line ministries and IPs) will share changes that have led to their improved ability to operationalize the standards and improve children's well-being.
At the end of the "piloting" of standards, a national workshop will be organized to review evidence gathered about the standards and best operational practices.
In addition to the piloting efforts, HCI will continue to explore with the Ministry best mechanisms to strengthen communication and sharing across IPs, such possibilities might include regional Implementing Partners Group meetings led by the Regional Representatives of FMWASD.

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 12460** | **Mechanism Name: MICROLINKS Livelihood & Food Security Technical Assistance (LIFT)** |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Academy for Educational Development | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 400,000** | |
|---|---|
| **Funding Source** | **Funding Amount** |

| | |
|---|---|
| GHCS (State) | 400,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

In COP 2010, Microlinks will support the integration of food and nutritional security and Livelihood and Food Security Technical (LIFT) assistance to PEPFAR Nigeria OVC Program. The LIFT project will provide TA in food security and livelihood areas to PEPFAR Nigeria OVC Partners wanting to implement new or improved food security initiatives through livelihood approaches. The LIFT project will also assist in establishing economic strengthening priorities, conduct midterm or end project assessment to determine how OVC partners are implementing good practices around livelihoods and food security. The project will also be responsible for developing recommendations on what can be improved or addressed, review project PMPs and assist food security and livelihoods. The LIFT project will facilitate stakeholders engagement within and beyond the USG, conduct training courses to address specific capacity building needs, provide technical guidance for implementing partners as well as providing design and implementation support to specific livelihood and food security programs and support technical guidance with stakeholder knowledge management and sharing.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Economic Strengthening | 240,000 |

## Key Issues

Increasing women's access to income and productive resources

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **12460** |
| **Mechanism Name:** | **MICROLINKS Livelihood & Food Security Technical Assistance (LIFT)** |
| **Prime Partner Name:** | **Academy for Educational Development** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Care | HKID | 400,000 | |

**Narrative:**

In COP 2010, Microlinks will support the integration of food and nutritional security and Livelihood and Food Security Technical (LIFT) assistance to PEPFAR Nigeria OVC Program. The LIFT project will provide TA in food security and livelihood areas to PEPFAR Nigeria OVC Partners wanting to implement new or improved food security initiatives through livelihood approaches. The LIFT project will also assist in establishing economic strengthening priorities, conduct midterm or end project assessment to determine how OVC partners are implementing good practices around livelihoods and food security. The project will also be responsible for developing recommendations on what can be improved or addressed, review project PMPs and assist food security and livelihoods. The LIFT project will facilitate stakeholders engagement within and beyond the USG, conduct training courses to address specific capacity building needs, provide technical guidance for implementing partners as well as providing design and implementation support to specific livelihood and food security programs and support technical guidance with stakeholder knowledge management and sharing.

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 12461** | **Mechanism Name: Infant and Young Child Nutrition Project** |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Program for Appropriate Technology in Health | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

**Total Funding: 650,000**

| Funding Source | Funding Amount |
|---|---|
| GHCS (State) | 650,000 |

## Sub Partner Name(s)

| | | |
|---|---|---|
| CARE | The Manoff Group | University Research Corporation, LLC |

## Overview Narrative

The Infant and Young Child Nutrition (IYCN) Project is USAID's flagship project to improve infant and young
child growth and nutritional status, HIV-free survival of infants and young children, and maternal nutrition. Building on 25 years of USAID leadership in maternal, infant, and young child nutrition, IYCN focuses on prevention of malnutrition through proven interventions that are effective during pregnancy through the first
two years of life. The project is a globally funded five-year cooperative agreement led by PATH, in collaboration
with CARE, the Manoff Group, and University Research Co., LLC (URC).

The goal of this COP 10 activity is to integrate, expand, and monitor safe infant feeding practices and nutrition
care and counseling as essential parts of PMTCT, MCH and community-based services focused on pregnant a
nd lactating women, infants and young children of HIV+ mothers, and orphans and vulnerable children (OVC)
under five years. WHO Recommendations for HIV and Infant Feeding is undergoing a revision in 2009. Thus,
IYCN is poised to provide technical support for the adaptation and implementation of country policies and guidelines
that is focused on new options for women who breastfeed to significantly lower the risk of transmission. This includes
safe feeding (exclusive breastfeeding or replacement feeding) during the first six months postpartum, and appropriate
complementary feeding of infants and young children between six and 23 months to maximize HIV-free survival. In addition,
IYCN will work with PEPFAR OVC partners to integrate and strengthen the nutrition content of their programs and promote
a complementary food or supplement to improve the diets of infants and young children under two years.

IYCN's assistance will build on its experience in Nigeria, Zambia, Côte d'Ivoire, and Kenya to develop and update policies,
programs, BCC materials, job aids, training curriculum and supportive supervision tools. To improve the environment for
nutrition and HIV services, IYCN with the FMOH and partners will disseminate final national nutrition and

HIV policies and
guidelines to the state, district and LGA levels of the FCT and another state to be selected. IYCN will also support
community-based programs to promote and support nutrition of OVC's under five years, as well as reinforce PMTCT adherence,
and increase referrals to other health and community support services.

IYCN's partner, URC, will assist with quality improvement activities by facilitating a team approach, working with PMTCT and OVC
partners, the FMOH Nutrition and PMTCT Divisions and the Federal Ministry of Women Affairs to establish minimum standards
for nutrition services at PMTCT sites and OVC services. After establishing consensus on these standards, IYCN will adopt an
incremental approach promoting innovation and accountability for quality improvement as an internal process at PMTCT facilities.

IYCN's activities will be linked to existing wrap-around services such as micronutrient supplementation, hygiene and
sanitation, family planning/reproductive health, and household food security initiatives. IYCN will assist the FMOH to
demonstrate the full roll-out of activities in two states and the project will apply lessons learned to continue the scale-up
to other districts and states in future years.

For all of its activities, IYCN will closely collaborate with the appropriate MOH and partner staff to increase their capacity
to collect and use routine data for monitoring to promote continuous improvement. IYCN will introduce simple tools which
minimize the burden of human resources and promote sustainable monitoring systems. This will include a set of user-friendly
supervision tools that can be used at the facility level to monitor provider performance, identify and address inefficiencies in
service delivery, and assess the quality of care provided to mothers. In addition, IYCN will introduce a complementary set of
community-level monitoring tools for supervision of community-based workers and community-level nutrition activities. This
approach supports and encourages linkages between health facilities and communities through the

monitoring of a two-way
referral system.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Food and Nutrition: Policy, Tools, and Service Delivery | 541,645 |
| Human Resources for Health | 108,355 |

## Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation
Child Survival Activities
Safe Motherhood

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **12461** |
| **Mechanism Name:** | **Infant and Young Child Nutrition Project** |
| **Prime Partner Name:** | **Program for Appropriate Technology in Health** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HKID | 650,000 | |

**Narrative:**

IYCN will work with the FMOH Nutrition Division to provide technical assistance to PEPFAR OVC partners,
the Federal Ministry of Women Affairs (FMWA) and others to assist them to integrate nutrition education and
counseling as part of their OVC programs. Often programs that target OVC focus on support for school-aged
and older children. The nutritional needs of infants and young children under five years who are HIV affected are
often missed. In addition, adolescent girls suffer from high rates of anemia and need iron

supplementation and to
eat an iron-rich diet during this stage in their development. These young children and adolescent girls are particularly
vulnerable to undernutrition. IYCN will develop appropriate counseling guide for 6-23months and adolescent OVC
nutrition as well as provide specialized training for Caretakers and other support groups of such children and
adolescents to practice and provide optimal care and feeding of these children.

