Nigeria

Operational Plan Report

FY 2012

Operating Unit Overview

OU Executive Summary

Country Context

The Federal Republic of Nigeria consists of six geo-political zones that include thirty-six (36) states and the Federal Capital Territory (FCT), which, in turn, contain seven-hundred seventy-four (774) local government areas (LGAs). Nigeria occupies an area more than twice the size of the State of California. In both geographic size and population, many states are larger than some African countries. The country has 2.98 million HIV-positive individuals and constitutes the second greatest burden of HIV/AIDS care and treatment worldwide. Adding to this burden are the estimated 2.18 million children orphaned by HIV/AIDS. Nigeria also has one of the highest tuberculosis (TB) burdens in the world (311/100,000 population) 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.

Since reporting of the first case of AIDS in Nigeria in 1986, the epidemic has become generalized. This illness affects all population groups and spares no geographical area. Generalized prevalence among 15-49 year olds is about 3.6 percent , but significantly higher rates exist among most-at-risk populations (MARPs), including commercial sex workers (30.2-37.4 percent), injecting drug users (5.6 percent), and men who have sex with men (13.5 percent) . Heterosexual transmission accounts for up to 95 percent of HIV infections. Women account for close to 60 percent of all adults living with HIV.

HIV prevalence varies widely across states as well as rural and urban areas. Lower levels of HIV prevalence occur in particular geographic regions and within certain segments of the population. The variability in prevalence by states was demonstrated in a 2010 antenatal prevalence (ANC) survey, with prevalence ranging from a low of one percent in Kebbi State to 12.7 percent in Benue state . The ANC survey recorded seventeen states and the FCT at sero-prevalence of at least five percent and a sero-prevalence level of seven percent or higher in seven states and the FCT . Four of the states located in the South-South geo-political zone had seven percent or higher prevalence while no states from the South-West and the North East zones had such prevalence. The geographic dissimilarities in the dynamics of the epidemic suggest that the influence and contributions of various high-risk behaviors may vary in communities and geographical settings.

The drivers of the HIV epidemic include low-risk perception, multiple concurrent partners, informal transactional and inter-generational sex, lack of effective services for sexually-transmitted infections

(STIs), and poor quality of health services. Gender inequalities, poverty, and HIV/AIDS-related stigma and discrimination also contribute to the continuing spread of the infection. Risky behaviors continue and are targets for key prevention interventions.

PEPFAR Focus in 2012

The United States Government (USG) programmatic approach for COP12 will shift as a result of its commitment to implementing the Global Health Initiative (GHI) Strategy and the Partnership Framework Implementation Plan (PFIP). Priorities of the GHI and PFIP strategies include: improved human resources for health; greater focus on women and children; delivery of highest-impact service interventions, particularly at the primary health care (PHC) level; and strengthened leadership, management, governance, and accountability for program ownership and sustainability. The USG will provide technical assistance to the Government of Nigeria (GON) by shifting its focus to state and local levels of government to improve capacity in planning, management, and leadership of HIV/AIDS and TB programs.

The U.S. Department of Defense Walter Reed Program (DOD WRP-N), U.S. Agency for International Development (USAID), and U.S. Health and Human Services /Centers for Disease Control and Prevention (CDC) implement this program. In COP 2012, the DOD WRP-N will continue to strengthen its partnership with the Nigerian Ministry of Defense Emergency Plan Implementation Committee (NMOD – EPIC) to promote country ownership and sustainability for the USDOD-NMOD HIV Program. USAID and CDC will continue to work with their implementing partners (IPs) in close collaboration with the GON at all levels across the full array of HIV/AIDS service delivery areas. USAID will implement USAID/FORWARD, which complements both GHI and the PFIP through its emphasis on direct engagement of state and local governments as well as civil society organizations and its commitment to increasing the number of directly-funded local organizations. CDC will expand existing efforts to accelerate transition of activities to indigenous organizations with an increased focus on government partners at federal and primary health care (PHC) levels.

USG programmatic shifts are inter-related and support GHI principles. For example, the new focus on improving PHCs will allow the down-referral of patients from overcrowded secondary and tertiary facilities and create opportunities to start additional patients on ART. Further, better functioning PHCs will increase the availability of prevention of mother-to-child transmission (PMTCT) services as women seek ante-natal, family planning (FP), and reproductive health services, pediatric vaccinations, and other services at this level. A core component of Nigeria's National Strategic Health Development Plan (NSHDP) includes improving PHCs in an effort to improve delivery of maternal and child health, FP, and reproductive health services. Efforts to support this plan will create opportunities for HIV/AIDS and

maternal and child health co-funding and planning as PHCs improve.

1. PMTCT

The USG PMTCT portfolio has increased engagement with state and local government through the “Lead Partners” concept to build technical capacity of states and local governments in planning. The USG will support partners to expand PMTCT activities to PHCs and secondary facilities. Integration of PMTCT services into maternal and neonatal child health service outlets and increasing private sector engagement for PMTCT services expansion are among the strategies.

The USG is leveraging resources for PMTCT commodities, which include laboratory test kits for HIV testing, reagents for Early Infant Diagnosis (EID). and antiretroviral (ARV) drugs for prophylaxis. In 2009, about 18.7 percent of HIV-positive pregnant women received anti-retroviral therepy (ART) to reduce the risk of mother-to-child transmission (MCT). The USG will continue to emphasize 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 technical assistance to the GON, especially in the fields of quality assurance, quality control, and logistics management.

With “PMTCT Plus-Up” funds in FY 2012, the USG will continue its efforts to support expansion of coverage of PMTCT services to pregnant women. The USG will continue to dialogue with other stakeholders, particularly the United Nations Children’s Foundation (UNICEF), and the GON, to implement this expansion strategically and reach out to high prevalence communities and rural areas, where many women give birth without a skilled birth attendant. The USG continues to expand its coverage started in FY 2008 with the provision of PMTCT services using the “hub and spoke” model to increase PMTCT coverage. This expansion builds on PEPFAR PMTCT networks, leveraged resources from UNITAID and UNICEF, and the GON plans for the elimination of MCT.

2. Treatment Scale-up

Treatment activities include the provision of ARVs and services to eligible patients and laboratory support for the diagnosis and monitoring of HIV-positive patients identified through USG activities and in-line with goals and strategies of the National Strategic Framework (NSF) and the PFIP. We will use funds to purchase FDA-approved or tentatively-approved ARVs in their generic formulation whenever possible to maximize the number receiving treatment. Harmonization, quality of service, reduced target costs, and cost leveraging remain mainstays of the treatment program. Standardized services and health care worker training is provided across all implementing partners. Pediatric treatment services also remain a priority in FY 2012. The USG will continue its efforts to leverage GON, Global Fund (GF), and other

development partners for ARVs.

The USG will use a 'Test to Treat' strategy focusing on identifying positive persons eligible for treatment based on a CD4 count of 350 or less. Partners are also encouraged to use the provider-initiated approach (PITC) for all patients accessing health facilities. HIV-exposed children less than 18 months of age will be diagnosed for HIV infection and started on ARVs and provided with co-trimoxazole prophylaxis. Priority areas in the provision of care and support services will include scaling-up pediatric care and support services, early identification of HIV-infected children using PITC, integration into maternal and new-born child health (MNCH), and scaling-up PMTCT.

USG partners will scale up ART services by focusing on: high burden states and states with high unmet need; early identification of HIV infected persons, linkages and retention in care; continued decentralization of ART services to PHC level using the 'hub and spokes" model; and expansion of the pool procurement mechanism to include selected laboratory commodities/reagents in addition to antiretroviral drugs and rapid test kits.

Partners will increase coverage and access to ART among HIV-infected children and reduce the number of deaths attributable to pediatric HIV/AIDS. Key priorities will include: early detection through provision of PITC at all entry points of services for children, support of GON pediatric ARV drug logistics (especially with the transition of CHAI support of pediatric ART to GON); and support scale-up of national EID services. Services will be integrated into the broader MNCH services as well as strengthen linkages between pediatric treatment, PMTCT, orphans and vulnerable children (OVC), and adult treatment programs.

Phased transition of first-line ARV procurement to the Ministry of Health (MOH) remains an important goal in the PFIP and COP 2012. To support this goal, the USG and other donors will build the capacity of MOH, support the ministry's efforts to forecast, identify, and expand access to lower-cost drugs, and develop an ARV transition plan. USG will also support MOH efforts to maximize the impact of first line ART through effective adherence and retention measures, detecting HIV drug resistance, and developing strategies to respond.

In FY 2012, the USG will continue to pool all ARV procurements through the Partnership for Supply Chain Management System (SCMS). This method, based on PEPFAR and GON forecasting, decreases duplication by individual partners and increases efficiency. The USG supports logistics management activities, a key component of ARV delivery, through ongoing development of a Logistics Management Information System and an Inventory Control System.

Preventing and treating TB-HIV co-infections remains a priority due to the high TB burden. A major focus for FY2012 is the expansion and enhancement of TB-HIV sites at the state and local levels. The USG will contribute medical equipment, testing commodities, and training to support treatment and testing sites. In the TB Directly Observed Treatment Short-Course (TB DOTS) settings, the USG will continue provider-initiated routine HIV testing. This will greatly increase access to services for adults and children co-infected with HIV and TB. We also seek to reduce TB transmission, improve diagnosis and management of TB and multi-drug resistant TB (MDR-TB) cases especially among HIV positive patients. Data from the ongoing USG-supported national MDR-TB and HIV survey will become available and incorporated into evidence-based service provision in the TB-HIV program.

3. HIV Testing and Counseling and Other Prevention Programs

The GON has committed to make the prevention of new infections the focus of the national HIV/AIDS response. Prevention activities include prevention of mother-to-child-transmission (PMTCT); prevention of sexual transmission [abstinence and be faithful (AB) programs]; condoms/other prevention initiatives (C); Positive Health, Dignity and Prevention programs (PHDP); prevention of medical transmission (blood and injection safety); and HIV counseling and testing.

Only 14 percent of the adult population knows their HIV status. Thirty percent of adults perceive themselves as having no or low risk of HIV infection. The USG Sexual Prevention strategic focus includes the following: 1) prioritize combination prevention approach (biomedical, behavioral and structural) in line with the National Prevention Plan's Minimum Prevention Package Initiative; 2) have behavioral interventions focus on minimizing sexual risk and increasing protection in focus populations; 3) and seek behavioral interventions via mass media campaigns and community and social mobilization by partners.

Blood transfusion services still remain a source of transmission for HIV and other pathogens despite the gains made by the National Blood Transfusion Service (NBTS) since 2007. In FY 2012, the USG will continue supporting the review, dissemination, and implementation of existing policy protocols as well as advocating, building service provider capacity, and providing technical assistance (TA) to encourage the adoption of universal precaution services.

Prevention activities will be integrated into all care and treatment activities, including HIV counseling and testing (HCT) services. Efforts to reduce new infections among high-risk and high-transmission communities will continue. Multiple HCT strategies (provider initiated testing and counseling, mobile HCT, couples HCT, and door-to-door HCT) will be employed to enable target populations to know their HIV status as a launch-pad into prevention, care, and treatment services.

4. Health Systems Strengthening

USG activities in systems strengthening will support TA for the establishment and strengthening of local and state agencies for the control of AIDS (LACAs and SACAs) to coordinate sustainable and gender-sensitive multi-sectoral HIV/AIDS responses. The USG will also work to strengthen coordination mechanisms at all levels. Planned activities include developing and coordinating a lead IP strategy and providing TA for cross-cutting regionalization efforts. The USG will also strengthen civil society organizations at all levels by providing financial and technical support, management training, planning, and advocacy skills. The USG will also help build the capacity of GON officials to help them scale up their financial contributions to the HIV/AIDS response from the current seven percent to 50 percent in 2015.

A critical shortage of health care workers exists, with significant disparities across zones. Maintaining functional Human Resources for Health (HRH) planning and management units at the state and federal levels is challenging. To help mitigate the shortage, the USG will support the establishment of a National HRIS electronic database and work to improve retention and training of skilled health workers. Strategies include supporting the GON and other stakeholders on curriculum development, assessing factors affecting uneven distribution of health care workers throughout Nigeria, and providing TA to GON on retention issues, HRH policy, and plan implementation.

The USG will support the National Primary Health Care Development Agency (NPHCDA) to provide an effective and efficient Community Care Workers' (CCW) workforce to support comprehensive, multidisciplinary community services, and also strengthen partnerships between government, civil society and communities to consolidate, manage, and focus the services provided by CCW.

5. Other Programs

The USG and GON will continue to work towards establishing a basic package of services for HIV-positive people and their families. In FY 2012, care services will be provided to all HIV-positive patients identified in USG programs. These include basic care kits; management of opportunistic infection and sexually transmitted infections; laboratory follow-up; nutritional, PHDP, psychosocial, and spiritual support; and referral to a care network. People living with HIV/AIDS will receive support services and access to psychosocial support. The USG will promote access to community home-based care and strengthen networks of health care personnel and community health workers. The USG will continue to support the harmonization of training materials and their use and increase focus on adherence counseling and pooled commodity procurements.

Children of HIV-infected adults currently in care will be linked to specialized OVC services. The USG will continue to support the federal, state, local government, and civil society to collaboratively provide, manage, and monitor integrated, comprehensive care to OVC and their families. The USG will also continue to support the Ministry of Women Affairs and Social Development (MWASD) OVC Division to improve its capacity for better coordination of activities, initiatives, and advocacy to address the overwhelming needs of OVC and their caretakers. The OVC program will scale up household economic strengthening to empower families to respond to the needs of vulnerable children. Other strategies include promotion of community-initiated responses, child protection, early childhood development, HIV/Sexually transmitted infections (STIs) prevention, and social workforce strengthening.

Integral to the provision of all programs, laboratories will continue to scale-up services. Increased treatment targets and the continuing focus on treatment decentralization will require increased laboratory capacity and upgraded infrastructure. Phased laboratory expansion will be controlled and sustainable. USG-supported laboratories will continue to focus on maintaining services through the implementation of expanded and harmonized lab quality assurance/quality control systems. Other USG assistance will include training and accreditation for laboratory professionals and establishing partnerships with universities to improve curricula and increase capacity of medical laboratory science programs for the increased sustainability of laboratory expansion.

In FY 2012, the continued development of a five-year National Laboratory Strategic Plan will remain important in identifying nationwide needs and service gaps. Improved cost efficiencies will result from this overall approach to reduce treatment costs and making routine monitoring available to all ART patients. For sustainability and ownership of laboratory program, the USG directly funds GON agencies, including the MOH and Medical Laboratory Science Council of Nigeria (MLSCN). The funding will focus on building laboratory networks systems and the capacity of MLSCN to conduct assessments and accreditation of laboratories. The USG is contributing to the establishment of an African Center of Laboratory Equipment Maintenance (ACLEM) to support maintenance and certification of laboratory equipment.

Strategic information remains a key over-arching program. The national HIV/AIDS strategy adheres to the principle of the “Three Ones”: one action framework (the Partnership Framework), one national HIV/AIDS coordinating authority (the National Agency for the Control of AIDS -- NACA), and one country-level monitoring and evaluation system. Helping to establish this M&E system is key to aligning with the strategy. Establishing a national system is a five-year goal. FY 2012 activities include strengthening the technical and managerial skill sets of GON leaders, program managers, and M&E staff at all levels; streamlining and standardizing indicators, tools, and reporting systems; and supporting operations research and population-based surveys that answer specific questions relating to the HIV

epidemics and public health interventions.

PF/PFIP Monitoring

In 2009, NACA led an intensive, comprehensive strategic and operational planning process to review the National AIDS Policy and the National HIV/AIDS Response, resulting in preparation of the Second National Strategic Framework (NSF2), which covers 2010-2015. This was followed by the preparation of the National Implementation Plan which was finalized and presented in February 2010.

On August 25, 2010, the U.S. and Nigerian Governments signed the Partnership Framework (PF) on HIV/AIDS for 2010-2015. The PF involves a five-year agreement that reaffirms both governments' commitments to the goals, strategies, and objectives set forth by the GON. In line with the NSF2, the six principal strategic areas addressed by the PF include:

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; and
6. Monitoring and Evaluation, Research, and Knowledge Management.

U.S. Ambassador to Nigeria Terence P. McCulley and Secretary to the Government of the Federation Senator Anyim Pius Anyim signed the Partnership Framework Implementation Plan (PFIP) on HIV/AIDS 2010-2015 on December 1, 2011 -- World AIDS Day 2011.

The PFIP incorporates a transition plan that shifts USG from providing direct delivery of services to providing increased support and capacity building of indigenous organizations and the public sector to carry out service delivery. The primary USG policy objective is to support GON by strengthening the capacity and systems of GON and IPs in the design, implementation, and coordination (including monitoring and evaluation) of effective evidence-informed programs at national and sub-national levels. Additionally, we will continue to use PFIP funds to support the decentralization of direct health service provision. Decentralization is a critical avenue for realizing the PEPFAR and GHI goal of health services integration in support of broader health systems strengthening while continuing to scale-up HIV services provision. This strategy is integral to both the expansion of access to quality HIV services and to the integration of these services with other priority health interventions.

Country Ownership Assessment

At the 2011 General Assembly High-Level Meeting on HIV/AIDS in New York, Nigerian President Goodluck Ebele Jonathan committed to achieving universal access to HIV prevention, treatment, and care, and support. President Jonathan stated that the GON needs to commit to 50 percent of HIV/AIDS funding. Although this commitment is impressive, the challenge around country ownership and sustainability remains significant. The majority of GON funding for strategic planning and program interventions continues to come from development partners. This is not sustainable, particularly at a time of global economic crisis. While leadership at the national-level has improved significantly over the last five years, several factors prevent attainment of universal access to HIV prevention, treatment, and care. Traditionally, organizational and technical capacity among government offices and staff has been low at the state and LGA levels. Insufficient staff, significant staff turnover, poorly defined and over-lapping job descriptions, and insufficient resources to carry out key functions (e.g., coordination, planning, monitoring, and reporting) are a few of the challenges facing state and LGA level offices. Staff members often receive insufficient training to carry out key government functions, supervision remains poor and mentoring limited, and few opportunities for ongoing professional development exist. In addition, offices at the state and LGA levels have few mechanisms to collect data on their own performance and have limited opportunities to contribute to national HIV/AIDS priorities and work plans. Reporting lines are often unclear and confusing. There is poor data gathering and analysis on HIV/AIDS. The effectiveness of HIV/AIDS programming has been insufficient.