IYCN will engage a local consultant to conduct a rapid assessment of current services for OVC in the two focus
states (FCT and Lagos or Kano States). The assessment will include a review the existing literature, including
project reports, local and international publications on OVC and nutrition and dietary practices, and interviews of key
program managers and implementing partners, in order to: understand the OVC nutrition landscape in Nigeria,
specifically within the two targeted states; understand available services; describe OVC infant and young child and
adolescent girl nutrition beliefs and practices; and identify gaps in information that can be examined through rapid
formative research. Using the results from the assessment, IYCN will engage in a participatory process with
stakeholders from PEPFAR OVC partners, NGOs, community-based organizations, and government to develop a
behavior change and communications (BCC) strategy. This process will result in clear messages about infant and
young child feeding and nutrition of adolescent girls that can be communicated consistently across OVC programs.
It will also help develop appropriate tools such as service provider job aids and take-home materials for OVC,
OVC caretakers, support groups and community in general.

To mitigate the impact of HIV/AIDS on the nutritional status of exposed infants, IYCN will design a two-way referral
system to identify malnourished at-risk OVC. The referral system will link caretakers to and from nutrition, child health

and well baby clinics for therapeutic and supplementary feeding and from clinical services to community outreach or
other community programs for monitoring and follow up.

IYCN will collaborate with the MARKETS project and its partners to provide young OVCs with quality dietary support.
The MARKETS Project works with famers on key crops: rice, cow peas, sesame, sorghum, and cassava and with
manufacturers of cereals to provide food supplements for OVCs and their host families to improve the food security of
20,000 OVC. IYCN will work with the MARKETS Project to support the identification and promotion of an acceptable
complementary food that is based on locally available foods that can provide optimum nutrition to OVC age six to
23 months. IYCN will explore the use of a micronutrient powder or a local food-based nutrient-dense supplement
(based on experience and in-depth food research conducted in Zambia but can be adapted to Nigeria) that could be added
to the food to improve its nutritional composition. The MARKETS Project has implementing partners (local NGOs) that work
in the community, training caregivers how to prepare food for OVC. IYCN will assist them with infant and young child feeding
BCC and education materials that are in line with the government guidelines that would enable their partners to better support
and educate families with OVC. Their staff will also be invited to participate in the training of trainers in maternal and infant and
young child nutrition in the context of HIV being conducted through the MOH.

Indicator:
Number of health workers who successfully completed an in-service training programs

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| Mechanism ID: 12462 | Mechanism Name: CDC RFA - PMTCT |
|---|---|

| | |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: TBD | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: Yes | Global Fund / Multilateral Engagement: No |

| Total Funding: Redacted | |
|---|---|
| **Funding Source** | **Funding Amount** |
| Redacted | Redacted |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

These funds are to be used by the award recipients of the FY10 HHS/CDC RFA, with emphasis on local implementing partners, to facilitate increased acceptance and use of PMTCT services by building strong linkages between health care providers and community support networks strengthening these linkages will support the mobilization of pregnant women to utilize appropriate PMTCT services. Funds will also support the strengthening of linkages between facility based activities and other programs/community based activities. This will improve the follow-up of PMTCT clients (mother/infant pair) and increase the utilization of PMTCT services.

An estimated minimum of 75,000 women will receive PMTCT services, be tested and receive their test results with 3,450 HIV+ being placed on ARV prophylaxis. It is estimated that 150 local staff in about 30 service outlets will be trained in PMTCT program standards in at least 4 Nigerian states.

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## Key Issues

(No data provided.)

## Budget Code Information

| | | | |
|---|---|---|---|
| **Mechanism ID:** | **12462** | | |
| **Mechanism Name:** | **CDC RFA - PMTCT** | | |
| **Prime Partner Name:** | **TBD** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Prevention | MTCT | Redacted | Redacted |

**Narrative:**

The recipients will be responsible for continuing to provide PMTCT services in current clinical outlets and service delivery sites. Counseling and testing with the "opt out" and will be provided to all pregnant women presenting at antenatal services. HIV infected women will be counseled on risks of HIV transmission and goals of the PMTCT program. They will be encouraged to bring partners and other family members for counseling and testing. HIV infected women eligible for ART will be provided with ART following the National guidelines. All participating laboratories will either have the capability of clinical HIV assessment including CD4 determination to ascertain ART eligibility by national and international ART criteria or will refer women to such services at another HIV service outlet in the geographic area. HIV infected women ineligible for initiation of ART will be offered combination of zidovudine from 28 weeks and single dose nevirapine at onset of labor as per the national guidelines. Women presenting at labor will be offered rapid testing and if HIV infected provided with single dose nevirapine. All infants born to HIV infected women will be provided with single dose nevirapine at birth and zidovudine for 6 weeks. After delivery, mothers and infants will be followed to monitor the mother's health and determine HIV status of the baby. Infant diagnosis of HIV will be by referral to qualified PEPFAR laboratories performing PCR if not available at the site, and if found positive the baby will continue to be monitored for eligibility for ART and per medical indications, be provided with cotrimoxazole prophylaxis.

CONTRIBUTIONS TO OVERALL PROGRAM AREA:
With 30 sites in 4 states, the above described activity is in line with the USG`s target of having 80% coverage for PMTCT across the country.

LINKS TO OTHER ACTIVITIES:
This activity is also linked to HVOP (12969.08), HBHC (12970.08), HCT (12972.08), HKID (14087.08), HVTB (12971.08), HTXS (14089.08) and joint awards for these program areas are anticipated.

| |
|---|
| Prevention for positives counseling will be integrated within PMTCT care for HIV+ women<br><br>POPULATIONS BEING TARGETED:<br>This activity targets pregnant women who will be offered HIV counseling and testing, HIV+ pregnant women who will be offered ARV prophylaxis and infant feeding counseling, and HIV+ infants who will be offered ARV prophylaxis and infant HIV diagnostic testing.<br><br>EMPHASIS AREAS: The PMTCT service has an emphasis on Human Resources and Local Organization Capacity Development.<br><br>COVERAGE AREAS: TBD when awarded. |

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 12463** | **Mechanism Name: E & F Management Consultants - REACH Project** |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: TBD | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: Yes | Global Fund / Multilateral Engagement: No |

| Total Funding: Redacted | |
|---|---|
| **Funding Source** | **Funding Amount** |
| Redacted | Redacted |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

This activity will enhance program implementation through the availability of quality data, to guide program management and track achievement. By providing functional feedback measures, results of

monitoring activities will enhance program performance as well as program design

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## Key Issues

(No data provided.)

## Budget Code Information

| Mechanism ID: | 12463 | | |
|---|---|---|---|
| Mechanism Name: | E & F Management Consultants - REACH Project | | |
| Prime Partner Name: | TBD | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Other | HVSI | Redacted | Redacted |

**Narrative:**

The award recipients of FY 10 HHS/CDC RFA will focus on providing sound monitoring and evaluation activities related to the program areas in accordance with the PEPFAR requirements and in line with Nigeria's M&E plan. This activity will include provision of HIV/AIDS behavioral and biological surveillance, facility surveys, monitoring results, reporting results, supporting health information systems, assisting Nigeria to establish and/or strengthen such systems, and related analyses and data dissemination activities.

This RFA recipient will train personnel in SI and provide TA to several other local organizations.

LINKS TO OTHER ACTIVITIES:
The SI activities will be linked to HVCT (12972.08), HVOP (12969.08), PMTCT (12968.08), HVTB (12971.08), HTXD (14088.08), HTXS (14089.08), HLAB (14090.08) and OVC (14087.08).

EMPHASIS AREAS: This activity has an emphasis in capacity building for staff responsible for data collection and reporting.

COVERAGE AREAS: TBD when awarded.

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| Mechanism ID: 12464 | Mechanism Name: CDC RFA Comprehensive |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: TBD | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: Yes | Global Fund / Multilateral Engagement: No |

| Total Funding: Redacted | |
|---|---|
| **Funding Source** | **Funding Amount** |
| Redacted | Redacted |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

HHS/CDC will put out a Funding Opportunity Announcement to invite implementing partners to apply for funds to provide comprehensive HIV/AIDS services in FY 2010. Partners receiving HHS/CDC funding must place a clear emphasis on developing local indigenous capacity to deliver HIV/AIDS related services to the Nigerian population and must also coordinate with activities supported by Nigeria, international or USG agencies to avoid duplication. Partners receiving HHS/CDC funding must collaborate across program areas whenever appropriate or necessary to improve service delivery and must continue activities in HIV services that are currently ongoing in the PEPFAR program, in order to ensure no break in services to clients.

The partner will implement activities both directly and, where applicable, through sub-grantees; the partner will, however, retain overall financial and programmatic management under the oversight of HHS/CDC and the strategic direction of the Office of the U.S. Global AIDS Coordinator. The partner must show measurable progressive reinforcement of the capacity of currently supported tertiary, secondary and primary health facilities to respond to the national HIV epidemic as well as progress towards the sustainability of activities.

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## Key Issues

(No data provided.)

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **12464** |
| **Mechanism Name:** | **CDC RFA Comprehensive** |
| **Prime Partner Name:** | **TBD** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HBHC | Redacted | Redacted |

**Narrative:**

These funds are to be used by the award recipients of the FY10 HHS/CDC RFA, with emphasis on local implementing partners, to continue to implement HIV care and support programs in underserved areas of Nigeria. Basic Health Care package services that may be included by the award recipient include: basic medical, laboratory and nursing care, adherence counseling, prevention for positives, linkage to psychosocial support through participation in PLWHA support groups and individual counseling operational at points of service with transportation, communication and referrals, pain and symptom management, and provision of community home based care (HBC). Provision of clinical care will include prevention and treatment of OIs and other HIV/AIDS-related complications including malaria and diarrhea (providing access to commodities such as pharmaceuticals, insecticide-treated nets, safe water interventions and related laboratory services), prevention of cervical cancer, pain and symptom relief, and nutritional assessment and support including food.

The recipients will be expected to provide palliative and home based care both at the facility level and in communities with an appropriate combination of models which will be utilized depending upon the site preference. The RFA will supplement site staffing with trained PLWHAs and volunteers from communities to provide this service. An identified trained Basic Care and Support Program Officer with a counseling background at each facility will work with support groups to improve educational and support programs, and coordinate linkage of the facility points of service to the communities.

Training essential for program success and sustainability will target doctors, nurses, health aids, counselors, PLWHAs and community volunteers. This training will be conducted by RFA program staff at the site level to maximize coverage. Training will be done using the training manual which is being developed with the GON by current large treatment partners through PEPFAR support. All HBC providers will receive a provider's manual describing methods of assessment, diagnosis, treatment, management and referral for HIV related symptoms. This will ensure all PLWHAs, including HIV positive pregnant women as well as all TB/HIV patients, get the correct care and the same quality of care across the sites. There will also be Standard Operating Procedures for Basic Care and Support at all service outlets.

CONTRIBUTIONS TO OVERALL PROGRAM AREA:
This activity provides services which are a high priority for the President's Emergency Plan by providing a basic package of care for all PLWHA including HIV positive pregnant women and TB/HIV patients. The services are consistent with the Guidelines for Palliative Care in Nigeria as well as the Nigerian Guidelines for ART which emphasize HBC, symptom management, and OI prophylaxis. Capacity development at the site level and consistency with national guidelines will ensure sustainability. RFA identified staff will contribute to development of a national palliative care training curriculum, identified as a priority by the Government of Nigeria (GON).

LINKS TO OTHER ACTIVITIES:
This activity is linked to HVCT (12972.09), HVOP (12969.09), PMTCT (12968.09), HVTB (12971.09), HKID (14087.09) and HTXS (14089.09). HCT will target at risk populations including all pregnant women and all TB patients. All patients are monitored and linked to ARV therapy when indicated. Care and Support services such as psychosocial support and symptom management promotes ARV adherence. Prevention for Positives which includes counseling and condom availability will be integrated into this activity. Services are co-located with TB Directly Observed Treatment Services (DOTS) centers with referrals from other DOTS centers. RFA identified staff will work with sites to ensure effective referral/linkage and coordination systems are in place. High quality laboratory services supported by CDC/RFA facilitated laboratory QA program will be available at sites.

POPULATIONS BEING TARGETED:
Services are offered to all PLWHAs including HIV positive TB patients and pregnant women identified through TB DOT Centers and PMTCT programs, respectively. Doctors, nurses, other health workers, PLWHAs and volunteer caregivers of PLWHA are targeted for training. The volunteers participate in providing HBC services as well as adherence counseling.

EMPHASIS AREAS: The emphasis area for this activity is training as capacity development for

sustainability is a key focus.

COVERAGE AREAS: TBD when awarded.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HKID | Redacted | Redacted |

**Narrative:**

These funds are to be used by the award recipients of the FY10 HHS/CDC RFA, with emphasis on local implementing partners, to continue to implement HIV OVC programs in underserved areas of Nigeria. It is expected that the recipients will continue to provide support to HIV/AIDS affected and infected children (0-17) and their families/households in an integrated and holistic manner that improves the children's overall well-being, through household-centered approaches that link OVC services with HIV-affected families (through linkages with PMTCT, palliative care, treatment, etc.) and strengthen the capacity of the family unit (caregiver), along with strengthening community structures that protect and promote healthy child development.

Other services to be provided under this intervention include safe water (by promoting the use of Water Guard) and malarial prevention through the use of Long-lasting Insecticide Treated Nets (LLITNs). Nutritional and educational support will be provided either directly or through linkages to other USG partners providing such services as appropriate. OVC care providers may have access to income generating skill building through these awards, and community members will be recruited to serve as mentors to aid OVCs receiving services. These activities will be achieved in line with the National Guidelines and Standard Operating Procedures (SOPs).

CONTRIBUTIONS TO OVERALL PROGRAM AREA:
This activity is a high priority intervention area for the President's Emergency Plan by providing a comprehensive package of services to children orphaned or rendered vulnerable by HIV/AIDS, including those infected with HIV. It is also a priority for the GON. Its components, especially the human resource capacity development aspect, will enhance sustainability and the development of health care systems in Nigeria.