In support of greater country ownership and sustainability, activities set forth in COP 12 reflect the objectives outlined in the NSF2 and the NSHDP. Moreover, COP 12 activities specifically follow the commitments agreed upon by the USG, GON, and other PFIP stakeholders. In preparing for COP 12, USG consulted with working and high level contacts within the GON as well as the multitude of stakeholders currently supporting HIV/AIDS and wider-health interventions. At the national level, USG engaged in specific dialogue with the GON via NACA, the Ministry of Defense, and the MOH (specifically the National TB and Leprosy Control Program and the National AIDS and Sexually Transmitted Infections Control Program), the MWASD, National Agency for Food and Drug Administration and Control (NAFDAC), the National Planning Commission (NPC), the Secretary of the Government to the Federation (SGF), and NPHCDA. USG engagement occurs at a variety of levels. From March 2011 to September 2011, numerous high-level meetings occurred between the USG and GON in preparation of the Nigeria GHI Strategy. The outcomes of these high-level meetings as well as GON priorities were incorporated in to the development of COP 12. Technical level engagement with GON has become more formal over the years through the formation of National Technical Working Groups (TWG) through which USG incorporates GON priorities into the COP process. The additional planning and strategy development meetings held for the development of the GHI strategy enabled the USG to engage with

GON officials and technical advisors, civil society, special interest organizations, and other donors who ordinarily would not have been part of the COP process. For example, the USG meet with maternal and child health advisors within the MOH to provide additional insights into USG-supported PMTCT efforts.

U.S. officials continue to improve upon coordination with other donors, most notably the Global Fund (GF), ensuring complementary efforts and avoiding duplication. Joint planning and site visits between the USG and GF have occurred in previous years; however, more targeted efforts occurred during preparation of COP 12. The USG currently serves as the representative to Development Partners Group for HIV to the Country Coordinating Mechanism and occupies the Chair of the Oversight Committee. Implementation of USG decentralization efforts with PFIP Plus-Up funds has been accomplished through joint planning and analysis in close collaboration with the NPHCDA as well as the GF Round Eight Health System Strengthening efforts to identify appropriate sites and limit overlap and duplication in efforts. Joint planning and procurement design occurred between USG, United Kingdom (UK) Department for International Development (DFID), UNICEF, and the World Bank within sexual transmission prevention and OVC care and support efforts.

Historically, the USG has not presented a completed COP to any one GON entity prior to submission. Rather, the USG presents the COP post-submission to the SGF with all the effected ministry, agency, and program-specific leads in attendance. This joint USG-GON presentation to the SGF has historically been the most appropriate and efficient forum because the GON has such significant influence at various levels during the COP process.

Numerous challenges and opportunities exist within the newly-defined country ownership dimensions (for example: political ownership/stewardship, institutional and community ownership, capabilities, and accountabilities). While the GON has clearly articulated its priorities and plans, the GON remains dependent on technical and operational assistance from the USG and other donors to improve organizational capacity to oversee stakeholder activities. Increased institutional ownership requires greater amounts of support to local entities (e.g. local and state governments and non-governmental and civil society organizations) to more effectively monitor, coordinate, and oversee programmatic efforts. As outlined in the PFIP, the USG remains strongly committed to more direct engagement with local entities when appropriate. While some have benefited from the support of an active and committed civil society, a significant lack of organizational and technical capacity in local, indigenous civil society organizations (CSO) has limited the extent to which the most vulnerable beneficiaries can be identified and reached. Many of these local, indigenous CSOs include national organizations, community-based organizations, faith-based organizations (both Christian and Muslim), child and youth-led organizations as well as civil society networks, and coalitions. However, effectively addressing the needs of beneficiaries has been limited because many of these organizations are often unaware of organizational and technical best

practices and resources. Poor coordination of activities, weak mechanisms for referrals, poor processes for accountability, and inadequate systems for monitoring and evaluation contribute to the ineffectiveness of these organizations to address the needs of beneficiaries. In addition, significant challenges exist with accountability and good governance within the health and social welfare sectors. For example, the recent GF Office of the Inspector General (OIG) audit exposed numerous management shortcomings, such as poor accounting mechanisms, contracting, and procurement systems and weak personnel.

In addressing these numerous challenges, the USG has identified opportunities to transition its service delivery and capacity building efforts to local entities. Substantial progress has occurred with several projects designed exclusively for local entities commencing implementation in COP12. The USG has expertise in a wide variety of technical areas, including health systems strengthening and health care financing, to provide GON and other organizations with state of the art technical guidance and assistance. In COP 12, the USG has hired an individual whose portfolio will include a significant amount of engagement in joint USG-GF planning and implementation. Additionally, the USG has commenced efforts to decentralize service delivery which will allow for a more manageable program at the local level. The USG will accomplish this through targeted capacity building and direct engagement of state and local governments to leverage locally-available resources to achieve synergy and improve overall efficiency. The USG has entered the early planning stages of rationalizing comprehensive treatment efforts geographically with a “Lead IP” identified for each state. The intended vision of USG rationalization efforts is to prevent the overlap of activities, improve standards of care, improve coordination, advocacy, and capacity building efforts as well as increased coverage through targeted saturation of LGAs. As a critical component of the PFIP, rationalization offers a unique opportunity to improve the accountability of USG-supported IPs and ultimately create a more manageable program for the GON. Further, the process will allow IPs to more easily attain commitments from GON at the state and local levels.

Time Frame: October 2012 to September 2013

Population and HIV Statistics

Population and HIV Statistics				Additional Sources		
	Value	Year	Source	Value	Year	Source
Adults 15+ living with HIV	2,900,000	2009	UNAIDS Report on the global AIDS Epidemic			

			2010			
Adults 15-49 HIV Prevalence Rate	04	2009	UNAIDS Report on the global AIDS Epidemic 2010			
Children 0-14 living with HIV	360,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			
Deaths due to HIV/AIDS	220,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			
Estimated new HIV infections among adults	270,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			
Estimated new HIV infections among adults and children	340,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			
Estimated number of pregnant women in the last 12 months	6,081,000	2009	State of the World's Children 2011, UNICEF.			
Estimated number of pregnant women living with HIV needing ART for PMTCT	230,000	2010	Global HIV/AIDS response: epidemic update and health sector progress towards universal access:			

			progress report 2011			
Number of people living with HIV/AIDS	3,300,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			
Orphans 0-17 due to HIV/AIDS	2,500,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			
The estimated number of adults and children with advanced HIV infection (in need of ART)	1,400,000	2010	Global HIV/AIDS response: epidemic update and health sector progress towards universal access: progress report 2011			
Women 15+ living with HIV	1,700,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			

Partnership Framework (PF)/Strategy - Goals and Objectives

Number	Goal / Objective Description	Associated Indicator Numbers	Associated Indicator Labels
1	To facilitate the implementation of the goals, strategies and objectives of the National Strategic Framework for the Control of HIV/AIDS 2010-2015 (NSF2)		

	and the National Strategic Health Development Plan (NSHDP) of the Federal Ministry of Health.		
1.1	To assist the Federal Government of Nigeria in financing 50% of the cost for Universal Access by 2015	H3.1.N	H3.1.N Domestic and international AIDS spending by categories and financing sources
1.2	To strengthen the national logistics system to increase efficiency and reduce costs, enabling the GON to finance 50% of HIV commodities by 2015	NG.356	NG.356 Total expenditure on HIV commodities during the reporting period
1.3	To facilitate decentralization of service delivery in order to promote country ownership that will enable the Government of Nigeria to provide direct services in 50% of PEPFAR-Supported sites by 2015	NG.357	NG.357 Number of PEPFAR-supported sites graduated to GoN for continuing support

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

In what way does the USG participate in the CCM?
Voting Member

What has been the frequency of contact between the Global Fund Secretariat (Fund Portfolio Manager or other Geneva-based staff) and any USG team members in the past 12 months? If there has been no contact, indicate the reason.
4-6 times

What has been the frequency of contact between the Local Fund Agent (LFA) and any USG team members in the past 12 months? If there has been no contact, indicate the reason.
1-3 times

Has the USG or is the USG planning to provide support for Round 11 proposal development? Support could include staff time, a financial contribution, or technical assistance through

USG-funded project.
CCM is not planning to submit proposals

Are any existing HIV grants approaching the end of their Phase 1, Phase 2, or RCC agreement in the coming 12 months?
Yes

If Yes, please indicate which round and how the end of this grant may impact USG programming. Also describe any actions the USG, with country counterparts, is taking to enable continuation of any successful programming financed through these grants.
The GF Geneva directed the Nigeria CCM to consolidate the existing HIV and TB grants (Round 5 and 9) into the Single Stream Funding (SSF) mechanism. Phase I of the SSF for HIV and TB is funded through December 31, 2012. The planning and strategic design of Phase II is currently underway with an expected submission date of March 31, 2012. If Phase II is approved, activities will be funded through December 31, 2015. The process for preparing the Phase II application has been complicated by newly issued guidance from GF. After an extensive funding and expenditure analysis, the CCM is now required to revisit their budget plan to incorporate a 10 percent cut in funding as well as the newly mandated 20 percent host-country, counter-part funding requirements. The budgeting process has been further complicated by GF's Office of the Inspector General (OIG) recent mandate requiring the repayment of unaccounted and/or misappropriated funds of more than $10 million.

The planning and strategic design process for the Round 8 malaria grant is identical to that of the HIV and TB process and follows the same timeline. The Phase II application for the Round 8 malaria grant was submitted in November 2011. However, the application was considered to be incomplete and returned to the Nigeria CCM for revision. At the request of the Minister of Health, USG led the technical design team to overhaul the application for resubmission. During this process, senior USG technical staff worked off-site for one week with technical advisors from the CCM and the Government of Nigeria to redesign and improve the application. The revised application was submitted in December 2011.

In your country, what are the 2-3 primary challenges facing the Global Fund grant implementation and performance (for example, poor grant performance, procurement system issues, CCM governance/oversight issues, etc)? Are you planning to address those challenges through any activities listed in this COP?
Redacted

Did you receive funds for the Country Collaboration Initiative this year?
No

Is there currently any joint planning with the Global Fund?
Yes

If Yes, please describe how the joint planning takes place (formal/informal settings; the forums where it takes place (CCM?); timing of when it takes place (during proposal development, grant negotiation, COP development, etc.); and participants/stakeholders). Also describe if this joint planning works well and its effects (has it resulted in changes in PEPFAR programming, better anticipation of stock-outs and/or TA needs, better communication with PR, etc.)
Redacted

Has the USG stepped in to prevent either treatment or service disruptions in Global Fund financed programs in the last year either during or at the end of a grant? Such assistance can take the form of providing pharmaceuticals, ensuring staff salaries are paid, using USG partners to ensure continuity of treatment, , or any other activity to prevent treatment or service disruption.

Round	Principal Recipient	Assistance Provided	Value of Assistance (If Known)	Programming Impact	Causes of Need
9	NACA	drugs loan	12,000,000	Involved USG staff time	Disbursements delayed to the PR, due to in-country reasons; PR not able to procure on schedule
9	NACA	Warehouse space		Involved USG staff time	Disbursements delayed to the PR, due to in-country reasons; PR not able to procure on schedule

Public-Private Partnership(s)

Created	Partnership	Related Mechanism	Private-Sector	PEPFAR USD	Private-Sector USD	PPP Description

			Partner(s)	Planned Funds	Planned Funds	
2012 COP	New Pharmaceutical Warehouse PPP		TBD	Redacted	Redacted	The federal government in Nigeria currently lacks the ability to operate a reliable, secure, and adequately resourced central commodity warehouse. In addition, the GoN does not maintain sufficient warehouse space for all essential medicines (in particular ARV drugs); however, the GoN is willing to explore a public private partnership where they lease land to a private company that will construct and operate a central medical store Annex. The USG team in Nigeria will pursue an

						arrangement with the FMOH and RTT Trans Africa, a private pharmaceutical distributor. RTT Trans Africa is willing to construct and operate a warehouse for the public sector that will also store RTT Trans Africa's commercial supply of pharmaceuticals. Within the COP 2012 period, this public-private partnership will be developed in a multi-stakeholder workshop using the Cazneau Group as facilitators. The total estimated resource requirements are Redacted USD (with approximately Redacted from the GoN).

2012 COP	Central Medical Store Upgrades PPP		TBD	Redacted	Redacted	The federal government in Nigeria currently lacks the ability to operate a reliable, secure, and adequately resourced central commodity warehouse. A central warehouse exists in Lagos but it is in need of serious renovation and upgrading. A private partner called RTT Trans Africa has offered to partner with the GoN to upgrade a single bay within the central warehouse compound, and operate it as a “model bay” to show the GoN what could be gained through utilizing the private sector to operate its warehouse and

						distribution system. The USG team in Nigeria will support this public-private partnership after it is further developed in a multi-stakeholder workshop using the Cazneau Group as facilitators. The total estimated resource requirements are Redacted USD (with approximately Redacted from the GoN). USG resources are likely to go towards cold storage upgrades or distribution costs.
2012 COP	Zonal Reference Laboratories		Abbott Laboratories	2,100,000	2,100,000	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.
2012 COP	Workplace HIV Prevention		TBD	Redacted	Redacted	USAID will support the USG team in new public private partnerships to institute an integrated workplace prevent program that reinforces key prevention messages. These efforts will complement sexual transmission prevention efforts from USG Nigeria.

						PEFPAR in-kind contributions will be curriculum, printed materials, technical assistance and guidance. Private contributions will include distribution of materials, referrals to HIV/AIDS services, joint coordination with PEPFAR implementing partners on anti-stigma and discrimination training, abstinence, be faithful, and condom sensitization programs and HIV/AIDS counseling and testing.

Surveillance and Survey Activities

Surveillance or Survey	Name	Type of Activity	Target Population	Stage	Expected Due Date

N/A	Ante-natal Care Sentinel Survey	Sentinel Surveillance (e.g. ANC Surveys)	Pregnant Women	Planning	N/A
N/A	HIV Drug Resistance threshold survey	HIV Drug Resistance	General Population, Pregnant Women	Planning	N/A
N/A	HIV False Recent Rate (FRR) Survey	Recent HIV Infections	Other	Planning	N/A
N/A	HIV Incidence Study	Recent HIV Infections	Pregnant Women	Implementation	N/A
N/A	Integrated Biobehavioural survey	Behavioral Surveillance among MARPS	Female Commercial Sex Workers, Injecting Drug Users, Male Commercial Sex Workers, Men who have Sex with Men	Planning	N/A
N/A	Military Applicant Study	Population-based Behavioral Surveys	General Population, Uniformed Service Members	Planning	N/A
N/A	Monitoring of HIV drug resistance among patients on first line ART	HIV Drug Resistance	Other	Planning	N/A
N/A	National AIDs and Reproductive Health Survey +	Population-based Behavioral Surveys	Female Commercial Sex Workers, General Population, Migrant	Development	N/A

			Workers, Mobile Populations, Street Youth, Youth		
N/A	National Demographic Health Survey	Population-based Behavioral Surveys	General Population	Planning	N/A

Budget Summary Reports

Summary of Planned Funding by Agency and Funding Source

Agency	Funding Source				Total
	Central GHP-State	GAP	GHP-State	GHP-USAID	
DOD			14,942,795		**14,942,795**
HHS/CDC	14,330,999	3,056,000	198,744,125		**216,131,124**
HHS/HRSA			360,000		**360,000**
State			200,000		**200,000**
State/AF			300,000		**300,000**
USAID		0	246,680,362	0	**246,680,362**
Total	**14,330,999**	**3,056,000**	**461,227,282**	**0**	**478,614,281**

Summary of Planned Funding by Budget Code and Agency

Budget Code	Agency							Total
	State	DOD	HHS/CDC	HHS/HRSA	State/AF	USAID	AllOther	
CIRC			0					**0**
HBHC		1,473,118	20,735,045			14,929,312		**37,137,475**
HKID			6,600,119	360,000	300,000	31,746,959		**39,007,078**
HLAB		2,816,551	25,811,243			11,675,658		**40,303,452**
HMBL		35,492	6,330,406			466,969		**6,832,867**
HMIN		26,092	415,285			1,989,769		**2,431,146**
HTXD		693,850	8,227,434			60,229,987		**69,151,271**
HTXS		3,097,297	42,541,797			18,125,700		**63,764,794**
HVAB		388,886	2,762,574			5,175,842		**8,327,302**
HVCT		234,034	9,242,857			19,443,060		**28,919,951**
HVMS	200,000	2,395,716	17,542,955			6,563,712		**26,702,383**
HVOP		164,591	6,276,159			17,162,743		**23,603,493**
HVSI		1,409,366	9,485,547			7,935,026		**18,829,939**
HVTB		399,312	6,343,457			4,816,669		**11,559,438**

IDUP			0					**0**
MTCT		362,175	21,022,260			14,784,764		**36,169,199**
OHSS		1,131,873	23,990,822			26,317,200		**51,439,895**
PDCS		70,924	3,994,960			1,893,736		**5,959,620**
PDTX		243,518	4,808,204			3,423,256		**8,474,978**
	200,000	**14,942,795**	**216,131,124**	**360,000**	**300,000**	**246,680,362**	**0**	**478,614,281**

National Level Indicators

National Level Indicators and Targets

Redacted

Policy Tracking Table

Policy Area: Access to high-quality, low-cost medications						
Policy: Logistics and Supply Chain Management Policies						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Completed	Completed	Completed	On-going	TBD
Narrative					1. Assist the GoN strengthen the supply chain management and LMIS systems to ensure reliable forecasting and quantification. 2. Support Zonal warehousing to reduce transportation costs and ensure regular uninterrupted supply chain for medicines and other consumables. 3. Support	In view

					central supply management chain system that all stakeholders can subscribe to.	
Completion Date						
Narrative						

Policy Area: Access to high-quality, low-cost medications						
Policy: National Electronic Procurement and Logistical Management of HIV/AIDS and OI pharmaceuticals, laboratory infrastructure and medical equipment.						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	TBD	TBD	TBD	TBD	TBD	TBD
Narrative	Conduct baseline assesment	Engage relevant stakeholders in definition of problem	Provide TA for development of relevant task shifting guidelines and policy	Work with host country government to endorse the policy		
Completion Date						
Narrative						