LINKS TO OTHER ACTIVITIES:
This activity will be linked with HVCT (12972.09), HTXS (14089.09), PMTCT (12968.09), HVTB (12971.09), HVOP (12969.09), HVSI (14091.09), and HLAB (14090.09). HCT services will be accessible to all family members and relations of the HIV infected children as necessary. Children that qualify for either ART or TB treatment will be linked to the most proximal outlets for these services. Since some of

the services will be implemented by local indigenous NGOs, CBOs and FBOs, sub-agreements will be coordinated with relevant IPs to ensure non-overlap of funding, services and reporting. The OVC services will be implemented in coordination with the GON, other relevant IPs and the GFATM.

POPULATIONS BEING TARGETED:
OVC services are primarily targeted at care givers, OVC/PLWHAs and their affected families. The capacity development activities cover the facility based staff like doctors, nurses, and other health care workers. In the community, training is targeted at NGOs, CBOs, FBOs and volunteers. However, the direct beneficiaries of the services are HIV positive infants and children, as well as children orphaned or made vulnerable by HIV/AIDS.

EMPHASIS AREAS:
The major area for this intervention is training and human resources development in order to ensure the delivery of comprehensive services to Orphans and Vulnerable Children.

COVERAGE AREAS: TBD when awarded.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HTXS | Redacted | Redacted |

**Narrative:**

These funds are to be used by the award recipients of the FY10 HHS/CDC RFA, with emphasis on local implementing partners, to provide infrastructure, maintenance, training clinicians and other providers, exams, clinical monitoring and management of opportunistic infections, related laboratory services, and community-adherence activities. The recipient will also be expected to maintain facilities that provide ART services, provide clinical monitoring of management of opportunistic infections, provide laboratory services, and provide community adherence programs

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | PDCS | Redacted | Redacted |

**Narrative:**

These funds are to be used by the award recipients of the FY10 HHS/CDC RFA, with emphasis on local implementing partners, to continue to implement HIV care and support programs for children in underserved areas of Nigeria. Basic Health Care package services that may be included by the award recipient include: basic medical, laboratory and nursing care, pain and symptom management, and provision of community home based care (HBC). Funds are to be used for the continuation of ongoing health facility-based and community based care for HIV-exposed and infected children aimed at

extending and optimizing quality of life for HIV-infected clients and their families throughout the continuum of illness through provision of clinical, psychological, spiritual, social, and prevention services.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | PDTX | Redacted | Redacted |

**Narrative:**

These funds are to be used by the award recipients of the FY10 HHS/CDC RFA, with emphasis on local implementing partners, to provide infrastructure, maintenance, training clinicians and other providers, exams, clinical monitoring and management of opportunistic infections, related laboratory services, and community-adherence activities for children in underserved areas of Nigeria. The recipient will also be expected to maintain facilities that provide ART services, provide clinical monitoring of management of opportunistic infections, provide laboratory services, and provide community adherence programs.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HMBL | Redacted | Redacted |

**Narrative:**

These funds are to be used by the award recipients of the FY10 HHS/CDC RFA to continue improvements in creating a safe blood supply for Nigeria. Award recipients will be expected to continue to provide blood safety activities through supporting nationally-coordinated blood program to ensure a safe and adequate blood supply including infrastructure and policies, donor recruitment activities, blood collection, testing for Transfusion Transmissival Infections (TTIs), storage and distribution of blood, appropriate clinical use of blood, transfusion procedures and hemovigilance, training and human resource development for transfusion.

CONTRIBUTION TO OVERALL AREA:
This activity will enhance blood safety program implementation through support to the NBTS. This will allow for continued strengthening of the Nigerian NBTS after the conclusion of the Track 1.0 award mechanism.

LINKS TO OTHER ACTIVITIES:
This activity is linked to HVCT (12972.09), HLAB (14090.09) and injection safety

EMPHASIS AREAS: This activity has an emphasis in capacity building for staff.

TARGET POPULATION: This target population will be health care workers for training and advocacy in appropriate transfusion practices.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVOP | Redacted | Redacted |

**Narrative:**

These funds are to be used by the award recipients of the FY10 HHS/CDC RFA, with emphasis on local implementing partners, to implement the prevention of sexual transmission portfolio, specifically in the condoms and other prevention program, currently being provided in underserved areas in Nigeria. Recipients will be charged with the provision and implementation of prevention through education on abstinence among in and out of school youths, targeted interventions among high-risk groups [Men having sex with men (MSM), Female sex workers (FSW), transport workers (TW), uniformed servicemen, injecting drug users (IDU's), prison population and such other vulnerable populations as would be identified]. Activities will be designed to achieve clear behavior change objectives, address social norms and structural barriers to prevention and use biomedical interventions relevant to the population and setting.

Clients will be the focus of messages aimed at reducing HIV transmission in high risk populations including correct and consistent condom-use messages. Existing support groups or associations of People Living With HIV/AIDS (PLWHA) will have access to condoms and be targeted with 'prevention for positives' messages (funded under care) and skills on positive living, to reduce transmission and re-infection. This activity will provide referrals to basic care and support services as well as ARV services for those identified to be in need.

This activity will provide training to PLWHA as peer educators and lay counselors to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful. This RFA will strengthen the developed sustainability plan both at program and country level and will collaborate with other existing implementing partners to build capacity and reach proposed indicators.

CONTRIBUTIONS TO OVERALL PROGRAM AREA:
This activity will support the GON to increase local capacity to provide prevention services to most-at-risk populations.

LINKS TO OTHER ACTIVITIES:
This activity also relates to activities in HBHC (12970.09), HVTB (12971.09), HVCT (12972.09) and HTXS (14089.09). This activity provides community outreach to individuals identified as high risk for acquiring HIV and directs them into counseling and testing. Those who test positive will be referred to PMTCT services, HIV treatment services as well as care & support services as appropriate.

EMPHASIS AREAS:
This activity has an emphasis on gender equity and addressing male norms and behaviors.

TARGET POPULATION:
This activity will target Most At Risk Populations, HIV positive pregnant women and PLWHA.

COVERAGE AREAS: TBD when awarded.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | MTCT | Redacted | Redacted |

**Narrative:**

The recipients will be responsible for supporting PMTCT services in previously unserved clinical outlets. Counseling and testing with the "opt out" and will be provided to all pregnant women presenting at antenatal services. HIV infected women will be counseled on risks of HIV transmission and goals of the PMTCT program. They will be encouraged to bring partners and other family members for counseling and testing. HIV infected women eligible for ART will be provided with ART following the National guidelines. All participating laboratories will either have the capability of clinical HIV assessment including CD4 determination to ascertain ART eligibility by national and international ART criteria or will refer women to such services at another HIV service outlet in the geographic area. HIV infected women ineligible for initiation of ART will be offered combination of zidovudine from 28 weeks and single dose nevirapine at onset of labor as per the national guidelines. Women presenting at labor will be offered rapid testing and if HIV infected provided with single dose nevirapine. All infants born to HIV infected women will be provided with single dose nevirapine at birth and zidovudine for 6 weeks. After delivery, mothers and infants will be followed to monitor the mother's health and determine HIV status of the baby. Infant diagnosis of HIV will be by referral to qualified PEPFAR laboratories performing PCR if not available at the site, and if found positive the baby will continue to be monitored for eligibility for ART and per medical indications, be provided with cotrimoxazole prophylaxis.