Policy Area: Counseling and Testing						
Policy: Access of MARPS and other hard to reach populations to HCT support.						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion	Completed	Completed	Completed	Completed	Completed	TBD

Date						
Narrative					1. Promote provider initiated testing and counseling for all clients at the Outpatient Departments, STI clinics, TB programs, ANC, FP, hospital wards, and pediatric clinics. 2. Promote the implementation of the 2010-12 Ward Minimum Health Care Package strategy at all PHCs. 3. Promote private sector engagement with HCT services, e.g. involvement	No evaluation is planned

					of the NHIS to increase uptake.	
Completion Date						
Narrative						

Policy Area: Human Resources for Health (HRH)						
Policy: Task Shifting						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	On-going	On-going	Planned	TBD	On-going	TBD
Narrative	Policy dialogue still on-going	No policy guidance to implement task shifting	Provide TA for development of relevant task shifting guidelines and policy	Work with host country government to endorse the policy	1. Support development of a comprehensive task-shifting and task sharing strategy for health cadres laying out in specific detail who should provide what service iat waht levels	
Completion Date						
Narrative						

Policy Area: Human Resources for Health (HRH)

Policy: Task Shifting						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	On-going	On-going	Planned	TBD	On-going	TBD
Narrative	Policy dialogue still on-going	No policy guidance to implement task shifting	Provide TA for development of relevant task shifting guidelines and policy	Work with host country government to endorse the policy	1. Support development of a comprehensive task-shifting and task sharing strategy for health cadres laying out in specific detail who should provide what service iat waht levels	
Completion Date						
Narrative						

Policy Area: Human Resources for Health (HRH)						
Policy: HR Management, Training and Retention Policies						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	TBD	TBD	TBD	TBD	TBD	TBD
Narrative	Conduct baseline assesment	Engage relevant stakeholders in	Provide TA for development of relevant	Work with host country government to endorse	Support GON efforts to increase production,	

		definition of problem	task shifting guidelines and policy	the policy	retention and improve deployment of better trained health profesionals and community health workers. 2. Support both in-service and pre-service training. 3. Provide TA in HR manageme nt, logistics, costing and financial planning.	
Completion Date						
Narrative						

Policy Area: Human Resources for Health (HRH)						
Policy: Production and Retention of Health Profesionals						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	TBD	TBD	TBD	TBD	TBD	TBD
Narrative	Conduct baseline	Engage relevant	Provide TA for	Work with host country	1. Work with	

	assesment	stakeholders in definition of problem	development of relevant task shifting guidelines and policy	government to endorse the policy	profesional bodies and relevant government institutions to develop a model undergraduate medical curriculum. 2. Support implementation of the model curriculum in select universities. 3. Key studies in production and retention of healthcare workers. 3. Support creation of a range of trained non-professional types of health care workers.	
Completion Date						
Narrative						

Policy Area: Human Resources for Health (HRH)						
Policy: Task Shifting						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	TBD	TBD	TBD	TBD	TBD	TBD
Narrative	Conduct baseline assesment	Engage relevant stakeholders in definition of problem	Provide TA for developmen t of relevant task shifting guidelines and policy	Work with host country government to endorse the policy	1. Work with profesional bodies and relevant government institutions to develop an intergrated task-shifting service delivery algorithm for health cadres which will lay out in specific detail who should provide what service in different scenarios. 2. Support creation of a range of trained non-profess	

					ional types of health care workers.	
Completion Date						
Narrative						

Policy Area: Laboratory Accreditation						
Policy: Continuing Professional Development Policy						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Completed	Completed	Completed	On-going	On-going
Narrative	The need has been identied for a policy that would make the use of Continuing Medical Laboratory Education (CMLE) credits a requisite for the licensure of Medical Laboratory Scientists.	Consistent particpation in an approved Continuing Medical Laboratory Education is a requirement for Lab professionals for their facilities to get accredited. There is no policy requiring manadatory participation of Lab professional	The Medical Laboratory Science Council of Nigeria (MLSCN) (the arm of government that regulates the practice of medical laboratory science in Nigeria) has been supported to develop a policy that makes particpation in CMLE by	The MLSCN has reviewed and approved the Policy which is called Continuing Professional Development Policy	JHU.CCP/K4Health project is providing on-going support to the MLSCN as well as the Association of Medical Laboratory Scientists of Nigeria to ensure the full implementation of this policy	Part of the M&E plan for the project is to monitor the implementation of the policy in an on-going manner, and report on specific indicators on a yearly basis. The outcome/impact of the policy and the overall project is planned for September 2014

		s in an approved CMLE program, as a result licensure of lab professionals is not based on evidence of completeion of CMLE program.	Lab professionals manadatory and the use of CMLE credit as prerequisite for licensure.			
Completion Date						
Narrative						

Policy Area: Laboratory Accreditation						
Policy: Continuing Professional Development Policy						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Completed	Completed	Completed	On-going	On-going
Narrative	The need has been identied for a policy that would make the use of Continuing Medical Laboratory Education (CMLE) credits a requisite for	Consistent particpation in an approved Continuing Medical Laboratory Education is a requirement for Lab professionals for their	The Medical Laboratory Science Council of Nigeria (MLSCN) (the arm of government that regulates the practice of medical	The MLSCN has reviewed and approved the Policy which is called Continuing Professional Development Policy	JHU.CCP/K4Health project is providing on-going support to the MLSCN as well as the Association of Medical Laboratory Scientists of	Part of the M&E plan for the project is to monitor the implementation of the policy in an on-going manner, and report on specific indicators

	the licensure of Medical Laboratory Scientists.	facilities to get accredited. There is no policy requiring manadatory participation of Lab professionals in an approved CMLE program, as a result licensure of lab professionals is not based on evidence of completeion of CMLE program.	laboratory science in Nigeria) has been supported to develop a policy that makes particpation in CMLE by Lab professionals manadatory and the use of CMLE credit as prerequisite for licensure.		Nigeria to ensure the full implementation of this policy	on a yearly basis. The outcome/impact of the policy and the overall project is planned for September 2014
Completion Date						
Narrative						

Policy Area: Orphans and Other Vulnerable Children						
Policy: Protection for Widows and OVC (including inheritance rights, protection against violence, access to education, shelter, food and social support.						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Completed	Completed	TBD	TBD	TBD
Narrative				Policies are pending	1. Strengthen	

				National Executive Council's endorsement	OVC coordination structures at all levels. 2. Put in place a national guideline on care and support of widows and OVC. 3. Support the development of an operational definition of minimum package of care for community and home based care 4. Support the development of a stigma index tool to collect data on Stigma. 5. Strenthen CSO involvement for advocasy functions.	
Completion Date						

Narrative						

Policy Area: Orphans and Other Vulnerable Children						
Policy: Protection for Widows and OVC (including inheritance rights, protection against violence, access to education, shelter, food and social support.						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Completed	Completed	TBD	TBD	TBD
Narrative				Policies are pending National Executive Council's endorsement	1. Strengthen OVC coordination structures at all levels. 2. Put in place a national guideline on care and support of widows and OVC. 3. Support the development of an operational definition of minimum package of care for community and home based care 4. Support the	

					development of a stigma index tool to collect data on Stigma. 5. Strenthen CSO involvement for advocasy functions.	
Completion Date						
Narrative						

Policy Area: Orphans and Other Vulnerable Children						
Policy: Protection for Widows and OVC (including inheritance rights, protection against violence, access to education, shelter, food and social support.						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Completed	Completed	TBD	TBD	TBD
Narrative					1. Strengthen OVC coordination structures at all levels. 2. Put in place a national guideline on care and support of widows and OVC. 3. Support the	

					development of an operational definition of minimum package of care for community and home based care 4. Support the development of a stigma index tool to collect data on Stigma. 5. Strenthen CSO involvement for advocasy and watchdog functions.	
Completion Date						
Narrative						

Policy Area: Stigma and Discrimination						
Policy: Anti-Stigma and Anti Gender Discrimination Policies, Laws and Practices.						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Completed	Completed	On-going	On-going	TBD
Narrative				Work in progress.	1. Support technical	

				The harmonized anti stigma bill before the National Assembly is yet to be passed. 1. Increase advocacy for the passage of anti stigma bill at the national and state levels 2. Wide disseminati on of the bill to all stakeholder s when the law is passed.	capacity building for organization s and institutions that address the violation of the human rights of vulnerable populations especially of PLHIV. 2. Support integration of monitoring of adherence to ethical standards into existing M&E systems at all levels. 3. Provide TA to government and other stakeholder s for greater involvement of PLHIV, civil society and the private	

					sector in decision making .	
Completion Date						
Narrative						

Policy Area: Stigma and Discrimination						
Policy: Anti-Stigma and Anti Gender Discrimination Policies, Laws and Practices.						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Completed	Completed	On-going	On-going	TBD
Narrative				Work in progress. The harmonized anti stigma bill before the National Assembly is yet to be passed. 1. Increase advocacy for the passage of anti stigma bill at the national and state levels 2. Wide disseminati on of the bill to all stakeholder s when the	1. Support technical capacity building for organization s and institutions that address the violation of the human rights of vulnerable populations especially of PLHIV. 2. Support integration of monitoring of adherence to ethical standards	

				law is passed.	into existing M&E systems at all levels. 3. Provide TA to government and other stakeholders for greater involvement of PLHIV, civil society and the private sector in decision making .	
Completion Date						
Narrative						

Policy Area: Stigma and Discrimination						
Policy: Anti-Stigma Policies and Laws and Anti Gender Discrimination Policies, Laws and Practices.						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Completed	Completed	On-going	On-going	TBD
Narrative				Work in progress. The harmonized anti stigma bill before the National Assembly is	1. Support technical capacity building for organizations and institutions that	

				yet to be passed. 1. Increase advocacy for the passage of anti stigma bill at the national and state levels 2. Wide disseminati on of the bill to all stakeholder s when the law is passed.	address the violation of the human rights of vulnerable populations especially of PLHIV. 2. Support integration of monitoring of adherence to ethical standards into existing M&E systems at all levels.	
Completion Date						
Narrative						

Policy Area: Stigma and Discrimination						
Policy: Involvment of PLWHA in Prevention Activities						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Completed	Completed	On-going	On-going	N/A
Narrative				Work in progress. Host country government is yet to endorse the	1. Support capacity building for organization s involved in HIV prevention.	Not Planned

				policy	2.Provide TA for adpatation, diseminatio n and implementat ion of national policies for HIV prevention, service intergration and behaviour change communicat ion. 3. Provide TA to government and other stakeholder s for greater involvement of PLHIV, civil society and the private sector in decision making .	
Completion Date						
Narrative						

Policy Area: Strengthening a multi-sectoral response and linkages with other health and

development programs						
Policy: Linkage of HIV Programs to Other Health Programs						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	TBD	TBD	TBD	TBD	TBD	TBD
Narrative	Conduct baseline assesment	Engage relevant stakeholders in definition of problem	Provide TA for development of policy	Work with host country government to endorse the policy	1.Strengthen linkages between referral service points through appropriate networking to reduce movement of clients between sites and bureaucracy involved with such linkages. 2. Promote the implementation of the Ward Minimum Health Care Package strategy at all PHCs to integrate STI , SRH, ART, TB,HCT	No evaluation is planned

					and PMTCT services	
Completion Date						
Narrative						

Technical Areas

Technical Area Summary

Technical Area: Care

Budget Code	Budget Code Planned Amount	On Hold Amount
HBHC	37,137,475	0
HKID	39,007,078	0
HVTB	11,559,438	0
PDCS	5,959,620	0
Total Technical Area Planned Funding:	**93,663,611**	**0**

Summary:
BACKGROUND: U.S. Government (USG)-supported care efforts in COP 12 will focus on decreasing morbidity and mortalities among persons living with HIV (PLHIVs) and orphans and vulnerable children (OVC) by improving access to and delivery of quality care and support services in accordance with commitments made in the government of Nigeria (GON) -USG Partnership Framework Implementation Plan (PFIP) 2010 – 2015. USG care activities will continue to provide non-anti-retroviral therapy (ART) clinical, psychological, social, spiritual, and preventative services to HIV-infected and affected persons. Services will continue to be made available in facility, community, and home-based care settings. Significant emphasis will continue to be placed on promoting patient retention by providing quality, accessible services provided in culturally appropriate environments. Technical areas of focus include early identification of HIV-infected persons, psychological and spiritual support, nutrition, co-morbidities with other diseases, and palliative care. In COP 12, $ 92,242,086 (including 2,329,750 to SCMS for procurement of commodities) is allocated for the delivery of care services through 15 implementing partners (IPs).

Objectives of USG-supported care efforts in COP 12 include: (1) increased access and improved coverage of care services through improved efficiencies in service and decentralization of services to the primary health care level; (2) improved quality and integration of care services through the development of a cost-effective package of integrated HIV services consistent with national guidelines and standards of care; (3) improved stewardship by Nigerian institutions for the provision of care and support services through organizational and technical capacity building of state and local governments (LGAs); (4) leveraging of local resources and those of other donors to provide a plan for developing long-term sustainability that includes on-going handover of elements to GON; (5) development of implementation strategies sensitive to cultural and gender norms that may constrain uptake of HIV services and facilitate gender equity in access to HIV services; (6) development of service networks with effective linkages and referrals between facility, community, and home-based care; (7) promotion of task shifting and task sharing towards a higher quality, multipurpose, multi-skilled heath worker; (8) and development of a more strategic method for costing of care services for use in planning.

In addition to supporting expanded access and increased quality of care and support services, USG efforts in COP 12 will continue to center on long-term sustainability. USG will accomplish this through

targeted capacity building and direct engagement of state and local governments to leverage locally available resources to achieve synergy and improving overall efficiency. The USG has entered the early planning stages of rationalizing comprehensive treatment efforts geographically with a "Lead IP" identified for each state. This effort will have a significant impact on the delivery of adult and pediatric care and support services. The intended vision of USG rationalization efforts is to stop overlap of activities, improve standards of care and treatment for HIV-positive individuals, enhance coordination, advocacy, and capacity building efforts as well as increase coverage through targeted saturation of LGAs. Rationalization is a critical component of the PFIP. It offers a unique opportunity to improve the accountability of USG-supported IPs and ultimately create a more manageable program for the GON. Further, the process will allow IPs to more easily attain commitments from GON at the state and local levels. Beyond improved coordination and rationalization of USG care and treatment efforts, the USG will continue to improve upon its coordination with other donors, most notably the Global Fund (GF), to complement efforts and avoid duplication. Joint planning and site visits between the USG and GF have occurred in previous years; however, more targeted efforts will occur during COP 12. The USG currently serves as the Development Partners Group for HIV representative to the Country Coordinating Mechanism and occupies the Chair of the Oversight Committee. PFIP Plus-Up funds are being used for the implementation of USG decentralization efforts. The implementation will be accomplished through joint planning and analysis in close collaboration with the National Primary Health Care Development Agency (NPHCDA) and the GF Round Eight Health System Strengthening to identify appropriate sites and limit overlap and duplication in efforts. USG-supported OVC efforts are implemented through a strong working relationship with the United Nations Children Fund (UNICEF) and the Ministry of Women's Affairs and Social Development (MWASD). Further, a strong working relationship for tuberculosis (TB) also exists between the USG, the World Health Organization (WHO), and the National TB and Leprosy Control Program (NTBLCP). The USG also actively participates in monthly and quarterly site monitoring visits, planning meetings, and strategy development activities for both OVC and TB.

ADULT CARE AND SUPPORT: A significant gap exists between the estimated number of PLHIV and the number currently receiving care. Less than 20 percent of an estimated 2.9 million PLHIV are enrolled into care. As of September 2011, the USG provided clinical care services to 649,500 PLHIV (587,356 HIV-positive adults and 62,144 HIV-positive children between 0-15 years of age) across the thirty-six states and the Federal Capital Territory (FCT). In COP 12 and COP 13, the USG plans to expand clinical care and support services to 889,470 and 1,231,453 PLHIVs, respectively. As outlined in the Treatment Technical Area Narrative (TAN), the USG will improve access to adult care and support services in COP 12 through an expanded effort in high burden states and states with high unmet need for HIV care. In accordance to commitments outlined in the PFIP, the USG will support the GON in the ongoing process of decentralization of care and support services to primary health care (PHC) levels using the "hub and spoke" model. USG decentralization of clinical services will occur through an assessment of the infrastructure, training, and staffing needs in the already identified PHCs. Based on this assessment and in collaboration with the NPHCDA, physical space will be reorganized or renovated, additional personnel will be deployed, and existing staff will be trained to provide integrated HIV/AIDS care and support services.

The USG will continue the "HIVQUAL Model" to guide health care facilities in developing a quality management infrastructure that supports ongoing processes to improve the quality of HIV care and support services. A minimum care package of services will be provided to each PLHIV. The package includes clinical care and two supportive services delivered at health facilities in accordance with the National Palliative Care Guidelines plus a basic care kit. Basic care kits contain long-lasting insecticide treated nets (LLITNs), water guard, a water vessel, soap, gloves, information, education and communication materials on HIV prevention, water, sanitation and hygiene, and condoms. HIV prevention services include provision of positive health dignity and prevention (PHDP) services including HIV testing and counseling (HTC) services for family members and sex partners, prevention messages focused on disclosure, partner testing, correct and consistent condom use, mutual fidelity, counseling on high risk

sexual behaviors, integration of sexually transmitted infections (STI,) and reproductive health. Further, USG will enhance networking and referral mechanisms and programming for pre-ART clients. Such efforts will improve retention in care through three months of clinical follow up and tracking of clients who miss their appointments via telephones and home visits. An integral component of the USG adult care and support efforts will involve service integration, using existing platforms and leveraging available resources particularly with TB, maternal child health, (MCH,) reproductive health (RH), and family planning (FP). Such efforts will provide for prevention of mother-to-child-transmission (PMTCT), unintended pregnancies, and opportunistic infections. Additionally, integration efforts seek to strengthen linkages between adult and pediatric care and support, as well as OVC, nutritional services, and PLHIV support groups.

USG-supported adult care and support activities occur at both the facility and community level. At the facility level, USG efforts include the administering of cotrimoxazole prophylaxis, nutritional assessment (anthropometric measurement, BMI, and so forth), nursing care, management of opportunistic infections (OI) and STIs, screening for TB, cervical cancer screening, and malaria prevention. Additionally, clinical care includes nursing care, prevention and treatment of opportunistic infections, assessment and management of pain and other symptoms, nutritional assessment and support, ART, community/home based care (CHBC), access to commodities such as pharmaceuticals, LLITN, 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. All HIV-infected persons remain eligible to receive community-based services. However, services differ depending on the stage of HIV infection. Asymptomatic HIV infected persons receive community psychosocial and mental services, on-going counseling for coping with status and living positively, disclosure support, testing and screening of partners and children, support from peer PLHIV support groups, PHDP, nutritional services, water and hygiene sanitation, malaria prevention, and referrals for legal, income-generating activities (IGAs), and other services. During the symptomatic phase of HIV infection, PLHIVs receive all the services as non-symptomatic. They also receive basic nursing care at home, medication adherence, and pain management. Services provided at the community level during the end-of life phase extending into bereavement include nursing care, pain management, counseling, and community mental health services for PLHIV and family members as well as bereavement and grief counseling and preparation of children for placement, spiritual support, social support including support for burials, legal support, and linkages to OVC services. At this level, the USG continues to emphasize adherence to ART through education to address adherence barriers, utilizing volunteers, peers and buddy systems, and pill containers (as reminders for drug adherence). Terminal care, TB screening, water, hygiene, and sanitation education are also administered at this level.

Prevention interventions for PLHIV remain a critical component of USG adult care and support efforts. As outlined in the Prevention TAN, the USG will support IPs to provide a standardized and evidence-based positive prevention package tailored to each setting at both the facility and community level. Components of the package will include: (1) counseling PLHIV at every contact with the health system on reducing transmission risk; (2) encouraging disclosure of HIV status to all spouses/sex partners and promoting testing of spouses/partners; (3) provision of ongoing counseling for discordant couples on prevention practices to help negative partners stay negative; (4) ensuring adequate condom supply and distribution in clinics and other settings as well as demonstration of correct use; (5) assessment/screening for alcohol/substance use and counseling to reduce alcohol/substance use that contributes to high risk behaviors; (6) periodic assessment/screening of HIV patients for STIs as well as treatment to avoid co-infection; (7) linking family planning options to HIV-positive women who want to avoid pregnancy and referral to PMTCT services for those desiring pregnancy; (8) patient education on the continuing risks of HIV transmission (even during ART) as well as ongoing adherence counseling and support to retain PLHIV in care; (9) establishment of PLHIV support groups for ongoing reinforcement of positive prevention; (10) and possible task-shifting to lay counselors for more in-depth counseling needs.

PEDIATRIC CARE AND SUPPORT: COP 12 pediatric care and support efforts will maximize the findings and recommendations of the July 2011 assessment of USG-supported pediatric efforts. As was noted in the Pediatric Treatment section of the Treatment TAN, eight technical areas have been identified as priority areas for scale-up of pediatric services. These eight areas can be divided into two over-arching categories: those pertaining to continuity of care and those pertaining to strengthening the health system for improved pediatric services. Within the continuity of care category, USG efforts will focus on follow-up of mother-infant pairs, pediatric HIV testing and counseling, management of HIV-infected children, pediatric TB/HIV and retention, loss to follow-up and linages with other services. Within the health system strengthening category, USG efforts will focus on laboratory (early infant diagnosis and CD4 testing), monitoring and evaluation (site-level data and documentation), and procurement (transition away from donor procurement of ARVs to the state-ministry procurement).

For mother-infant pairs, the USG in COP 12 will design and implement a minimum package of services/support/data collection tools at PHCs to ensure quality service provision and measure mother/infant outcomes at 18-24 months. USG sites will be encouraged to fully use standardized, national HIV-exposed infant registrars (early infant diagnosis -- EID -- registrars) to facilitate monitoring and evaluation. At the national-level, increased representation of MCH staff at national pediatric task teams will ensure that guidelines, trainings, and implementation of PMTCT will be linked to broader MCH goals. For pediatric HIV testing and counseling, USG will continue the testing of all family members when one is HIV-positive, routine, op-out testing on in-patient pediatric wards, routinely testing pediatric TB patients for HIV and making HIV testing available at the TB site. The USG will also continue to use community outreach and support groups to promote testing and counseling. Further, the USG will strengthen procurement and supply chain systems for test kits (see the supply chain section for additional details), support development of guidelines and training materials for pediatric HIV testing and counseling, and improve efforts to collect data on HIV testing of children at national, IP, and site levels.

In COP 12, USG will seek to improve pediatric retention rates, decrease loss to follow-up, and provide linkages to other services through increased use of support groups for women and children; improved linkages between PMTCT and pediatric treatment; and improved data collection and analysis. The USG will work with IPs to define a minimum group of feasible strategies for implementation at PHCs as PMTCT and treatment services are decentralized. Support groups are low-cost interventions that will be scaled-up in COP 12 for HIV-infected women, children, and adolescents. Further, efforts will be made to strengthen linkages between adolescents and age-appropriate preventions with positives activities and support groups. Additionally, the USG will work with IPs at the site level to improve existing data collection and referrals tools and routinely review and share the data from EID registrars, medical records, and national ART registers.

The USG will continue to support national efforts to scale up EID services. Early identification of HIV-infected children will be done through the provider initiated testing and counseling (PITC) approach. Every HIV-exposed infant, HIV-infected child, and adolescent will have access to co-trimoxazole prophylaxis. Further, the USG supports the provision of basic child health interventions such as nutritional assessment, growth monitoring, immunizations, identification of TB, safe water and hygiene, food and nutrition, supplementary feeding support for clinically malnourished patients, pain management, provision of psychosocial services, and linkages to spiritual support and other child survival services. The GON is planning a fourth round of EID scale-up. USG pediatric care will support GON scale up of a number of clinical sites collecting dried blood spot samples for EID, building capacity of health care workers, and strengthening linkages of sites to the appropriate laboratories in the National EID network.

The facility-based pediatric care and support program will be linked to community-based care and support, OVC, youth friendly centers, and other wrap around services within the community or LGA to ensure a continuum of care. Every HIV infected and affected child identified at the clinic will be linked to

an OVC program so that the child benefits from provided services. As children becomes adolescents, they will be linked to youth friendly centers and programs developed to serve as peer educators to improve access to HIV services. The capacity of health care workers (HCWs) and community members will be improved through a various means to include training; on-site hands-on mentoring and support supervision on providing quality pediatric care in the area of facility and community based adherence support, disclosure, pain management; and the provision of job aides and standard operating procedures. The HCWs and community volunteers will be supported during routine supportive supervisory visits, lessons learned, and sound practices that can be shared to improve the quality of pediatric care being provided. Strengthened youth-friendly and adolescent centers/clubs can provide a safe space for HIV-positive adolescents to share experiences regarding their illness, receive peer counseling to re-enforce adherence, promote PHDP, and transition to adult services. These services will be established in partnerships with schools and communities to ensure sustainability.

Efforts will be made in COP 12 to strengthen GON (and other stakeholder) monitoring and evaluation capacities through joint monitoring and supervisory visits to USG and non-USG supported pediatric care settings. Additionally, the USG will support training opportunities for key pediatric program officers at the state and local levels. USG will support the Ministry of Health (MOH) to streamline and standardize pediatric HIV treatment and care indicators to be line with both PEPFAR indicators and global reporting requirements. This will improve pediatric ART and care data collation, reporting, and utilization. Also, the USG will support the GON to streamline and standardize indicators to strengthen the monitoring and tracking of the quality of pediatric care and treatment.

TB-HIV: The USG has pioneered, strengthened, and scaled-up TB-HIV collaboration and services. As of September 30, 2011, a total of 20,521 TB-HIV positive patients were identified and put on treatment. The FY 2012 target is to place 35,579 PLHIV on TB treatment. The proportion of TB patients tested for HIV has increased from 62.5 percent in 2009 to 79 percent in 2010. This will be increased to 85 percent by the end of FY 12. The USG TB-HIV program is implemented in over 762 sites in government and private health facilities nationwide with more than 23 States having functional TB-HIV working group as a result of rapid expansion of TB-HIV services. In the last two years, the USG has supported the National Tuberculosis and Leprosy Control Program (NTBLCP) to develop technical guidelines; policy documents; training manuals; information, education, and communication (IEC) materials; and quality assurance tools to support TB-HIV collaborative activities. In COP 12, the USG will continue to support the GON increased TB case finding through the scale-up TB-HIV services coverage to high TB and HIV burden states; strengthening clinic screening using the WHO and GON TB screening checklist; improving laboratory diagnosis using the fluorescent microscope and support of pilot of a Gene Xpert machine in country; supporting infrastructural upgrades of directly observed treatment short (DOTS) clinics and laboratories to ensure TB infection control; and support of co-location of DOTS clinics at the HIV comprehensive care and treatment centers to strengthen referral linkages between HIV and TB service points.

In addition, the USG will strengthen laboratories through the integration of fluorescent microscopy and other enhanced TB diagnostics (TB culture, drug susceptibility testing, and TB molecular assays) and by ensuring functional TB-HIV laboratories meet national and international accreditation standards. The co-location of DOTS in the same facility with an ART clinic will facilitate early ART initiation in HIV-positive TB patients. DOTS providers' capacity will be built on basic HIV WHO staging. Criteria for ART initiation and monitoring will be encouraged to harmonize TB and ART clinic appointments for easy patient assessment and referral for appropriate services. All comprehensive ART centers will be encouraged to have functional TB-DOTs units. ART will be initiated in TB patients according to GON national guidelines. The USG will support the national multi-drug resistant tuberculosis (MDR-TB) surveillance and treatment through establishment of MDR-TB wards, TB culture, TB-Polymerase Chain Reaction diagnostic laboratories that will improve TB diagnosis, and TB drug logistics of the NTBLCP. Although government-driven, the TB program remains dependent on donor funds. The implementation of TB-HIV

collaborative activities is weak, particularly at the sub-national level. Most HIV control programs at the state-level lack structure and capacity to ensure adequate collation of the data on intensified case finding (ICF) and facility level reports. TB screening at point of entry is not adequate. Other challenges faced by the TB program are low uptake of isoniazid preventive therapy and cotrimoxazole prophylaxis. Some of the challenges faced by USG are the lack of Rifabutin needed for the management of TB among HIV-positive TB co-infected clients on second line ARVs and frequent stock outs of HTC test kits. The revised national TB-HIV indicators will be added as custom indicators for USG reporting. The USG will advocate to the National AIDS/STI Control Program (NASCAP) and the NTBLCP for the inclusion of TB indicators in the HIV program pre-ART and ART registers and the care card so that TB screening for HIV at every visit and isoniazid (INH) prophylaxis can be easily captured by the program.

FOOD AND NUTRITION: Nutrition and food security support is a critical component of the USG comprehensive HIV/AIDS care and support program. The aim is to improve clinical outcomes for PLHIVs and mitigate the impact of the disease on HIV affected families, particularly OVC. The USG continues to support GON and its partners' efforts. Modest achievements have been recorded in the USG nutrition and food security program. Recognizing the critical role nutrition plays in HIV care and support services, the USG in FY 10 and 11 adopted the following strategies to help mitigate the impact of the disease on HIV-affected families and OVC: (1) nutrition care (assessment, counseling, food demonstrations, and provision of therapeutic and supplementary feeding support for undernourished children and adult PLHIVs); (2) infant feeding counseling in PMTCT settings; (3) support for livelihood and food security (linking PLHIVs with government agricultural projects that allows access to agricultural loans for their empowerment); (4) initiating and supporting meetings of PLHIVs (members come together and form cell groups that register and gain access to loans through the Village Savings and Loans Association, microfinance institutions, or government agencies); (5) linking PLHIVs and caregivers of OVCs with local partners that focus on skills acquisition training/income generating activities for household economic strengthening; (6) and initiating community efforts by PLHIVs to leverage community resources including the establishment of community food banks in support of PLHIVs and OVCs.

These strategies have been enhanced through the linkages of the food and nutrition programs to USG-supported and other international and development partners' ongoing programs. For instance, the Clinton Foundation's Food and Nutrition program has provided Ready-to-Use Therapeutic Food (Plumpy Nut) to USG-supported pediatrics care and OVC partners. This contributed to the health of severe to moderately malnourished children within the project sites. Through its Infant and Young Children Nutrition (IYCN), program, PATH, conducted and disseminated results of a Nutritional Impact Assessment under its Feed the Future Initiative. This was done to ensure that the food and nutrition programs are not harmful to households of vulnerable children. Utilizing results from IYCN's nutritional assessments and other studies, the USG in COP12 and 13 will continue to support and strengthen clinical and community partnerships in priority areas. The strategies will include nutritional care (assessment, counseling, and provision of therapeutic and supplementary feeding); provision of micro-nutrient supplements; infant feeding and PMTCT; scaling-up of community food bank programs; strengthening referrals to income-generating activities and linkages to water, sanitation, and hygiene (WASH) programs; and collaborate with other donor partners to leverage nutritional support for PLHIV and OVCs. The USG will continue to work with the GON and IPs to strengthen partnerships/collaboration and linkages, as well as community structures and leadership for sustainable nutrition and food security support and interventions. In particular, the USG will collaborate with USAID programs in Economic Growth and Environment (EGE) to ensure that most vulnerable families benefit from such programs to guarantee food security and achieve economic viability, especially through MARKETS II and SHARE programs.

ORPHANS AND VULNERABLE CHILDREN (OVC): Nigeria has an estimated 17.5 million orphans and vulnerable children (OVC), including 7.3 million from all causes and 2.23 million from the death of their caregiver due to HIV/AIDS (NG-SAA 2008). Data from the recently released UNAIDS (2008) report estimates that the number of children (ages 0-14) living with HIV/AIDS is 2,200,000. Vulnerability as a

result of poverty and other causes, including a general disregard of the rights of children, continue to impact the magnitude of the OVC situation. Consequently, support to OVC remains a critical component of the USG comprehensive HIV/AIDS care and support program which aims to mitigate the impact of HIV/AIDS on affected children and families. As a result, the USG supports the GON improved coordination of OVC response and IPs' provision of care and support services to OVC. Strategies hinge on direct service delivery to affected and infected children. In COP10 and11, OVC programs began to favor family and community-centered approaches to ensure households can directly care for the vulnerable children.

In line with the system-strengthening approach of PEPFAR II, in COP12 and 13 social workforce strengthening will be one of the major thrusts of OVC programming. Activities will include: (1) social workforce educational assessment; (2) capacity building of senior and middle-level managers at the federal and state levels to effectively lead and manage OVC programs; (3) provision of tools and continuing education; (4) and pre-and in-service training for social workers. The National Monitoring Information System (NOMIS) will be rolled out at LGA, state, and federal levels to strengthen coordination and evidence-based programming. Furthermore, there will be continuous advocacy for increased budgetary allocation for OVC programs at all levels. A new National Plan of Action 2011-2016 will also be finalized that will guide OVC programming.

The USG will continue to scale-up household economic strengthening (HES) approaches to empower families to respond to the needs of vulnerable children. Through linkages and partnership with other programs, including the USG MARKETS and SHARE, HES activities, such as agro-based enterprises, entrepreneur skills building activities, and Village Savings and Loans, will be included. This will ensure the family is both economically empowered and food is secured year-round. Other strategies to be deployed include: promotion of community-initiated responses; child protection; early childhood development; HIV/STIs prevention for OVC; and exit strategies for OVC that turn eighteen years old. USG-supported OVC activities will seek to mainstream gender sensitive approaches into the delivery of OVC services. The delivery of OVC services addresses five cross-cutting gender strategic areas: (1) increasing gender equity in OVC activities and services; (2) reducing violence and coercion; (3) addressing male norms and behaviors; (4) increasing women's and vulnerable children's legal protection; (5) and increasing women's and vulnerable girl's access to income and productive resources. Age-appropriate activities will be carried out that drawing from evidence-based programming and lessons learned. For instance, children under five (5) years of age will be especially targeted for specific services including birth registration, completion of immunization schedule, and growth monitoring. Adolescent OVC will be specifically targeted for sexual and reproductive health education, life skills, and other coping mechanisms for the challenges of growing up.

The much-anticipated OVC procurement "Addressing the Gaps: Scale-Up of Care and Support Services for Orphans and Vulnerable Children (OVC) in Selected States," (listed as "OVC UGM) has entered the final stages of the procurement process and is expected to be awarded in April 2012. This award will seek to improve the accessibility and quality of OVC services through strengthening government and civil society systems and structures to improve the wellbeing of OVC and their families. This activity will prioritize interventions appropriate to the Nigerian context over costly and highly technical strategies to ensure continuity of care well beyond the life of a project. The activity will seek to (1) build local ownership of OVC programs through community mobilization; (2) support key policy interventions intended to increase OVC access care and treatment; (3) integration of OVC beneficiaries into maternal, newborn, and child health services; (4) and the development of public-private-partnerships. These activities will complement the roll-out of an initiative to directly engage local partners to implement prevention and OVC activities. This procurement is a limited competition initiative to further increase direct USG investments in local organizations.

The USG will continue its collaboration with the GON, private enterprises, committed entities, and other

Development Partners, such as GF, UNICEF and the United Kingdom (UK) Department for International Development (DFID) to strengthen service delivery and ensure sustainable OVC programming. GF and USAID/other partners have differing opinions on the standard practice of OVC programming, given the USG's new approach favoring sustainability over emergency service provision. Therefore, the GF OVC program will be particularly targeted for technical assistance (joint collaboration and participation) to ensure uniform and effective programming for vulnerable children.

CROSS-CUTTING (PUBLIC-PRIVATE-PARTNERSHIP): The USG will continue to support the facilitation of private partnerships with organizations to increase access to care services. To provide vitamins and micronutrients, many food processing industries are fortifying sugar, oil, and flour with micronutrients like Vitamin A and iodine. This supports growing children and prevents micronutrient deficiencies. The USG will continue to partner with the private for and non-profit sectors to strengthen HIV and TB diagnosis and treatment. Faith-based, private-sector non-profits provide about 30 percent of TB treatment. The National Public Private Mix strategy for TB control has four schemes for engaging the private for-profit sector to be front-line providers for TB diagnosis and treatment. The USG through its IPs will continue to strengthen partnership efforts in the area of food support for children and OVCs through existing private organizations, such as Dangote, that develop partnership arrangements with some children hospitals across the country.