CONTRIBUTIONS TO OVERALL PROGRAM AREA:
With 30 sites in 4 states, the above described activity is in line with the USG`s target of having 80% coverage for PMTCT across the country.

LINKS TO OTHER ACTIVITIES:
This activity is also linked to HVOP (12969.08), HBHC (12970.08), HCT (12972.08), HKID (14087.08), HVTB (12971.08), HTXS (14089.08) and joint awards for these program areas are anticipated. Prevention for positives counseling will be integrated within PMTCT care for HIV+ women

POPULATIONS BEING TARGETED:
This activity targets pregnant women who will be offered HIV counseling and testing, HIV+ pregnant women who will be offered ARV prophylaxis and infant feeding counseling, and HIV+ infants who will be offered ARV prophylaxis and infant HIV diagnostic testing.

EMPHASIS AREAS: The PMTCT service has an emphasis on Human Resources and Local Organization Capacity Development.

COVERAGE AREAS: TBD when awarded.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HLAB | Redacted | Redacted |

**Narrative:**

These funds are to be used by the award recipients of FY10 HHS/CDC RFA to support PMTCT, CT, TB/HIV and ART treatment/services through the development of laboratory infrastructure at health facilities within Nigeria. Recipients will be expected to continue strengthening of laboratory systems and facilities to support HIV/AIDS-related activities including purchase of equipment and commodities and provision of quality assurance, staff training and other technical assistance.

The basic infrastructure at each facility will be enhanced to ensure constant electrical power and water. Labs will be equipped with automated CD4, hematology and blood chemistry equipment. Supplies for manual CD4 determinations will be available as a backup. HIV diagnosis will be performed at all sites using the GON approved rapid testing algorithm. All labs will have light microscopy for diagnosis of OIs (including TB). Funding will be used to support didactic and wet lab technical training of laboratory staff. Along with technical training, all staff will receive instruction in lab safety, good laboratory practices, record keeping and reagent/specimen storage. Standardized training curriculums currently exist (or are under development) for each of these areas and will be utilized. On-site refresher training will be provided to all laboratorians on a yearly basis. The quality of testing at all labs will be monitored through an extensive quality assurance (QA) program, including training of all staff on QA, proficiency testing and quarterly supervisory site visits (using a standardized evaluation tool). To facilitate these activities, two laboratorians will be responsible for coordinating training (as master trainers) and QA activities.

CONTRIBUTION TO OVERALL PROGRAM:
Enhancement of additional labs in Nigeria will contribute to the goal of maintaining high quality lab services as the number of patients provided with testing and treatment continues to rise. These labs will

support the identification and monitoring of new patients for ART therapy. Development of a new lab facility to deliver training supplements the over all lab capacity in Nigeria.

LINKS TO OTHER ACTIVITIES:
Having a strong laboratory infrastructure, with appropriately trained/supervised staff, within healthcare facilities provides support for many of the other EP program areas. Laboratory staff play a vital role in training those individuals performing HIV diagnostic testing in PMTCT (12968.09) and Counseling and Testing (12972.09) programs. Appropriately equipped labs allow for identification of HIV positive adult and children, ART Services (14089.09) and OVC (14087.09) and support monitoring of those with TB/HIV coinfection (12971.09).

POPULATIONS BEING TARGETED:
This activity will provide essential laboratory services to adults living with HIV/AIDS, HIV positive pregnant women, HIV positive infants and HIV positive children. Laboratory workers from the public sector will be targeted with technical training.

EMPHASIS AREAS:
This activity includes emphasis on renovation (specifically laboratories at healthcare facilities) and on training, development of network/linkages/referral system and quality assurance.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HVTB | Redacted | Redacted |

**Narrative:**

These funds are to be used by the award recipients of the FY10 HHS/CDC RFA, with emphasis on local implementing partners, to implement an HIV care and support program in underserved areas of Nigeria. Funds will be used to increase access to high quality TB services for HIV-infected individuals including pregnant women and children and to increase access to quality HIV testing at DOTS centers. The award recipients will be expected to establish or improve TB/HIV service provision in about 5 facilities with potential to expand to other facilities if funding is available. Continued provision of clinical monitoring, related laboratory services, treatment and prevention of tuberculosis (including medications), as well as screening and referral of TB clinic clients for HIV testing and clinical care is expected. The location of current HIV/TB activities includes general medical settings, HIV/AIDS clinics, home-based care and traditional TB clinics and hospitals.

The FY10 HHS/CDC RFA award recipients will establish and maintain TB laboratory capacity at all program sites in collaboration with the National TB program and facility staff to ensure timely and

accurate diagnosis of TB in HIV-infected individuals. Specific TB diagnostic laboratory support will include equipment upgrades (e.g. light microscopes and commodities for sputum smear microscopy) and training for 20 laboratory technicians from program sites which will focus on improving basic microscopy techniques. Support is to be provided for a quality assurance/quality control (QA/QC) system in collaboration with the National TB and Leprosy training center. This QA/QC system will involve qualified personal who will regularly visit sites to evaluate practices, microscopy proficiency testing and blind rechecking of a sample of slides. Funds will also be allocated for hiring a dedicated TB/HIV program officer who is responsible for providing strategic and technical direction to TB/HIV program implementation. S/he will also work with other GoN and Emergency Plan partners to promote synergy and to limit redundant efforts related to TB/HIV.

CONTRIBUTION TO OVERALL PROGRAM AREA:
The activities supported with these funds are in line with both the Government of Nigeria and Emergency Plan strategy for addressing HIV/AIDS as well as the dual TB and HIV epidemic in Nigeria. A key component of these strategies is to identify the need to improve HIV care by providing TB screening services and linkage to TB care as appropriate for HIV infected individuals. Regular screening for TB and a strong linkage to quality TB diagnostic and care services will identify these high-risk individuals who will benefit from access to TB and HIV care and treatment, thus supporting the National HIV/AIDS strategy and contributing to the care and treatment objectives of the Emergency Plan. Funds will also be used to routinely provide HIV counseling and testing services to TB patients. The HHS/CDC RFA award recipient should be uniquely positioned to provide services to underserved populations due to its history of working with and in the rural community along with other indigenous partners.

LINKS TO OTHER ACTIVITIES:
These TB/HIV activities are related to HVCT (12972.08), PMTCT (12968.08), HVOP (12970.08), HBHC(12970.08), HKID (140870.08), and HTXS (14089.08).

EMPHASIS AREAS:
To achieve success in this activity emphasis will be placed on the development of network linkages and referral systems between TB and HIV programs. In addition, emphasis will be placed training, infrastructure, human capacity, quality assurance/improvement/and supportive supervision as explained above.

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| Mechanism ID: 12465 | Mechanism Name: Delta Monitoring TBD |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Contract |
| Prime Partner Name: TBD | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: Yes | Global Fund / Multilateral Engagement: No |

| Total Funding: Redacted | |
|---|---|
| **Funding Source** | **Funding Amount** |
| Redacted | Redacted |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

HHS/CDC will put out a bid to invite contractors to apply for funds to provide program monitoring and management services in the Niger Delta region in FY 2010. Award recipients must place a clear emphasis on developing local indigenous capacity to efficiently manage and deliver HIV/AIDS related services to the Nigerian population. Since US mission personnel (including locally employed staff) are prohibited from visiting the Niger Delta region on any official business, there is an urgent need to engage the services of a contractor to monitor CDC implementing partner sites in that area. These funds will pay for such services to ensure there is effective program management across the country. The contractor will implement activities both directly and, where applicable, through sub-contracts; the contractor will, however, retain overall financial and programmatic management under the oversight of HHS/CDC and the strategic direction of the Office of the U.S. Global AIDS Coordinator.