CROSS-CUTTING (GENDER): Gender integration into care and support services is an important focus area of the Global Health Initiative (GHI). The USG will focus on increasing gender equity in accessing care and support services, addressing male norms and behaviors to seek services for themselves and their partners, and increasing women and vulnerable girls' access to income and productive resources. These will be achieved by advocacy to men in their role as family heads and the need for their participation in HIV care and support services. Further, empowerment of women and access of women and girls to economic resources and opportunities will be accomplished through skills acquisition and income generating activities (IGAs). The USG will increase gender equity in programming through counseling and educational messages targeting vulnerable women and girls. Furthermore, 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 via gender-sensitive programming and improved quality services.

CROSS-CUTTING (MOST AT RISK POPULATIONS - MARPS): The 2008 Integrated Bio-Behavioral Sentinel Survey (IBBSS) shows an HIV prevalence of 13.5 percent among men who have sex with men (MSM), 37.4 percent among brothel-based sex workers, and 30.2 percent among non-brothel sex workers. The USG will continue to support activities to reduce HIV among MARPs. Men who have sex with men, sex workers, and injection drug users will be targeted with prevention messages, including HIV counseling and testing. The USG has specialized care services for MARPS especially MSM with programs that address their needs. STI clinics will be strengthened to address the health needs of MSM in COP 12. Collaborating with other partners, the USG will advocate for policies to ensure MSM have access to HIV services.

CROSS-CUTTING (HUMAN RESOURCES FOR HEALTH): In-service training, mentoring, and capacity building are the predominant ways of supporting workforce development. In accordance with principles of task shifting, the National Primary Health Care system has a cadre of community health officers and community health extension workers who are the first point of contact for diagnosis of Malaria, TB, and common infectious diseases. In COP 12, USG will continue the decentralization of HIV care and support and ARV refills to PHC facilities. Integral to this is the establishment and revision of guidelines and continuous professional development through in-service training.

CROSS-CUTTING (LABORATORY): The USG will continue to provide adequate and appropriate support for those patients in the care and support program through provision of diagnostic and monitoring tests.

To achieve this, proficiency testing will be incorporated. Tiered laboratory network and referrals will be strengthened through capacity development in the area of quality management systems (QMS) with a focus on regular site monitoring and laboratory audits. Enhanced TB diagnostic (fluorescent microscopy, culture and Drug Sensitivity Testing (DST), Hain assay, and GeneXpert) will be provided and supported. The GeneXpert is being evaluated and validated in nine (9) pilot sites. The outcome will inform decision on further roll out. Additionally, routine malaria diagnostic services (microscopy research and technique) to all HIV patients in care and support will be provided. USG will support the upgrade of TB laboratories to meet acceptable standards for infection prevention and control. USG will collaborate with NTBLCP to integrate fluorescent microscopy and other enhanced TB diagnostics in the national TB strategy. Also, the USG will collaborate with the national Continuum of Care and Treatment (COCT) Technical Working Group in formulating appropriate diagnostic monitoring tests for HIV and other related infections which is inclusive of other OIs and STIs.

CROSS-CUTTING (STRATEGIC INFORMATION): The USG has a strong history of collaboration with the GON and other stakeholders to improve monitoring and evaluation efforts for adult and pediatric ART. The USG has supported the harmonization of monitoring and evaluation indicators and tools, the development of the five-year Nigerian National Response Information Management System (NNRIMS) and Operational Plan, the Annual Joint National Data Quality Assessments (DQA), and other various national technical working groups in the development of national indicators for the PFIP. Other achievements include institutionalizing monitoring and evaluation trainings in two universities, organizing the Nigerian Health Management Information System (NHMIS) consensus workshop, and support for the ANC Sentinel Survey and the Integrated Biological Behavioral Surveillance Survey (IBBSS). However, the USG continues to experience challenges arising from poor government leadership at all government levels, inadequate resource support for programs, parallel reporting systems resulting in conflicting national reports, and lack of adequate data collection tools and systems. Additionally, use of data and information among policy makers within the GON remains suboptimal. The USG has initiated a training of policy makers on data use for programming at federal and state levels

COP 12 efforts will focus on country ownership and sustainability. Key to effective implementation of USG activities involves establishment of effective data and information management systems. The GON has adopted the District Health Information System (DHIS) as the national platform for electronic reporting. The USG will support GON efforts to use the DHIS as the reporting platform for the NHMIS. Efforts will be geared towards building capacity towards country ownership and the ability to oversee and manage the system through MEASURE Evaluation mechanism. The USG will collaborate with the GON to implement the use of DHIS 2.0 as the electronic platform for the NNRIMS 2.0 and work with IPs to adopt the system for monthly reporting from facilities. “Lead IPs” will work with the state governments to build capacity for the use of electronic reporting systems. The USG will continue to work with partners on activities to strengthen the use of data for strategic planning, decision making, improving quality of care, and research. The USG will collaborate with the GON to build capacity of the HIV/AIDS Division at the MOH to conduct qualitative population-based surveys and surveillance activities aimed at informing the current state of the HIV epidemic and response.

CROSS-CUTTING (CAPACITY BUILDING): The USG provides technical assistance to the GON to improve capacity to oversee and coordinate the planning and management of health programs. By supporting leadership training, the USG is engendering the evolution of a critical mass of inspired and committed leaders in the health sector who have the skills to drive positive change in their respective fields. The USG will continue to support the GON with institutional capacity strengthening for the delivery of efficient HIV/AIDs services to ensure greater responsibility and accountability. The USG will also work with the GON to develop a health research policy for effective coordination of research activities with evidence-based decision-making in line with the NSHDP. The USG continues to support collaboration and coordination across the health sector by participating in relevant national technical and coordination bodies. The USG supports the development of proper legislation and regulatory frameworks that

address policy challenges in distribution and compensation for health workers and issues of corruption, lack of accountability, and transparency. The USG will build the capacity of local civil society organizations (CSOs) and the media to become effective watch-dogs for the health of the populations and to hold government accountable and responsive to the needs of the population. The USG will increase partnership with local organizations for program implementation to increase capacity for program design and implementation, engender sustainability, and foster ownership. The USG will also increase support to private providers to become more involved in HIV/AIDS programs and expand access to quality HIV prevention, treatment, care, and support services. Furthermore, we will continually promote public-private-partnerships will assist individuals, communities, private organizations (for-profit and nonprofit), and government to work in concert to take responsibility and explore all available resources to respond adequately to health situations in their communities.

Technical Area: Governance and Systems

Budget Code	Budget Code Planned Amount	On Hold Amount
HLAB	40,303,452	0
HVSI	18,829,939	0
OHSS	51,439,895	0
Total Technical Area Planned Funding:	**110,573,286**	**0**

Summary:
BACKGROUND: The Nigerian Government (GON) delivers health services through a weak and badly understaffed public sector health care system. Lack of political will and absence of strong GON financial support for primary health care (PHC) contribute to this situation. The National Strategic Health Development Plan (NSHDP) for 2010 to 2015 states, that despite considerable investment, health services suffer from inequitable distribution of resources, decaying infrastructure, poor management of human resources, negative attitudes of health care providers, weak referral systems, poor coverage of high-impact cost-effective interventions, unavailability or shortages of essential drugs and other health commodities, lack of integration, poor supportive supervision, and financial barriers that prevent access by the population to services. Consequently, the public sector health care system cannot provide basic, cost-effective services for the prevention and management of common health problems especially at Local Government Area (LGA), ward, and community levels. Quality remains a concern in both public and private sector health care. Nigerians heavily patronize private-sector or overseas health services. Physicians and nurses remain relatively sufficient, but largely urban-based. Nigeria could hasten the pace of improvements in its overall health status if authorities encouraged better distribution and use of these health-care workers and greater availability of other cadres that deliver services.

COP 12 represents a pivotal moment for U.S. Government (USG) efforts in Nigeria. The USG will use its financing and reach throughout the health system to continue to build the capacity of civil society and the GON to plan, oversee, manage, and implement health services. The USG will increase emphasis on areas beyond improving HIV/AIDS services. We describe opportunities that the USG will take for health systems strengthening (HSS) in the following sections, including specific examples of how the USG will continue emphasize country ownership, capacity building, sustainability, and transition planning.

GLOBAL HEALTH INITIATIVE (GHI): The USG intends to align the GHI strategy with the NSHDP. Priorities of the Nigerian GHI strategy include (1) improved human resources for health; (2) delivery of highest-impact service interventions, particularly at the PHC level; (3) and strengthened leadership, management, governance, and accountability for program ownership and sustainability. The USG will contribute to implementation of the NSHDP through support to three cross-cutting HSS priority objectives to promote delivery of the highest impact health interventions, particularly at PHC level. The three priority objectives include reaching the GHI outcome of reduced incidence of communicable diseases; providing more human resources for health; and enhancing leadership, governance, management, and accountability. The NSHDP will drive USG strategic integration of HIV/AIDS and Tuberculosis (TB) activities and leverage existing platforms (malaria, family planning and maternal and child health).

USG support has led to progress in saving lives through HIV prevention, treatment, and care and support services since 2004. The U.S. and Nigerian Governments have prioritized decentralization of HIV/AIDS services to PHC levels, presenting an opportunity to strengthen health care provision at PHC levels and expand technical assistance and resources to LGAs. The USG will provide LGAs with support in planning, procurement, staffing, and other areas of HSS with the goal of achieving “spill-over effects” in improving other health services. The emphasis will be for PHC service providers to implement cost-effective clinic- and community-based high-impact health interventions that focus on midwives, community health extension workers (CHEWs), and village health workers, physicians, and nurses.

In addition to providing services, the USG continues to contribute to HSS efforts by upgrading facilities and laboratory services, providing institutional support, training staff, and improving logistics, supply chain management systems, and health management information systems (HMIS). The USG has also supported development of various policies, strategies, tools, and guidelines that are country-owned and accepted by all stakeholders. The USG supports education and training of public sector and community health workers to increase the quantity and quality of health professionals. The USG will continue to support the GON in improving public sector human resources planning and management at all levels to enable expansion of primary health care. Such actions include support for development and use of a Human Resource Information System (HRIS). The USG will continue to pilot innovative mechanisms for retaining health workers in rural areas as well as other innovative human resource capacity building programs and partnerships with Nigerian universities.

The USG continues to seek increased funding and ownership of the HIV/AIDS response from the GON through the Partnership Framework Implementation Plan (PFIP) that outlines anticipated U.S. and GON investments from 2010-2015. Under the PFIP, the GON should substantially increase its HIV/AIDS budget funding over time. The U.S. will continue advocacy and dialogue to reinforce the need for country ownership and responsibility for health outcomes to promote progress in achieving PFIP and GHI goals.

LEADERSHIP, GOVERNANCE AND CAPACITY BUILDING: The USG provides technical assistance to the GON to improve capacity to oversee and coordinate the planning and management of health programs in the country. By supporting leadership training, the USG has promoted development of a critical mass of inspired and committed leaders in the health sector with the skills to drive positive changes in their respective fields. To ensure greater responsibility and accountability, the USG will continue to support the GON with institutional capacity strengthening for the delivery of efficient HIV/AIDs services. The USG will also work with the GON to develop a health research policy for effective coordination of research activities with evidence based decision making consistent with the NSHDP.

The USG will continue to support collaboration and coordination across the health sector by participating in relevant national technical and coordination bodies. The USG will support development of proper legislation and regulatory frameworks; address policy challenges in distribution and compensation for health workers; and tackle issues of corruption, lack of accountability and transparency. The USG will build the capacity of local civil society organizations (CSOs) and the media to become effective

watch-dogs for the health of the Nigerians and hold the government accountable and responsive to the needs of the population.

The USG will increase partnership with local organizations for program implementation that will increase capacity for program design and implementation, engender sustainability, and foster ownership. The USG will also increase support to private providers to become more involved in HIV/AIDS programs and expand access to quality HIV prevention, treatment, care, and support services. Furthermore, we will promote public-private partnerships to assist individuals, communities, private organizations (for-profit and non-profit), and government to work in concert and take responsibility for and explore all available resources to respond appropriately to health situations in their communities.

STRATEGIC INFORMATION: COP 12 Strategic Information (SI) strategies will complement the USG goal of enhancing more sustainable, country-led initiatives and programs. To achieve this, the USG will collaborate with the GON to implement a fully-functional monitoring and evaluation (M&E) framework with buy-in from all stakeholders in the Nigerian National HIV Response. We will focus on three main areas: strengthening national capacity for M&E of HIV programs; building in-country capacity to manage and strengthen the National Health Management Information System (NHMIS) and the use of electronic information systems for program reporting; and supporting the GON build capacity for disease surveillance.

Over the years, the USG has collaborated with the GON and other stake-holders to harmonize M&E indicators and tools, develop a five-year Nigerian National Response Information Management System (NNRIMS) Operational Plan, implement Annual Joint National Data Quality Assessments (DQA) to assess the quality of data generated at service delivery points (SDPs), and support various national technical working groups (TWGs) in developing national indicators for the PFIP. Other achievements included institutionalizing M&E training at two universities, organizing the NHMIS consensus workshop involving all stakeholders, as well as support for the ANC Sentinel Survey and the Integrated Biological Behavioral Surveillance Survey (IBBSS). However, the USG has had to contend with challenges arising from poor leadership at all levels of government, inadequate resources for programs, parallel reporting systems that result in conflicting national reports, and lack of adequate data collection tools and systems.

As part of building in-country capacity for M&E, the USG will support implementation of the lead implementing partner (IP) (“Lead IP”) concept for each state, under which the IPs will collaborate with state Ministry of Health (MOH) counterparts (State Agency for the Control of AIDS (SACA) and State AIDS and STI Control Program (SASCP) to coordinate M&E activities in the state. The “Lead IP” will work to build capacity within SACAs and SASCPs to monitor HIV-related program activities thus enhancing effectiveness and ensuring synergy. The USG will support the GON to roll out the newly-revised data collection tools, as well as support implementation of harmonized indicators across all partners and donor agencies. Furthermore, the USG will support the GON to finalize and implement the NNRIMS-2 to track track national responses more effectively across all thematic areas. We will focus on activities that enhance the quality of data generated across program areas, sites, implementing partners, states, and programs. All USG partners will be required to support strategies at the state level to improve HIV Service Delivery data collation and outcomes from private health facilities and ensure inclusion into the national reporting system.

The key to effective implementation of USG programs will involve establishment of effective data and information management systems. The GON has adopted District Health Information System (DHIS) as the national platform for electronic reporting. The USG will support GON efforts to use the DHIS as the reporting platform for the National Health Management Information System (NHMIS). We will gear efforts towards building capacity to provide country ownership, oversight, and management of the system. The USG will collaborate with the GON to implement DHIS 2.0 as the electronic platform for the NNRIMS 2,

as well as work with IPs to adopt the system for monthly reporting. We will gear efforts towards facility-based reporting using DHIS 2.0 for GON and USG reporting requirements. “Lead IPs” will work with state governments to build capacity for using electronic reporting systems. The USG will also support development and roll-out of program specific information systems to enhance the quality of program management and reporting. The USG will finalize development of the USG Data Warehouse system, which will serve as a national repository for data from USG, other donors and partners, surveillance, and research activities. The USG will work with partners to promote use of data for strategic planning, decision making, improving quality of care, and research. The USG will also collaborate with the GON and the USG Prevention TWG to evaluate the Prevention Intervention Tracking Tool’s use over the last two years to track, store, analyze, and validate prevention minimum package data.

During the COP 12, the USG will collaborate with the GON to build capacity of the HIV/AIDS Division of the Ministry of Health (FMOH) to conduct qualitative population-based surveys and surveillance activities that will provide better information on the current state of the HIV epidemic as well as show trends in the response.

SERVICE DELIVERY: More than ever before, we will base COP 12 decisions on the HIV/AIDS priority target populations and areas of coverage based upon data generated from epidemiologic and population-based, behavioral, and other health and social services data. Continuum of response (CoR) program delivery will target population and areas of higher need as defined by data. Comprehensive care and treatment programs will target states and local governments with higher HIV/AIDS burdens. We will also promote HIV prevention in communities with lower prevalence. The data generated from the IBBSS will guide the USG in focusing resources for CoR programs in states with larger, most-at-risk populations.

To ensure a family and community-centered approach to CoR, the USG will continue to support the GON in its bid to integrate and decentralize HIV/AIDS service delivery. The USG will seek to integrate HIV/AIDS services better into other health care delivery services. Decentralization of CoR programs to the PHC level will make services more readily available to families and communities promote greater local participation in decision making. We will integrate HTC and PMTCT initiatives into antenatal (ANC), maternal and child health (MCH), STI, TB, and family planning clinics. Continuous quality improvement will remain a critical aspect of HIV/AIDS service delivery. The USG will continue to implement innovative approaches to service quality improvement both in public and private sector facilities. Other community-based approaches will engage CSOs and HIV support groups to increase community dialogues around CoR programs. To facilitate and sustain positive behaviors among clients, we will integrate training on inter-personal communication skills and the behavior change process into existing curriculum for front-line health-care providers.

One of the key approaches the USG will use to increase sustainability will be to support and build the capacity of the MOH, State Ministries of Health, and National Primary Health Care Development Agency (NPHCDA) in planning, implementing, and monitoring CoR programs at service delivery points.

HUMAN RESOURCES FOR HEALTH (HRH): In the past, HRH activities focused on improving the effectiveness and efficiency of HIV/AIDS service delivery through in-service training. To date, we have devoted only limited efforts to improve pre-service education and strengthening HRH planning and management. In COP 12, activities will consolidate the gains of previous years and strategies in tandem with the GON HRH and NSHD Plans as reflected in the PF, GHI strategy, and 2010 USG HRH state of the program area (SOPA) priorities.

In COP 12, the USG will contribute to the congressional mandate of training 140,000 new health care workers by 2014 through pre-service training that will increase the pool of local health work-force and improve overall quality of services. We will target the pre-service program at community health-care workers, nurses, doctors, laboratory scientists, pharmacists, pharmacy and laboratory technicians, field

epidemiologists, and other cadres of health-care providers based on identified needs. In this regard, the USG will seek to train 1,200 new health-care workers using COP 12 funding.

The USG is collaborating with the GON to strengthen the capacity of the MOH in human resource management and planning by providing continual support to the HRH branch of the MOH, and more specifically, by supporting development and management of a Human Resource Informatics System (HRIS).

In-service training will further strengthen the skills of the existing health workforce to deliver quality services. We will sustain current efforts in standardizing and harmonizing in-service training packages. We will also assess current approaches to in-service training for efficiency and effectiveness. The USG will seek to improve in-service training through better coordination and integration. We will incorporate as much material as possible into on-going continuing education programs of health workers for sustainability. We will also strengthen data management capacity of relevant health regulatory bodies, given the importance of professional health regulatory bodies in creating a virile health workforce. We will also support GON public health leaders by supporting public health management and leadership training modeled after the U.S. Sustainable Management Development Program (SMDP) to strengthen management and leadership skills.

We will also support the GON by building upon the successes of the HRH summit held in October 2011 to address the challenge of mal-distribution of health workers in the country. The USG will create a forum at which all stakeholders will meet periodically to brain-storm and develop innovative and sustainable retention strategies along the North – South and Urban - Rural divide.

As the decentralization of ARV services continues to the PHC level, we will seek to leverage HIV/AIDS services into existing best practices for efficiency optimal benefits. For example, we plan to integrate HIV/AIDS management into the Midwifery Service Scheme (MSS) of the NPHCDA. We will encourage policies supporting task shifting to strengthen the health workforce for effective and efficient service delivery.

Finally, we will help the GON to carry out activities with direct or spill-over effects on strengthening the country's health workforce. For example, we will seek to strengthen the Department of Health Planning, Research, and Statistics (DHPR&S) to carry out its oversight function of supervising NSHDP implementation. We will support establishment of a national HSS technical working group to coordinate all HSS activities and the conduct of an assessment of the distribution of health workers to strengthen HRH offices at state levels.

LABORATORY STRENGTHENING: As part of strategies for achieving the PFIP targets and goals, the USG will implement laboratory activities to achieve the following four objectives: (1) strengthen sustainable and integrated laboratory network systems that provide quality diagnostics, treatment monitoring, and disease surveillance to meet PEPFAR goals for prevention, care, and treatment; (2) develop functional tiered-network of clinical/public health laboratories with national and/or international accreditation; (3) provide technical assistance and support to the national laboratory programs in the areas of HIV, TB, malaria, and other HIV- related conditions, as well as laboratory quality management systems essential for laboratory accreditation; (4) and contribute to HSS through development of policies and guidelines for laboratory services, health workforce expansion, and correction of infrastructural weaknesses.

We seek to achieve these goals through the following planned activities:

In COP12, USG will continue to build GON capacity to run laboratories currently supported by IPs. PEPFAR will support limited expansion and upgrading of existing laboratory structures to meet scale-up

demands, including for early infant diagnosis (EID) and HIV viral load reach, laboratory infection control, and efforts to increase the health workforce and laboratory accreditation program.

The USG will work with the GON to implement the already-existing National Medical Laboratory Policy; initiate discussions and activities in developing and implementing a National Medical Laboratory Strategic Plan (NMLSP); continue to support the phased expansion and development of laboratory capacities with emphasis on the primary healthcare level and linkages to the referral network; and support the evaluation and validation of appropriate point-of-care technologies or platforms for enhanced PMTCT services.

The USG will support establishment of quality management systems in all areas of clinical laboratory services to achieve national and international accreditation through the Strengthening Laboratory Management Towards Accreditation (SLMTA) program. The National Laboratory External Quality Assurance Program (NLEQAP) will continue to provide appropriate technical assistance and support in conducting proficiency testing across the sites. The NLEQAP's support includes, but is not limited to, supporting Post Market Validation (PMV) of HIV rapid test kits; building the capacities of GON agencies, such as the Central Public Health Laboratory (CPHL), HIV and AIDS Division (HAD), National Agency for Food and Drug Administration and Control (NAFDAC), National Agency for the Control of HIV/AIDS (NACA), National TB program, Medical Laboratory Science Council of Nigeria (MLSCN); and building the capacity of managers of laboratory professional associations to obtain grants. The USG will strengthen the capacity of the MLSCN laboratory accreditation system. We anticipate that, by the end of COP 12, all 23 pilot laboratories for the WHO/AFRO accreditation scheme will become ready for external assessment prior to accreditation.

The laboratory program will prioritize the physical and managerial integration of USG-supported laboratories with mainstream laboratories (where applicable) to ensure consistent quality service delivery across the board. This laboratory service integration should improve overall service levels and promote program ownership and leadership.

We seek to define and harmonize laboratory service menus for each level of care. In addition, the USG will begin pooling the procurement of laboratory commodities inclusive of EID/VL and CD4 count reagents with harmonized laboratory equipment platforms. The USG will also implement equipment maintenance service contracts to ensure the ongoing functional integrity of equipment, reliability of testing results, and training of biomedical equipment maintenance personnel. The USG will also urge the GON to allocate funding for equipment maintenance and training of biomedical engineers to further support sustainability. The USG will also support the expansion of pre-service training programs at the university level for biomedical sciences, as well as in schools of health technologies for other cadres of laboratory staff, who provide critical services at the PHCs. Such actions will increase the pool of healthcare workforce and help ensure provision of quality laboratory services.

The USG will support the development of a robust laboratory information management system linked to all levels of the laboratory network. This system will inform public health, laboratory policies, and management decisions. These are just a few examples of how implementing GHI principles will contribute to the strengthening of health systems through integration of HIV/TB/Malaria, laboratory infection control, and bio-safety training.

The USG will support technical assistance towards establishing a national laboratory technical working group that will provide guidance and advocacy for the implementation of laboratory policies.

SUPPLY CHAIN AND LOGISTICS: Supply chain strengthening has become one of the largest governance and systems areas in the USG portfolio. Until recently, the USG remained reluctant to use or invest in the federal central supply system, because it lacked the capacity to store and distribute drugs

safely and reliably. Basic infrastructure and governance challenges seemed insurmountable. In COP 12, the USG will support and strengthen the national health supply chain system at a much broader scale than before to fulfill a vision of greater country ownership. In COP 12, the USG will work on two separate tracks: unifying and strengthening the USG supply chains and strengthening GON supply systems. The ultimate goal of the COP 12 supply chain strengthening activities will be to advance USG efforts towards a merger with the GON's supply system within three to five years. We provide information in the following paragraphs on improvements needed to facilitate this merger.

The USG will continue to pool commodity procurements and add a new set of products pooled in the COP 12 (CD4 reagents and early infant diagnosis commodities). Pooled procurement remains a relatively new approach for the USG and promotes added visibility into the supply system and decreased wastage. However, we will need to promote various additional improvements to the actual distribution system. Starting in 2011, all USG IPs maintained stock within maximum and minimum levels of inventory to reduce the overall cost of inventory held in USG supply chains. This COP reflects savings resulting from this measure. To improve the performance of each IP's supply chain, the USG and partners will review key logistics data captured in a scorecard with USG activity managers each quarter. In addition, the GON and USG will begin to conduct regular joint monitoring and support visits to USG-supported facilities to review inventory management practices and provide feedback to partners supporting those facilities.

The USG is moving towards one unified HIV/AIDS supply chain system to improve the performance and reduce the overall cost of the USG. Currently a dozen vertical chains exist for ARVs alone. In the coming years, the unified supply chain will rely on state-owned warehouses already upgraded by the USG. We will use COP 12 resources to promote this unification and use lessons from this pilot program to unify the entire system in subsequent years. The USG will build upon the existing, paper-based Logistics Management Information System (LMIS) by developing and piloting an electronic LMIS with COP 12 resources. This electronic version of the LMIS will have the flexibility to track a broad range of commodities for the national program, not just USG partners, and will improve the availability and use of logistics information within the GON. Ultimately, these interventions will seek to increase the likelihood that the GON will start managing portions of the USG supply system.

The USG will use an innovative approach by partnering with the government and the private sector to build upon existing GON infrastructure. The GON currently lacks the ability to operate a reliable, secure, and adequately-resourced central commodity warehouse. However, the GON has expressed willingness to work with private-sector warehouse operators. In COP 12, the USG will pursue an arrangement with the MOH to allow a private company to operate a new central medical store with the capacity to serve the national program. Within COP 12, we will seek to develop this public-private partnership (PPP) further during a multi-stakeholder workshop. The USG will fund the approved PPP to accelerate the renovation or construction of a warehouse.

The USG will focus on achieving concrete PFIP goals to build GON procurement and supply management capability at both the federal and state levels. Specifically, transition of first-line ARV procurement to the MOH will serve as an important goal in the PFIP and in COP 12. To support this goal, the USG and other donors have worked to build MOH capacity to resupply commodities; forecast drug needs; create robust supply plans; and procure commodities according to international procurement standards (CHAI and the GF). In addition, the USG has supported the FMOH in developing a national strategic plan for supply chain strengthening and will work with multiple donors to help the GON implement the strategy. The GON may identify additional ways in which the USG can strengthen the supply chain workforce. However, before completion of this strategy, the USG will train additional pharmacists from public and private facilities on inventory control systems. In COP 12, we will standardize and extend this training to other personnel handling HIV/AIDS commodities, such as laboratory scientists and counseling and testing site personnel. We will seek to minimize wastage and expiries as much as possible and handle inevitable wastes in accordance with established best practices.

During COP 12, in collaboration with stakeholders, the USG plans to promote access to quality-assured medicines available in-country by supporting manufacturers of non-ARV pharmaceuticals, notably co-trimoxazole (used for management of opportunistic infections), to acquire WHO pre-qualification.

Ongoing USG work appears to have advanced GON capabilities to manage supply systems, as evidenced by the recent national quantification led by the GON. However, the USG and other donors remain uncertain whether this increased capacity will result in the GON increasing procurement of commodities for the national program. The GON made discouraging cutbacks to ARV budgets in 2011. The GON has no clear plan yet to undertake the commodity procurements previously done by UNITAID and CHAI. In addition, the Federal Central Medical Store remains under-resourced, even though it should serve as the centerpiece of the national supply chain. In summary, the USG expects continued lack of GON financing for commodity procurement and supply chain management, which will remain a major obstacle to transferring the costs of procurement and distribution of HIV/AIDS commodities to the GON in the foreseeable future. However, this obstacle will not prevent the USG from improving the cost, performance, and overall manageability of the systems used to supply HIV/AIDS commodities.

HEALTH EFFICIENCY & FINANCING SECTION: Health financing remains one of the eight priority areas in the GON NSHDP. However, adequate health financing has remained a challenge over the years. In recognition of this challenge, the NSHDP called for increased health-care funding both in absolute terms and as a proportion of the national budget. If signed into law, the proposed national Health Bill could improve health financing. The bill earmarks an increased level of funding for the consolidated Federal Revenue for health with a significant proportion of the funds assigned to the PHC level.

On health-care financing, the USG seeks to improve availability, efficiency, transparency, and sustainability of resources, including efforts under the National Health Insurance Scheme to create a pool of resources to reduce out-of-pocket expenditure from the current 70 percent. The USG has also supported the GON in conducting the National HIV/AIDS Spending Assessments and National Health Accounts and continues to strengthen financial management systems and skills in the public health sector.

In line with the GHI strategy, the USG in COP 12 will use all available media and opportunities to advocate for increased GON financial commitments for health to reach the NSHDP goals. As a strategy to increase impact of donor funds, the USG will intensify policy dialogue and health diplomacy to urge that the GON increase allocations for health. In addition, the USG will help the GON link financing and budgeting to performance. We will explore innovative funding schemes to support long-term sustainability and growth of the HIV/AIDS program (e.g., strengthening of public private partnerships strategies to support HIV/AIDS financing).

We will make deliberate efforts to increase credit for private-sector health-care providers who provide HIV-related services. USG will continue support for activities to improve transparency and accountability in resource allocations and use in the public sector. Additional key priorities will include costing studies and assessments for program planning and implementation to inform resource allocation and decision making.

GENDER: The GON has acknowledged the gender dimensions of HIV/AIDS by developing and implementing gender-sensitive HIV/AIDS policies and programs, with gender equality serving as a central aspect of the HIV/AIDS National Strategic Framework. The GON established a gender desk office within the national HIV/AIDS coordinating agency that handles gender activities. The USG contributed to the development of the National Gender Policy and will continue to provide technical support to the GON on implementation. In COP 12, USG will continue to provide guidance and direction on gender programming in Nigeria. The USG will support strategies to ensure gender equality mainstreaming into prevention,

care, and treatment programs. Gender equity, women empowerment, addressing male norms and behaviors, legal protection, and economic strengthening remain key thematic areas addressed under gender mainstreaming.

The USG will continue to support assessments and monitoring and evaluation activities that highlight gender issues in health systems and human resources, including the National HIV/AIDS & Reproductive Health Survey (NARHS). This survey highlights sexual behaviors; knowledge about family planning; attitudes and use of family planning; availability, affordability and accessibility of family planning products; reproductive rights and violence against women; and awareness of maternal mortality. In addition, the USG will disaggregate targets by gender for all reporting indicators to measure additional aspects of gender equity in prevention, care, and treatment services. This action will enable USG program managers to monitor gender equity and adjust program strategies accordingly. The USG will continue to improve the capacity of its staff and implementing partners in providing gender-sensitive programming.

Finally, we will encourage implementing partners to ensure access to gender-appropriate prevention messages and services related to rape, sexual abuse, and life skills programs for boys and girls. Prevention programs will also focus on most-at-risk persons, including border traders, young males, and female market agents.

Technical Area: Management and Operations

Budget Code	Budget Code Planned Amount	On Hold Amount
HVMS	26,702,383	
Total Technical Area Planned Funding:	**26,702,383**	**0**

Summary:
(No data provided.)

Technical Area: Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
CIRC	0	0
HMBL	6,832,867	0
HMIN	2,431,146	0
HVAB	8,327,302	0
HVCT	28,919,951	0
HVOP	23,603,493	0
IDUP	0	0
MTCT	36,169,199	0
Total Technical Area Planned	**106,283,958**	**0**

Funding:		

Summary:
EPIDEMIC OVERVIEW: The HIV epidemic in Nigeria is characterized as mixed, with significant geographic and risk population heterogeneity. The 2010 Antenatal Care (ANC) Sentinel Survey reported HIV prevalence among pregnant women of 4.1 percent -- a slight decrease from 4.6 percent in 2008. However, this national ANC prevalence masks significant geographic variations in prevalence and related factors in many parts of Nigeria. For example, ANC 2010 showed that Benue State had the highest prevalence at 12.7 percent and Jigawa, Ekiti, and Kebbi states had the lowest prevalence with 1.5, 1.4, and 1.0 percent, respectively. Sixteen states and the Federal Capital Territory (FCT) had prevalence above five percent. The South-South, South-West, South-East and North-Central regions demonstrated increases in prevalence over the past five years while the North-East and North-West did not. Locations of key interest remain Benue, Akwa Ibom, Nasarawa, Cross River, and Rivers States, as well as the FCT. These locales have consistently ranked among the 10 highest prevalence states since 2005.

The 2007 National HIV/AIDS and Reproductive Health Survey (NARHS-Plus) reported that the general population HIV prevalence is 3.6 percent. This rate is slightly higher amongst females (4.0 percent) than males (3.2 percent) and in urban areas. Geographic heterogeneity was significant and ranges from 5.7 percent in the North-Central zone to 2.6 percent in the South-East zone. It was highest among respondents with primary education (4.6 percent) and lowest among respondents that had no education (2.7 percent). HIV prevalence ranked highest among the 30 to 39 years age group (5.4 percent) and lowest among the 15 to 19 years age group. Most-at-risk persons (MARPs), including their clients and partners, constituted about 3.4 percent of the population, but, with their partners, accounted for an estimated 41.3 percent of new infections, according to the Modes of Transmission study. Using ANC data in ages 15 to 24, the rate of new infections showed marginal decreases. This decrease has likely resulted from huge investments in the prevention of mother-to-child transmission (PMTCT). Low-risk heterosexual sex and casual heterosexual sex (with partners) contributed 42.3 percent and 23.9 percent, respectively, to the total of new infections. We have identified key high prevalence populations in the course of nation-wide, population-based surveys, including widowed, divorced, and separated women, who had HIV prevalence of 9.7 percent, 11.8 percent, and 9.8 percent, respectively. Other sub-populations having significantly higher HIV prevalence with figures well above the national median included brothel-based female sex workers (BBFSWs) with a current estimated prevalence rate at 27.4 percent. Non-brothel based female sex workers (NBBFSWs) had an estimated prevalence rate at 21.7 percent and men having sex with men (MSM) had an estimated prevalence of 17.2 percent. While the HIV prevalence among Female Sex Workers (FSWs) and transport workers has dropped, the prevalence has increased among MSM – from 13.5 percent in 2007 to 17.4 percent in 2010 (IBBSS, 2010). Male circumcision remains a common practice in most parts of Nigeria. According to the 2008 District Health Survey (DHS,) 98 percent of men are circumcised with little variation across age groups, location, ethnicity, zones, and education levels.

The epidemic is largely being fueled by low risk perceptions of HIV and high risk behaviors like multiple partnering, low condom use as a result of inadequate knowledge of HIV transmission, and low health seeking behaviors amongst MARPs. Stigma and discrimination remains high, particularly among children infected with the virus or children who had lost one or both parents to the disease. At the community level, various factors contribute to the spread of HIV, including increased poverty, high informal transactional sex, gender inequalities, high rates of drug and alcohol abuse, high misconceptions about condom efficacy and HIV transmission, high stigma, and decreasing age at first sexual debut.