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## Key Issues

(No data provided.)

## Budget Code Information

| Mechanism ID: | 12465 | | |
|---|---|---|---|
| Mechanism Name: | Delta Monitoring TBD | | |
| Prime Partner Name: | TBD | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Other | OHSS | Redacted | Redacted |

**Narrative:**

ACTIVITY DESCRIPTION:
These funds are to be used by the award recipients of the FY10 HHS/CDC contract mechanism, with emphasis on local contractors, to provide supervisory program and administrative monitoring in the Niger Delta geopolitical zone of Nigeria. The Niger Delta zone is currently prohibited from visits by the Regional Security Office of the US Mission in Nigeria. All Mission staff are prohibited from conducting any business in that zone due to the heightened risk for hostage taking and violence currently endemic in the region. However, there are multiple PEPFAR implementing partners providing services there, who need to be monitored for adherence to PEPFAR priorities and goals, proper financial management, and program quality. This mechanism will allow CDC to contract with a firm who can conduct site visits on behalf of CDC and ensure programs are being implemented as intended by PEPFAR.

POPULATIONS BEING TARGETED:
This activity targets implementing partners in the Niger Delta geopolitical zone of Nigeria.

EMPHASIS AREAS: Program monitoring and management.

COVERAGE AREAS: Niger Delta.

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 12466** | **Mechanism Name: Policy Enabling Environment Project** |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Policy Enabling Environment Project | |

| | |
|---|---|
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| **Total Funding: 2,018,660** | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 2,018,660 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

Policy Enabling Environment Project

Policy Enabling Environment Project (PEEP) is a five year project designed to provide an enabling environment that supports improvements in HIV/AIDS and TB services and systems at the national and state level so that Nigerian organizations can function more effectively. Furthering the implementation of policies already developed, or under revision as the PEPFAR team moves towards systems strengthening with a view to improving the way in which policies affecting Health Systems Strengthening, Orphans and Vulnerable Children and Adult Treatment are promulgated, debated, decided, funded and implemented.

The Implementing Partner will use the following mechanisms:

Technical Assistance to Nigerian organizations to build capacity directly related to improving the enabling environment, for example to a) formulate new policies, guidelines, protocols and standards; b) to review and update existing ones; c) to draft legislation; d) develop strategies to see policies implemented at the national and state levels by relevant authorities; e) to disseminate and conduct awareness building campaigns for policy understanding and adoption; f) to monitor impact of policy advancement.

Training for Nigerian organizations to build their capacity in areas cited above, but where the preferred intervention is the transfer of knowledge, skills and attitudes through short-term sessions, either designed and delivered by the PEEP for the Nigerian organization or their participation sponsored.

Research and Analysis of policy needs, of constraints to implementation, to conduct stakeholder mapping for policy advancement, and to amass evidence for policy development or revision in Health Systems

Strengthening, Orphans and Vulnerable Children and Adult Treatment; research and analysis can be obtained from within the PEEP implementing partner or through the use of short term consultants.

Information Dissemination – strategic delivery of policies and information generated by policy development to decision makers, the media and key stakeholders in order to build understanding, expand awareness of the policy and increase responsible and rational allocation resources based on policy guidance and evidence. Dissemination as compared to distribution, the form implying cultivating the receptivity for policy application in order to achieve impact.

Facilitating dialogue and meetings to introduce the need or policy formulation, build concensus among key stakeholders for policy advancement, to resolve disagreements on key policy issues that are impeding adoption or implementation.

This Award will be managed by the USAID IIP teams – education, health and HIV/AIDS-TB. USAID HIV/AIDS-TB team will have an activity manager assigned within the team that will work closely with the HIV/AIDS Team Leader and the AOTR.

Links to other activities –PEEP will further policy development and implementation in Nigeria in three sectors that make up the Mission's IIP Office – Education, Health and HIV/AIDS-TB.

Populations targeted – the project will target the HIV/AIDS-TB team, implementing partners, Nigerian organizations, National and state ministries and parastatals.

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## Key Issues

(No data provided.)

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **12466** |
| **Mechanism Name:** | **Policy Enabling Environment Project** |
| **Prime Partner Name:** | **Policy Enabling Environment Project** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HKID | 400,000 | |

**Narrative:**

Policy Enabling Environment Project (PEEP) is a five year project designed to provide an enabling environment that supports improvements in HIV/AIDS and TB services and systems at the national and state level so that Nigerian organizations can function more effectively. Furthering the implementation of policies already developed, or under revision as the PEPFAR team moves towards systems strengthening with a view to improving the way in which policies affecting Orphans and Vulnerable Children (OVC) are promulgated, debated, decided, funded and implemented.

The Implementing Partner will use the following mechanisms:

Technical Assistance to Nigerian organizations to build capacity directly related to improving the enabling environment, for example to a) formulate new policies, guidelines, protocols and standards; b) to review and update existing ones; c) to draft legislation; d) develop strategies to see policies implemented at the national and state levels by relevant authorities; e) to disseminate and conduct awareness building campaigns for policy understanding and adoption; f) to monitor impact of policy advancement.

Training for Nigerian organizations to build their capacity in areas cited above, but where the preferred intervention is the transfer of knowledge, skills and attitudes through short-term sessions, either designed and delivered by the PEEP for the Nigerian organization or their participation sponsored.

Research and Analysis of policy needs, of constraints to implementation, to conduct stakeholder mapping for policy advancement, and to amass evidence for policy development or revision as it relates to OVCs; research and analysis can be obtained from within the PEEP implementing partner or through the use of short term consultants.

Information Dissemination – strategic delivery of policies and information generated by policy development to decision makers, the media and key stakeholders in order to build understanding, expand awareness of the policy and increase responsible and rational allocation resources for OVC programming based on policy guidance and evidence. Dissemination as compared to distribution, the form implying cultivating the receptivity for policy application in order to achieve impact.

Facilitating dialogue and meetings to introduce the need or policy formulation, build concensus among key stakeholders for policy advancement, to resolve disagreements on key policy issues that are impeding adoption or implementation.

This Award will be managed by the USAID IIP teams – education, health and HIV/AIDS-TB. USAID HIV/AIDS-TB team will have an activity manager assigned within the team that will work closely with the HIV/AIDS Team Leader and the AOTR.

Links to other activities –PEEP will further policy development and implementation in Nigeria in three sectors that make up the Mission's IIP Office – Education, Health and HIV/AIDS-TB (OVC).

Populations targeted – the project will target the HIV/AIDS-TB team, implementing partners, Nigerian organizations, National and state ministries and parastatals.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HTXS | 318,660 | |

**Narrative:**

Policy Enabling Environment Project (PEEP) is a five year project designed to provide an enabling environment that supports improvements in HIV/AIDS and TB services and systems at the national and state level so that Nigerian organizations can function more effectively. Furthering the implementation of policies already developed, or under revision as the PEPFAR team moves towards systems strengthening with a view to improving the way in which policies affecting Adult treatment programming are promulgated, debated, decided, funded and implemented.