STRATEGIC OVERVIEW: U.S. Government (USG) prevention efforts derive guidance from: (1) USG commitments in the Partnership Framework (PF) and PF Implementation Plan (PFIP); (2) the Nigerian National Prevention Plan and the Minimum Package Prevention Interventions (MPPI); (3) the recently

issued PEFPAR Prevention Guidance; (4) and the 2010 Inter-agency USG Prevention Assessment. Core interventions for the next two years will include scaling-up PMTCT, comprehensive condom programming (inclusive of female condoms) and interventions to address MARPs, and people living with HIV/AIDS (PLHIV). The USG will focus programming across state and local governments with high HIV burdens and sero-prevalence higher than the national median of 4.1 percent to channel resources strategically and achieve cost efficiency, Further, we will target services towards sub-population groups with the highest burden of disease and highest risk of transmission and acquisition of the virus. In addition to FSWs, MSMs, and people who inject drugs (PWIDs), we will also aim efforts towards other vulnerable populations in the general population, including widows, separated and divorced women, and girls engaged in transactional sex. The strategy will also adopt rigorous and regular monitoring and supportive supervision while continuing to focus on building the capacity of civil society and sub-national levels of government in the planning, implementation, and evaluation of prevention activities through the lead implementing partner ("Lead IP") concept. We will seek and use technical assistance for capacity development on prevention programming, including systems strengthening for provision of highly-effective combination prevention interventions and other integrated services at sub-national levels. One major challenge remains lack of an enabling policy environment to support more open and robust programs targeted at MSM and PWID (e.g., proposed legislation that contains provisions seeking to infringe upon freedoms of speech and association for those advocating same-sex marriage and behavior). We will intensify advocacy efforts to provide better information to legislators and policy makers on public health and human rights issues to ensure adequate protection and provision of services for these groups.

The USG will continue to collaborate with the Global Fund (GF) and other partners to ensure adequate coverage and provision of services while avoiding duplication of efforts. Recently, GF site selection activities benefited from technical assistance, and stakeholders established a mechanism for joint quarterly review meetings and appropriate supervision. The USG has also partnered with the World Bank and the National Agency for the Control of AIDS (NACA) on strategic focusing and "scale up" of MARP interventions through development of a schedule and protocol of a "Local Epidemic Appraisals." Also, the USG has leveraged funding from the United Kingdom (UK) Department for International Development (DFID) to support the Enhancing the National Response (ENR) program to provide condoms for MARP programs.

The USG will continue to build on key achievements, such as the promotion of greater national priority for MARP interventions and a corresponding increase in prevention programming for MARPs, with acknowledgement of MARPs in national HIV policies. USG-sponsored surveys provide important insights into the intricately "mixed nature" of the epidemic and poor knowledge about HIV and poor exposure to HIV interventions among MARPs. Further, USG programs have moved from few partners working with MARPs to having the most partners (excluding faith-based partners) to implement programs for MARPs, particularly for FSW and MSMs. Thus, MARP-friendly services have arrived in geographic locations near implementing agencies working with MARPs.

PREVENTION OF MOTHER-TO-CHILD TRANSMISSION (PMTCT): PMTCT remains a priority intervention for preventing infections among the pediatric population and expanding access to care while integrating other needed healthcare services for women and their families. USG efforts focus on strengthening overall maternal and child health (MCH) care. The USG seeks 90-percent coverage of HIV-positive pregnant women who receive prophylaxis in PMTCT programs in accordance with national priorities. USG efforts include improved public health outcomes through service integration and utilization of strategies that strengthen sub-national government levels to initiate, plan, implement, and supervise the expansion of PMTCT services. Initially, scale-up efforts will concentrate on increased service coverage in eighteen states that have prevalence above the national median of 4.1 percent while also continuing service delivery in other states. The revised Acceleration Plan contains the following seven strategies: (1) expansion of PMTCT activities at sub-national levels (states and LGAs); strengthened support to states and LGAs to address human resource, commodities, and other systemic challenges and

develop transition plans towards graduation of sites for assumption of responsibility by states and LGAs; (2) integration of PMTCT services into MCH service outlets through adoption of a stepwise approach to service provision with concentration of PMTCT facilities in high-prevalence communities and high-birth rates; (3) leveraging of other prevention programs to focus intervention on PMTCT prongs 1 and 2 at community levels with strategic emphasis on reaching women and girls of reproductive age consistent with the Global Health Initiative (GHI); (4) demand-creation interventions to re-direct health-seeking behavior of pregnant women from patronizing traditional birth attendants (TBAs) to seeking comprehensive quality services; (5) strengthen PMTCT management information systems (MIS) for improvement of the national PMTCT program; (6) engage the private sector and faith-based organizations healthcare facilities to expand PMTCT services; (7) and ensure that mother-infant pairs from PMTCT and early infant diagnosis (EID) services link up with care and treatment programs, including those for orphans and vulnerable children (OVC,) pediatric care and support, pediatric treatment, adult care and support, and adult treatment programs to promote continuity of care after exiting the PMTCT program. We will provide additional information in the USG Nigeria PMTCT Accelerated Plan. As part of our strategy to increase the uptake of HTC at antenatal clinics in supported PMTCT facilities in priority States, we shall defray/absorb antenatal booking/registration fees for all pregnant women. In addition, we shall ensure that communities served by the health facilities are adequately informed of this benefit/privilege through local media outlets and strategically placed IEC materials. As part of our strategy to increase the number of HIV positive pregnant women who receive ARV prophylaxis, all USG PMTCT partners are required to increase health facility coverage through scale-up into additional secondary facilities and primary health care facilities using the 'hub and spoke' model (with at least 3 spokes to one hub). To this end, each partner is expected to provide a list of new secondary (hubs) and PHC (spokes) facilities they into to expand into guided by HIV prevalence, availability of ANC (and other MCH) services as well as volume of ANC clients/patronage with a view to prioritize engagement of high yield facilities. These new sites for expansion must be disaggregated by State, LGA and facility type (primary, secondary or tertiary). USG will be actively engaged in site selection process to influence the hub-and-spoke model and to allow USG to identify most efficient strategies for expansion.

HIV TESTING AND COUNSELING (HTC): The National HTC goal seeks to achieve "Universal Access" by 2015. USG HTC efforts will support this goal by providing capacity-building and system-strengthening activities. USG implementing partners (IPs), in collaboration with the GON, United Nations (UN) agencies, and the GF, have developed strategic interventions in accordance with international and national minimum standards and guidelines. Key HTC focus areas include: strengthening HCT integration and linkages with all other prevention and treatment programs; expansion of targeted testing especially for MARPs; enhanced service provision for children, couples, and relatives of index cases of home-based care and support program; integration and linkages with family planning programs; and prevention with positive programs.

In COP 12, the USG will emphasize: (1) the scale-up of provider-initiated testing and counseling (PITC) at all points of services for MARPs, antenatal clinic clients, tuberculosis (TB) patients, patients with sexually-transmitted infections (STIs) and HIV-related diseases; (2) the scale-up of couples' HIV-testing and counseling (CHCT) to identify sero-discordant couples and link them to appropriate follow-up services; (3) mobile and outreach HTC targeting sub-populations that include MARPs to increase the coverage and scale of specific vulnerable populations; (4) scale-up of pediatric testing; (5) strengthening referral networks and linkages between facilities and communities to achieve continuity of care and treatment to meet the PLHIV needs; (6) linkage of every testing site to an external quality assurance program to ensure continued provision of high-quality HTC services; (7) and laboratory support focusing on supporting the GON in ensuring the quality of testing through establishment of appropriate testing algorithms, post-market validation of HIV rapid test kits, and continuous monitoring of kit quality. We will give priority to promoting quality management systems through continuous provision of training, control panels, retesting programs, proficiency testing, and on-site monitoring.

Capacity building efforts will engage the private sector to provide services utilizing any one or a combination of HTC models. Initial private sector focus will be on those who provide services under the guidance of the National Health Insurance Scheme (NHIS). We will conduct advocacy with GON and donor agencies to assist private facilities with free HIV rapid test kits, capacity building, relevant aspects of quality assurance, and supervision. We will continue efforts to ensure integration of HTC services into ANC services, maternal and child health, STI, TB, family planning clinics, screening for high-risk HIV-negative clients/patients, children in pediatric wards, and out-patient and in-patients clinics in all comprehensive sites. IPs will explore use of trained lay counselors, volunteers, and PLHIV to complement the number of HTC service providers in facilities.

CONDOMS: Promotion of consistent and correct use of condoms and provision of condoms remain essential components of USG prevention efforts for MARPs, the general population, and PLHIV. Condom and lubricant use are promoted through improved self-efficacy, including skills related to condom negotiation and utilization. Condoms are promoted using state-level mass media and community-based interventions using generic and branded messages largely by implementing partners. DFID's ENR project has become the largest condom procuring mechanism with a project mandate to procure and distribute 1.2 billion male condoms during six years. In COP 11, the USG procured and distributed nine million condoms through IPs. Female condoms are not widely available and are costly, despite the existence of female condom promotion since 2008 through civil society organizations (CSOs). OXFAM Novib has just finished a pilot of female condoms in three states. The results will provide further insights for future female condom programming. In the past, such efforts have resulted in gradual increases in the uptake of female condoms and increased public discussions about them. In 2010, IPs distributed 218,154,440 male condoms and 886,979 female condoms through social marketing.

Socio-cultural, economic, and programmatic factors continue to affect greater female condom uptake and access. Examples include: poor supply chain management and inadequate promotion and targeting, particularly to sex workers and women at government family planning clinics; the high price of the product, making them unaffordable; low level of awareness of the product benefits; inadequate skills on proper usage and limited male involvement. The USG will continue to procure condoms and leverage others from UK DFID's ENR project and distribute them to sexually-active persons through prevention partners. The USG will continue to leverage GON condom social marketing campaigns to increase the uptake and use of condoms.

VOLUNTARY MEDICAL MALE CIRCUMCISION: Voluntary medical male circumcision programs have not become a priority intervention for USG-support, given the high prevalence of male circumcision throughout Nigeria (98 percent).

POSITIVE HEALTH DIGNITY AND PREVENTION (PHDP): Prevention interventions for PLHIV remain critical components of USG efforts. High rates of discordance among couples persist due to low partner testing, fear of disclosure, and low condom use in stable relationships. Routine community care for PLHIV includes counseling on risk reduction and behavior change, promotion of consistent and correct condom use, provision of condom supplies, provision of water guard, and education on personal and home hygiene with provision of nutritional counseling and micronutrient supplements. At both the facility and community level, the USG will support IPs to provide a standardized and evidence-based positive prevention package tailored to each setting. Components will include: (1) counseling PLHIVs at every contact with the health system on how to reduce transmission risk; (2) encouraging disclosure of HIV status to all spouses/sex partners and promoting testing of spouses/partners; (3) provision of ongoing counseling for discordant couples on prevention practices to help negative partners stay negative; (4) ensuring adequate condom supply and distribution in clinics and other settings as well as demonstration of correct use; (5) assessment/screening for alcohol/substance use and counseling on reducing alcohol/substance use that contributes to high-risk behaviors; (6) periodic assessment/screening of HIV patients for STIs as well as treatment to avoid co-infection; (7) linking family planning options to

HIV-positive women who want to avoid pregnancy and referral to PMTCT services for those desiring pregnancy; (8) patient education on the continuing risks of HIV transmission (even during ART) as well as ongoing adherence counseling and support to retain PLHIVs in care; (9) establishment of PLHIV support groups for ongoing reinforcement of positive prevention; (10) and possible task-shifting to lay counselors for more in-depth counseling needs. Integration of such efforts into all comprehensive treatment settings remains a critical priority for the USG and provides an opportunity for incorporating prevention into existing and new treatment programs. Further, the USG intends to standardize easy-to-use PHDP data collection tools across implementing partners which can be harmonized into the national system. Such efforts will allow IPs to monitor whether the minimum package of PHDP is delivered at all patient encounters in both community and facility settings.

MARPs: USG prevention efforts for MARPs have increased in recent years as a result of better epidemiological data. Efforts focus on increased access to a comprehensive package of HIV sexual prevention activities at sufficient intensity, dosage and quality, including improved continuum of community- and facility-based prevention, care, and treatment. MARP efforts emphasize improved use of data to prioritize and target MARPs and plan HIV program interventions utilizing evidence-based strategies. COP 12 efforts to address MARPS include the PEPFAR-defined minimum package of interventions (i.e., community-based outreach; distribution of condoms and condom-compatible lubricants; HIV counseling and testing; active linkage to health care and ART; targeted information, education and communication (IEC); and STI prevention, screening and treatment). We will also give priority to income-generating activities. Based on epidemiological and behavioral evidence, we will aim efforts at the following key populations: sex workers (SW), MSM, PWID, discordant couples, PLHIVs, men between the ages of 25-30, women between the ages of 20 – 25 and widowed/separated/divorced women.

The focus on prevention for MARPs has begun to result in a full-range of program activities, specifically SW, MSM, and PWID. Many prevention activities for MSM and PWID are relatively new and synergistically take advantage of existing program activities. Men's Health Network, a project of the Center for the Right to Health and Population Council Nigeria, works with men at high risk (MSM, uniformed personnel, truck drivers, prisoners, and university students) and is one example of efforts in this direction. Future efforts will concentrate programs in settings where these MARPs reside or congregate and expand to ensure sufficient scale and intensity. Challenges in scaling-up have included securing adequate GON financial resources and identifying implementing agencies with sufficient capacity and experience in this area. Overall, government funding of HIV prevention remains low. Prevention efforts for MARPs compete with those of the general population and pose additional challenges for ongoing sustainability and ownership of the response for MARPs.

The USG has entered the final negotiation stages for a new award to provide comprehensive HIV prevention programming for targeted MARPs, FSWs, MSMs, and, to a minor extent, PWIDs. The project seeks to strengthen HIV sexual prevention services for female sex workers and their clients. To a lesser extent, MSMs and PWIDs will also receive support under this project. Four mutually-supportive strategies will contribute to the overall strategic objective of strengthened HIV prevention services for the most-at-risk populations, especially for female sex workers and their clients; (1) increased organizational capacity of local stakeholders to develop, manage, and evaluate effective HIV prevention interventions and create an enabling environment for service expansion; (2) increased access to a comprehensive package of HIV sexual prevention activities at sufficient intensity and quality; (3) improved continuum of community- and facility-based prevention, care, and treatment for targeted MARPs; (4) improved use of data to prioritize and target MARPs and plan HIV program interventions emphasizing evidence-based strategies.

We will undertake geographic mapping of services and prioritization of sites at both the macro- and micro-levels to facilitate overall planning for the new award roll-out. Micro-level mapping will identify venues

where MARPs engage in high-risk behaviors. Size estimation activities will assist the USG and partners to better understand the epidemic dynamics among MARPs as well as allow the team to rationalize resources geared towards MARPs. We will select and prioritize geographic units using a range of criteria, including prevalence, estimated rate of new infections, population size of geographic units, spatial relationship with identified epidemic epicenters, and epidemic trends in the various geographic units. The USG will conduct these analyses nationally, while we will require IPs to conduct them in the states with a bid to prioritize communities where interventions will avert the highest number of new infections in the shortest possible time.

In support of the GON's Minimum Prevention Package Intervention (MPPI) approach, USG-supported prevention activities will provide a suite of mutually-reinforcing interventions to address the risks of transmission/acquisition for an individual or within a fairly homogenous group of individuals at three levels (individual, community, and structural). At the individual level, interventions will address four components: improve knowledge; provide necessary skills for sustainable behavior change; improve access to and use of necessary commodities; and ensure provision or linkage to appropriate facility-based services. At the community level, interventions will address two components: identification and strengthening of the social networks and other factors that positively influence the behavior of the individual and promote "herd immunity" primarily through coverage and saturation of key population segments. At the structural level, interventions will focus on addressing institutions and policies within the macro- and micro-social spheres that influence the risk of new infections.

The USG will continue to support the GON in harmonizing and coordinating the MARP response through active participation and support to the National Prevention Technical Working Group. We will require IPs to +provide similar and continuing support to similar structures at the state and local government levels.

GENERAL POPULATION: The epidemic heterogeneity and limited resources for HIV prevention necessitate a targeted response, rather than one focused on national coverage. To maximize resources, USG prevention efforts for the general population will focus on high prevalence states and target prevention responses to address sub-populations within the general population at increased risk or vulnerability. USG prevention activities are based on combination prevention that focuses on risk reduction using behavioral and structural interventions while increasing demand for biomedical services and reinforcing behaviors that sustain their use (such as HTC and ART). The USG will utilize and leverage state-level epidemic and prevention response profiles that the GON will develop with World Bank assistance. We will intensify efforts to focus and saturate key target populations using relevant and appropriate packages of mutually-reinforcing interventions with the aim of affecting key populations. We will target in-school and out-of-school youth aged 15 to 24 in high-prevalence states with interventions that increase risk perception, knowledge, and skills for HIV prevention through peer education plus curriculum-based and non-curriculum-based interventions. In the past, an "ABC" approach neglected other initiatives that could reduce risk and vulnerability, such as programs to reduce sexual violence, transactional sex, stigma, and discrimination. Further, IPs found abstinence messages alone to be less effective or counter-productive for many at-risk populations. Interventions to discourage or delay the sexual debut of pre-adolescent youth have proven more effective as components of broader sexual health programs. As a result, most IPs will emphasize partner limitation coupled with other messages, including knowing the HIV status of oneself and one's partner and condom use for higher-risk sex. As with MARPS prevention activities, USG IPs utilize the GON MPPI approach, which provides a suite of mutually-reinforcing interventions to address risks of transmission/acquisition for individuals at three levels (individual, community, and structural).

Increased awareness of general HIV prevention has become a necessary component, as reducing risky behaviors alone has proven insufficient. Given low levels of comprehensive HIV knowledge in many states, contextually-appropriate state-level mass media, primarily via radio, has become a cost-effective tool to deliver messages around safer sexual behaviors and increased awareness of the availability of

services. The USG will promote and strengthen media projects and interventions that target youth aged 15-24 that encourage them to increase HTC-seeking behavior (to “know one’s status”), promote status disclosure, reduce stigma and discrimination, reduce alcohol and substance use, reduce multiple and concurrent partners, and promote correct and consistent condom use. Mass media messages will complement and reinforce those delivered via other platforms in alignment with best practices for behavior change communication.

Additionally, we are negotiating a work-place program award to cater to workplace populations with the highest risk of acquiring or transmitting HIV. We will target small- and medium-class enterprises for this intervention.