The Implementing Partner will use the following mechanisms:

Technical Assistance to Nigerian organizations to build capacity directly related to improving the enabling environment, for example to a) formulate new policies, guidelines, protocols and standards; b) to review and update existing ones; c) to draft legislation; d) develop strategies to see policies implemented at the national and state levels by relevant authorities; e) to disseminate and conduct awareness building campaigns for policy understanding and adoption; f) to monitor impact of policy advancement.

Training for Nigerian organizations to build their capacity in areas cited above, but where the preferred intervention is the transfer of knowledge, skills and attitudes through short-term sessions, either designed and delivered by the PEEP for the Nigerian organization or their participation sponsored.

Research and Analysis of policy needs, of constraints to implementation, to conduct stakeholder mapping for policy advancement, and to amass evidence for policy development or revision on adult treatment issues; research and analysis can be obtained from within the PEEP implementing partner or through the

use of short term consultants.

Information Dissemination – strategic delivery of policies and information generated by policy development to decision makers, the media and key stakeholders in order to build understanding, expand awareness of the policy and increase responsible and rational allocation resources for adult treatment programming based on policy guidance and evidence. Dissemination as compared to distribution, the form implying cultivating the receptivity for policy application in order to achieve impact.

Facilitating dialogue and meetings to introduce the need or policy formulation, build concensus among key stakeholders for policy advancement, to resolve disagreements on key policy issues that are impeding adoption or implementation.

This Award will be managed by the USAID IIP teams – education, health and HIV/AIDS-TB. USAID HIV/AIDS-TB team will have an activity manager assigned within the team that will work closely with the HIV/AIDS Team Leader and the AOTR.

Links to other activities –PEEP will further policy development and implementation in Nigeria in three sectors that make up the Mission's IIP Office – Education, Health and HIV/AIDS-TB (Adult Treatment).

Populations targeted – the project will target the HIV/AIDS-TB team, implementing partners, Nigerian organizations, National and state ministries and parastatals.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Other | OHSS | 1,300,000 | |

**Narrative:**

Policy Enabling Environment Project (PEEP) is a five year project designed to provide an enabling environment that supports improvements in HIV/AIDS and TB services and systems at the national and state level so that Nigerian organizations can function more effectively. Furthering the implementation of policies already developed, or under revision as the PEPFAR team moves towards systems strengthening with a view to improving the way in which policies affecting Health Systems Strengthening (HSS) are promulgated, debated, decided, funded and implemented.

The Implementing Partner will use the following mechanisms:

Technical Assistance to Nigerian organizations to build capacity directly related to improving the enabling environment, for example to a) formulate new policies, guidelines, protocols and standards; b) to review

and update existing ones; c) to draft legislation; d) develop strategies to see policies implemented at the national and state levels by relevant authorities; e) to disseminate and conduct awareness building campaigns for policy understanding and adoption; f) to monitor impact of policy advancement.

Training for Nigerian organizations to build their capacity in areas cited above, but where the preferred intervention is the transfer of knowledge, skills and attitudes through short-term sessions, either designed and delivered by the PEEP for the Nigerian organization or their participation sponsored.

Research and Analysis of policy needs, of constraints to implementation, to conduct stakeholder mapping for policy advancement, and to amass evidence for policy development or revision on Health Systems Strengthening; research and analysis can be obtained from within the PEEP implementing partner or through the use of short term consultants.

Information Dissemination – strategic delivery of policies and information generated by policy development to decision makers, the media and key stakeholders in order to build understanding, expand awareness of the policy and increase responsible and rational allocation resources for HSS programming based on policy guidance and evidence. Dissemination as compared to distribution, the form implying cultivating the receptivity for policy application in order to achieve impact.

Facilitating dialogue and meetings to introduce the need or policy formulation, build concensus among key stakeholders for policy advancement, to resolve disagreements on key policy issues that are impeding adoption or implementation.

This Award will be managed by the USAID IIP teams – education, health and HIV/AIDS-TB. USAID HIV/AIDS-TB team will have an activity manager assigned within the team that will work closely with the HIV/AIDS Team Leader and the AOTR.

Links to other activities –PEEP will further policy development and implementation in Nigeria in three sectors that make up the Mission's IIP Office – Education, Health and HIV/AIDS-TB (HSS).

Populations targeted – the project will target the HIV/AIDS-TB team, implementing partners, Nigerian organizations, National and state ministries and parastatals.

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| Mechanism ID: 12467 | Mechanism Name: Salesian Missions |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Salesian Mission | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | Global Fund / Multilateral Engagement: No |

| Total Funding: 150,000 | |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHCS (State) | 150,000 |

## Sub Partner Name(s)

| | | |
|---|---|---|
| Salesians of Don Bosco Namaliga Catholic Parish | | |

## Overview Narrative

I. Introduction

Salesian Missions in partnership with Salesians of Don Bosco in Nigeria is being implementing the CDC funded -Life Choices Voluntary Counseling and Testing Project as of July 2009.The Life Choices Nigeria – VCCT Project aims to increase the number of people that know their HIV status. The project will achieve this by increasing access to VCT services, by counseling and testing 7,500 youth and adults in five years and by improving quality of service delivery in the already existent VCT set-ups on a yearly basis. This project is being implemented in Akure -Don Bosco Health Center in Ondo State within a period of five years. The project will also work toward decreasing fear and stigma of HIV/AIDS at grass-roots level which will increase the willingness of people to be tested.

The project will use part of the experienced staff from Salesian Akure Health Center as well as has newly employed new staff that will bring new expertise to the team. The project will also use the vast network systems built previously by the Salesian Health Center. In the end of the project cycle sustainability will be ensured by continuing these services with funding from alternative sources in order to continue serving the local community needs.

II. Project Objectives and Strategy

The capacity and resources of Life Choices-Nigeria will enable the rapid integration of VCCT services into the current program and health center activities, since VCCT referrals have already been a part of the program. In COP10, however, the Life Choices will expand access for most-at-risk population by making services more readily available through mobile VCT services, and follow-up through support groups, further education, and/or treatment referrals.

To this end, the Life Choices Program have recruited, trained project staff with the national VCT services and have made the renovations so as to provide quality VCT services .In COP10 the following objectives are expected to met :

Objectives 1: Expanded facility based VCT services and one Mobile VCT services;
Objective 2: Test 1,500 youth & Adults for HIV;
Objective 3. Refer 1,500 clients to care, treatment and prevention interventions;
Objective 4: Organize 5 VCT sensitization workshops with community.

In order to build the capacity of Life Choices-Nigeria to carry out mobile VCCT services, Salesian Missions will provide assistance with activities covering procurement, technical expertise transfer, recruitment and training to service providers and other clinic staff, and best practices material adaptations.

Approach to increasing access to mobile VCT services: Life Choices-Nigeria will expand access to VCT services by: (a) integrating VCT into th; (b) offer health centering high schools and churches in the Ondo State with access to mobile VCT services; (c) improving the quality of youth friendly VCT services at existing VCT sites through training and mentoring of service providers and other clinic staff; (c) increase community mobilization within schools and churches via peer educators, educators, parents and community leaders; and (e) offering psychological support and counseling for onward care and support services to clients diagnosed HIV positive. Life Choices- Nigeria will also build the capacity of the local providers and clinic staff to provide quality youth-friendly VCCT services, including pre-test and post-test counseling of HIV+ and HIV- clients (this is b). Furthermore, the partnering organizations plan to use existing national VCCT and other treatment, care, and support guidelines for training and capacity building in the Ondo State.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 7,950 |

## Key Issues

Increasing gender equity in HIV/AIDS activities and services

Military Population

Mobile Population

Workplace Programs

## Budget Code Information

| **Mechanism ID:** | **12467** | | |
|---|---|---|---|
| **Mechanism Name:** | **Salesian Missions** | | |
| **Prime Partner Name:** | **Salesian Mission** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Care | HVCT | 50,000 | |
| **Narrative:** | | | |
| None | | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Prevention | HVAB | 100,000 | |
| **Narrative:** | | | |
| None | | | |

## Implementing Mechanism Indicator Information

(No data provided.)

## Implementing Mechanism Details

| **Mechanism ID: 12468** | **Mechanism Name: Accelerated PMTCT HSS TBD** |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: TBD | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: Yes | Global Fund / Multilateral Engagement: No |

| Total Funding: Redacted | |
|---|---|
| **Funding Source** | **Funding Amount** |
| Redacted | Redacted |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## Key Issues

(No data provided.)

## Budget Code Information

| **Mechanism ID:** | **12468** | | |
|---|---|---|---|
| **Mechanism Name:** | **Accelerated PMTCT HSS TBD** | | |
| **Prime Partner Name:** | **TBD** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Other | OHSS | Redacted | Redacted |
| **Narrative:** | | | |
| None | | | |

## Implementing Mechanism Indicator Information

(No data provided.)

# USG Management and Operations

**1.**

Redacted

**2.**

Redacted

**3.**

Redacted

**4.**

Redacted

**5.**

Redacted

## Agency Information - Costs of Doing Business

## U.S. Agency for International Development

| Agency Cost of Doing Business | Central GHCS (State) | DHAPP | GAP | GHCS (State) | GHCS (USAID) | Cost of Doing Business Category Total |
|---|---|---|---|---|---|---|
| Computers/IT Services | | | | 680,736 | | 680,736 |
| ICASS | | | | 362,000 | | 362,000 |
| Management Meetings/Professional Developement | | | | 856,171 | | 856,171 |
| Non-ICASS Administrative Costs | | | | 2,870,535 | | 2,870,535 |
| Staff Program Travel | | | | 2,667,900 | | 2,667,900 |
| USG Staff Salaries and Benefits | | | | 4,850,560 | | 4,850,560 |
| **Total** | **0** | **0** | **0** | **12,287,902** | **0** | **12,287,902** |

## U.S. Agency for International Development Other Costs Details

| Category | Item | Funding Source | Description | Amount |
|---|---|---|---|---|
| Computers/IT Services | | GHCS (State) | | 680,736 |
| ICASS | | GHCS (State) | | 362,000 |
| Management Meetings/Professional Developement | | GHCS (State) | | 856,171 |
| Non-ICASS Administrative Costs | | GHCS (State) | | 2,870,535 |

## U.S. Department of Defense

| Agency Cost of Doing Business | Central GHCS (State) | DHAPP | GAP | GHCS (State) | GHCS (USAID) | Cost of Doing Business Category Total |
|---|---|---|---|---|---|---|
| Capital Security Cost Sharing | | | | 145,550 | | 145,550 |
| Computers/IT Services | | | | 300,000 | | 300,000 |
| ICASS | | | | 591,771 | | 591,771 |
| Institutional Contractors | | | | 450,000 | | 450,000 |
| Management Meetings/Professional Developement | | | | 100,000 | | 100,000 |
| Non-ICASS Administrative Costs | | | | 1,182,290 | | 1,182,290 |
| Staff Program Travel | | | | 292,802 | | 292,802 |
| USG | | | | 300,000 | | 300,000 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Renovation | | | | | | |
| USG Staff Salaries and Benefits | | | | 1,528,842 | | 1,528,842 |
| **Total** | **0** | **0** | **0** | **4,891,255** | **0** | **4,891,255** |

## U.S. Department of Defense Other Costs Details

| Category | Item | Funding Source | Description | Amount |
|---|---|---|---|---|
| Capital Security Cost Sharing | | GHCS (State) | | 145,550 |
| Computers/IT Services | | GHCS (State) | | 300,000 |
| ICASS | | GHCS (State) | | 591,771 |
| Management Meetings/Professional Developement | | GHCS (State) | | 100,000 |
| Non-ICASS Administrative Costs | | GHCS (State) | | 1,182,290 |
| USG Renovation | | GHCS (State) | | 300,000 |

## U.S. Department of Health and Human Services/Centers for Disease Control and Prevention

| Agency Cost of Doing Business | Central GHCS (State) | DHAPP | GAP | GHCS (State) | GHCS (USAID) | Cost of Doing Business Category Total |
|---|---|---|---|---|---|---|
| Capital Security Cost Sharing | | | | 600,000 | | 600,000 |
| Computers/IT Services | | | | 973,579 | | 973,579 |
| ICASS | | | | 2,077,400 | | 2,077,400 |
| Institutional Contractors | | | | 2,030,000 | | 2,030,000 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Management Meetings/Professional Developement | | | | 250,000 | | 250,000 |
| Non-ICASS Administrative Costs | | | | 4,804,997 | | 4,804,997 |
| Staff Program Travel | | | | 1,035,000 | | 1,035,000 |
| USG Staff Salaries and Benefits | | | 3,056,000 | 3,373,448 | | 6,429,448 |
| **Total** | **0** | **0** | **3,056,000** | **15,144,424** | **0** | **18,200,424** |

## U.S. Department of Health and Human Services/Centers for Disease Control and Prevention Other Costs Details

| Category | Item | Funding Source | Description | Amount |
|---|---|---|---|---|
| Capital Security Cost Sharing | | GHCS (State) | | 600,000 |
| Computers/IT Services | | GHCS (State) | | 973,579 |
| ICASS | | GHCS (State) | | 2,077,400 |
| Management Meetings/Professional Developement | | GHCS (State) | | 250,000 |
| Non-ICASS Administrative Costs | | GHCS (State) | | 4,804,997 |

## U.S. Department of State

| Agency Cost of Doing Business | Central GHCS (State) | DHAPP | GAP | GHCS (State) | GHCS (USAID) | Cost of Doing Business Category Total |
|---|---|---|---|---|---|---|

| | | | | | | |
|---|---|---|---|---|---|---|
| Capital Security Cost Sharing | | | | 16,060 | | 16,060 |
| Computers/IT Services | | | | 30,150 | | 30,150 |
| ICASS | | | | 62,270 | | 62,270 |
| Management Meetings/Professional Developement | | | | 274,520 | | 274,520 |
| Staff Program Travel | | | | 75,000 | | 75,000 |
| USG Staff Salaries and Benefits | | | | 355,000 | | 355,000 |
| **Total** | **0** | **0** | **0** | **813,000** | **0** | **813,000** |

## U.S. Department of State Other Costs Details

| Category | Item | Funding Source | Description | Amount |
|---|---|---|---|---|
| Capital Security Cost Sharing | | GHCS (State) | | 16,060 |
| Computers/IT Services | | GHCS (State) | | 30,150 |
| ICASS | | GHCS (State) | | 62,270 |
| Management Meetings/Professional Developement | | GHCS (State) | | 274,520 |