CROSS_CUTTING (HSS/HRH): As comprehensive treatment services become decentralized to the primary health-care level, the USG will support IPs to implement HTC in high-risk communities and PHCs. Decentralization of services will require close collaboration with GON and supporting IPs to strengthen capacity at this level. USG prevention efforts will support education and training of public-sector and community health workers to increase the quantity and quality of health professionals. Health care providers meet with patients regularly and can deliver consistent, targeted prevention messages and strategies. These health care providers can also address biomedical prevention strategies, such as family planning and STI management. To assist providers in delivering prevention messages and services, the USG will support IPs to train PLHIV as lay (or peer) counselors. Lay counselors can reinforce provider-delivered messages and services and provide more in-depth HIV prevention counseling, including discussion of and assistance with safe HIV sero-status disclosure, delivery of a brief alcohol intervention (if indicated), medication adherence counseling, risk reduction counseling, and HIV testing of partners and family members. The USG will continue working with SACAs, IPs, and facility administration to support shifting of HIV testing to lay counselors and non-laboratory staff to streamline service delivery, reduce the unnecessary burden of HIV rapid testing on laboratory staff, and reduce client/patient movement within the health facility. We will train laboratory staff to support and supervise these services while providing quality assurance activities. Additionally, USG all- level scale-up of provider-initiated testing and counseling (PITC) will utilize CDC developed PITC training materials to improve health-care worker capacity for PITC data collection, monitoring, and utilization.

The USG will continue to support the GON to improve public-sector human resources planning and management at all levels to enable expansion of PHC, including support for development and use of a human resource information systems. Furthermore, we will promote public-private partnerships to assist individuals, communities, private organizations (both for-profit and non-profit) and governments to take responsibility for and explore all available resources to respond adequately to health situations in their communities.

The PEPFAR Nigeria prevention program will continue to support collaboration and coordination across health sectors by participating in relevant national technical and coordination bodies. As the decentralization of PMTCT services continues to the PHC level, the prevention program will leverage existing best practices and utilize the Midwifery Service Scheme (MSS) of the National Primary Health Care Development Agency (NPHCDA) for quality service provision. We will encourage policies supporting the shifting of tasks to build pools of health personnel for effective and efficient service delivery.

CROSS-CUTTING (MEDICAL TRANSMISSION PREVENTION): USG-supported injection safety efforts utilize a “lead IP” model to build capacity for injection safety, phlebotomy, and health care waste management (HCWM). In line with the PFIP, we will procure these commodities to support PHC facilities in partnership with the NPHCDA. The USG supports NPHCDA to develop a national HCWM framework to institutionalize standard operating procedures for waste management at facilities and commodity expiry management. We will strengthen advocacy efforts with the Ministry of Health (MOH), Ministry of Environment, and other relevant GON stakeholders for approval and implementation of the draft National

HCWM plan.

The USG focus on blood safety will help to ensure the testing of every unit of blood transfused for all the four transfusion transmissible infections (HIV 1&2, Hepatitis B, Hepatitis C, and Syphilis) using the fourth generation Enzyme Link Immunoassay (EIA) through the National Blood Transfusion Service (NBTS). We will adopt the hospital linkage program strategy to augment this effort. We will intensify social mobilization and health promotion messages through a media-driven campaign for donor recruitment and linkages to community-based HTC for blood donation, awareness creation, and recruitment. We will integrate Blood Safety into other HIV-related activities like STP, PMTCT, Care and treatment, and MNCH, with a focus on community-based programs. We will intensify advocacy for presentation of the National Blood Service Commission Bill by the MOH and passage by the National Assembly. Promotion of universal precautions through formation of infection control committees will continue. Public engagement programs promoting post-exposure prophylaxis (PEP) access by the general public do not exist, and PEP access remains limited to about 20 percent of health facilities. Authorities have yet to develop and adopt national gguidelines on PEP access, male circumcision procedures, future microbicides, and HIV vaccine access. NACA has initiated public discussion of use of ARVs for HIV prevention following revision of the national HIV vaccine plan.

CROSS-CUTTING (GENDER): PEPFAR Nigeria prevention efforts address underlying gender dynamics and norms that increase vulnerability to HIV infection for both men and women. Male and female power dynamics influence an individual's status within society, roles, and access to resources as well as the HIV/AIDS epidemic and the success of programs. Social and cultural norms about appropriate male and female behaviors, characteristics, and roles profoundly shape the epidemic. Women experience increased vulnerability because of cultural attitudes and norms (including heightened masculinity) that discourage safe sex practices, encourage cross-generational sex, and push women into transactional or commercial sex work. Gender norms contribute to the HIV epidemic, particularly among FSW and other MARPs.

NACA has constituted a Gender Technical Working Group, but its functionality seems ad hoc. The group apparently only meets to consider policy documents or development of plans. USG interventions emphasize gender-sensitive approaches and designs that address underlying gender dynamics and norms that increase vulnerability to HIV infection. Addressing male norms and behaviors have remained a priority in USG prevention efforts, particularly in the areas of male involvement in pregnancy and health seeking behaviors. Implementing partners apply gender analysis to the design of all projects. Some USG prevention efforts tackle social norms that influence high-risk behavior, including negotiation of condom use and sexual relations, expectations of acceptable behavior for women and men, gender-based violence. Interventions include mass media campaigns, peer education, counselor training, training of community social support providers, and the use Family Life HIV/AIDS Education (FLHE) curriculum addressing gender and social norms among youths.

In COP 12, the USG will continue to provide guidance and direction on gender programming. The USG will support strategies to ensure mainstreaming of gender-equality into prevention, care, and treatment programs. We will provide support to the federal minstries to review their sectoral policies and plans to integrate context-specific gender concerns and needs. We will continue support for assessments and monitoring and evaluation activities that highlight gender issues involving health systems and human resources. We will also promote disaggregation of gender data to inform programming through use of the Prevention Intervention Tracking Tool (PITT) and national tracking tool, which disaggregate data by sex, age, and type of intervention.

CROSS-CUTTING (STRATEGIC INFORMATION): Key challenges to USG strengthening prevention information remain lack of national capacity to monitor and evaluate HIV programs, manage and strengthen the National Health Management Information System (NHMIS), use electronic information

systems for program reporting; and to conduct disease surveillance. Challenges from limited government leadership at all local levels, inadequate resources for programs, parallel reporting systems that produce conflicting national reports, and lack of adequate and harmonized data collection tools and systems continue to plaque efforts to develop improved prevention information and use of such data. The GON has recently adopted the PITT as the national tracking tool for Minimum Prevention Package Interventions. The USG will provide technical assistance and capacity building to the GON through USG-funded IPs to make PITT operational. Authorities developed and implemented a five-year operational plan for implementation of the National Response Information Management System (NRIMS).. The NRIMS utilizes the District Health Information System (DHIS) as a platform for electronic reporting. Joint USG-GON national data quality assessments support National Prevention Technical Working Group (NPTWG) and on-going reviews of national indicators. The USG will continue to support critical national data surveys, such as the ANC Sentinel Survey and the Integrated Biological Behavioral Surveillance Survey (IBBSS).

In COP12, the USG will increase its evidence base for the strategic direction of program activities to improve strategic information collection and dissemination, including the National AIDS and Reproductive Health Survey (NARHS) and IBBSS. In COP 12, the USG will provide support for dissemination of IBBSS 2010 and capacity building for designing programs for MARPs. Dissemination of IBBSS 2010 among prevention stakeholders will occur via the NPTWG. We will use Data Analysis, Triangulation, and Evaluation (DATE) project findings to guide the design, implementation, monitoring, and evaluation of sexual transmission prevention programs. The findings will synthesize multiple data sources and points into actionable information. Collaboration with the World Bank will continue in COP 12, especially in the area of strategic information for efficient and effective HIV prevention efforts. We will collaborate further to develop the schedule and protocol for the “Local Epidemic Appraisal,” including its deployment. With World Bank support, the USG will conduct learning visits to similar MARP programs that have proven successful, with the goal of translating best practices from those programs to the Nigerian response. Collaboration with IPs will emphasize data collection of contextual factors that influence the transmission or acquisition of new infections to unearth contextual nuances that will further strengthen the tailoring of prevention programs to local community needs. In addition, we will collect data on costing information in COP 12 to determine the cost per individual reached with prevention interventions and the subsequent cost per new infection averted.

CROSS_CUTTING (CAPACITY BUILDING): USG capacity building efforts in prevention promote goals of the PFIP, PMTCT accelerated plan, USG objectives on engaging local partners, and decentralization of service delivery to PHC. Capacity building efforts will improve the technical and operational effectiveness of local organizations, public institutions, and governing bodies at all levels as well as professional capacity of health-care workers, advocates, and lay counselors. The USG seeks to build the capacity of various government institutions (NACA, FMOH, NHIS, SACA, and state MOHs) and civil society organizations across the country. The USG will build the capacity of all cadres of health personnel as “change agents” in leadership and management. We have documented and commended successes of leadership and management training for stimulating actions at all levels of program implementation and management. Government efforts on capacity building have spanned training on the utilization of the National Prevention Plan and making operational the MPPI and PITT. Recently, NACA initiated an effort to stream-line tools and indicators and seeks to develop a tool for assessing organizational capacity. Capacity building will commence after field testing of this tool. Evidence from the IBBSS 2010 confirmed rising prevalence of HIV among MSM, vice SWs and PWIDs, who have experienced a decline in prevalence. We will need aggressive capacity-building to respond to continuing expansion of work with MARPs and expanded research to increase the evidence base for creative and effective MARP programming. We will also focus on capacity building of civil society organizations (CSOs), as they play important roles in working with MARPs. Currently, donors support capacity building of CSOs, but the GON needs to recognize and invest in the work of civil society as well. The USG, with help from the World Bank and NACA, will develop capacity for evaluating MARP programs under a coordinated and

unified system for the entire country. Concurrently, those receiving such training will, in turn, develop the capacity of others at the national, state, and local levels.

Technical Area: Treatment

Budget Code	Budget Code Planned Amount	On Hold Amount
HTXD	69,151,271	0
HTXS	63,764,794	0
PDTX	8,474,978	0
Total Technical Area Planned Funding:	**141,391,043**	**0**

Summary:
BACKGROUND: Nigeria has a population of about 160 million people. The number of persons living with HIV infection reportedly involves over three million, including 360,000 children. Of the three million persons living with HIV infection, over one million reportedly need antiretroviral therapy (ART), including 212,720 children. Nigeria has the largest burden of pediatric HIV infection, accounting for 10 percent of the global burden. An estimated 154,920 new childhood infections occurred in 2010, the majority of which occurred during mother-to-child transmission. As a result of the combined efforts of the Government of Nigeria (GON) and the international donor community, current antiretroviral therapy coverage has reached 34.4 percent. In COP 12, the U.S. Government allocated $125,599,494 (including $4,526,104 for Supply Chain Management System – SCMS -- commodity procurement) for the delivery of adult and pediatric services through 13 implementing partners (IPs). USG adult and pediatric ART efforts in COP 12, in accordance with U.S. Government (USG) commitments in the GON-USG Partnership Framework Implementation Plan (PFIP) for 2010 to 2015, will seek to (1) increase the number of adults and children receiving ART; (2) maintain the delivery of highest-impact health interventions for patients; (3) maximize efficiencies of existing systems to reduce per-patient costs; and (4) reduce interruptions in service delivery as a result of weaknesses in the logistics and supply chain systems. Such efforts ultimately seek to position the GON better at the local, state, and federal levels to assume 50 percent of the cost of Universal Access by 2015. A critical GON first step will be to procure commensurate amounts of first-line anti-retroviral (ARV) drugs, while the USG focuses on more challenging procurements such as pediatric and second-line ARV drugs. Beyond procurement of ARV drugs, current USG efforts to rationalize Implementing Partners (IPs) and decentralize the delivery of services will make USG-supported ART activities more manageable for GON and allow IPs to help the GON attain commitments more easily at the state and local levels.

ADULT TREATMENT: As of September 2011, the USG provided ART services to 390,561 adults across 390 sites. In COP 12, USG implementing partners seek to expand ART services to 486,967 adult patients at 500 sites. This expansion in services reflects an increase of about 25 percent. The number of adults currently supported by the USG as well as the planned expansion accords with USG commitments in the PFIP. To achieve these targets, the USG will place greater emphasis on improving efficiency and cost savings, improving program quality, ensuring sustainability through coordination with the GON and Global Fund (GF), expanding pooled procurements, and strengthening existing health systems. Specifically, the USG will focus adult ART efforts around the following eight macro-level principles: (1) scale-up of adult ART services with emphasis on high-burden states and states with high unmet need; (2) continue with the decentralization of adult ART services to the primary health care (PHC) level using a

"hub and spoke" model; (3) rationalization of IPs using the a "Lead IP" concept for greater coordination and cost efficiency; (4) targeted, facility-level quality improvement programs and the establishment of pharmaco-vigilance activities; (5) expansion of pooled procurement to include selected laboratory commodities/reagents in addition to ARV drugs and rapid test kits; (6) improved networking and referral linkages, including networks to ensure more equitable access to viral load monitoring for treatment failure; (7) task shifting and task sharing towards higher quality, multi-purpose, multi-skilled heath workers; (8) and improve upon existing IP efforts to integrate reproductive health (RH), family planning (FP), and maternal and child health (MCH) with HIV services. Collectively, these strategies should encourage earlier identification of HIV-infected persons, improve linkages to and retention in care, and reduce HIV-related morbidity and mortality.

Authorities revised national guidelines for ART in 2010 to incorporate World Health Organization (WHO) recommendations to initiate ART at CD4 counts <350cells/mm3. Implementation and roll-out of the new guidelines has started, resulting in an increase in the estimated number of persons eligible. Further, the revised guidelines recommended the phase-out of Stavudine and introduced Tenofovir as a component of first-line regimen. The USG has commenced a scale up of adult ART services guided by the pattern of the epidemic due to the increase in the estimated number of persons eligible for ART as a result of the new guidelines and USG commitments in the PFIP. The USG intends to saturate high-burden local government areas (LGAs) in eighteen states with HIV prevalence above the national median of 4.1 percent. Complementary to this process, the decentralization of ART services to PHC facilities will increase the number of service delivery points available to patients and improve access to treatment and retention in care. Further, decentralization will assist in decongesting already over-burdened ART sites, reduce physician-to-patient ratios, provide shorter patient waiting times, and improve quality of care. A "hub and spoke" model will continue to be utilized to ensure good linkages and support for lower-level health facilities. An integral component of scale-up will be service integration, particularly with tuberculosis (TB), MCH, RH, and FP using existing platforms and leveraging available resources. Such efforts will provide for protection from HIV, unintended pregnancies, and opportunistic infections. In collaboration with the National TB Program, the integration of TB/HIV services will increase screening, detection, and treatment of TB among HIV patients and vice versa. Other areas of focus for integration include nutrition, water, sanitation, and hygiene as well as malaria all within the same setting as MCH and HIV services.

A priority in COP12 will be maintaining and ensuring standards of quality as the USG continues the transition of direct support for adult ART efforts to GON. USG will continue to improve adherence and retention through strengthening of adherence support and contact tracking of missed appointments. Most patients on treatment are currently being monitored for treatment failure using clinical and immunological parameters, resulting in lower rates of detection, and potentially higher rates of morbidity, mortality, and HIV drug resistance. Viral load technology has been available within the country; however, access to viral load monitoring is currently limited to patients accessing care in a small number of tertiary health facilities and protocols have varied by implementing partner. The USG will encourage a single standard for targeted viral load monitoring for all patients and develop a viral load network for equitable access to viral load monitoring, thus optimizing the available viral load capacity. Furthermore, the USG will continue its technical and operational support to National Agency for Food and Drug Administration and Control (NAFDAC) to monitor and ensure that ARVs remain safe for patient use. Pharmaco-vigilance activities for adverse drug reporting at USG-supported sites will be strengthened through training, improved documentation, and data analysis for decision making. Joint USG-IP-GON supportive supervision at USG-supported sites will incorporate best practices and improve technical knowledge. Capacity building efforts in this area will consist of training and mentorship to improve oversight, coordination, and monitoring functions at the state and local levels.

USG efforts in COP 12 will continue to center on long-term sustainability in addition to supporting expanded access and increased quality of ART. The USG will accomplish this goal by targeting capacity

building and direct engagement of state and local governments to leverage locally-available resources to achieve synergy and improve overall efficiency. The USG has entered the early planning stages of rationalizing comprehensive treatment efforts geographically with a "Lead IP" identified for each state. The intended vision of USG rationalization efforts involves stopping overlap of activities, improving standards of care, and improving coordination, advocacy, and capacity building efforts as well as increased coverage through targeted saturation of local government areas (LGAs.) As a critical component of the PFIP, rationalization offers a unique opportunity to improve the accountability of USG-supported IPs and ultimately create a more manageable program for the GON. Further, the process will allow IPs to attain GON state and local levels commitments more easily. Beyond improved coordination and rationalization of USG ART efforts, U.S. officials will continue to improve upon coordination with other donors, most notably the GF, to complement efforts and avoid duplication. Joint planning and site visits between the USG and GF have occurred in previous years; however, more targeted efforts will occur during COP 12. The USG currently serves as the Development Partners Group for HIV representative to the Country Coordinating Mechanism and occupies the Chair of the Oversight Committee. Implementation of USG decentralization efforts with PFIP Plus-Up funds has occurred through joint planning and analysis in close collaboration with the National Primary Health Care Development Agency (NPHCDA) as well as the GF Round Eight Health System Strengthening efforts to identify appropriate sites and limit overlap and duplication.

In COP 12, the USG will continue to support the Ministry of Health (MOH) and National Logistic Technical Working Group and the Partnership for SCMS in national ARV commodity forecasting exercises to ensure procurement of ARVs and other commodities consistent with the national ART guidance. Significant cost savings have occurred through pooled procurement of ARVs and rapid test kits. In COP 2012, this program will expand pooled procurement to include selected laboratory commodities and reagents. Such action will result in improved efficiency and cost savings. Increased effort will be made to improve forecasting and quantification of ARV drugs and other commodities to reduce expiries and wastages through mentoring of partners and training. The program will continue to support the use of registered generic formulations for cost efficiency.

PEDIATRIC TREATMENT: As of September 2011, the USG provided ART services to 26,408 children less than 15 years old. This represents six percent of all those (adults and children) receiving USG-supported ART services. From October 2010 to September 2011, 6,825 children were newly initiated on ART. Currently 390 USG-supported adult ART sites operate in Nigeria's 36 states and the Federal Capital Territory (FCT). Roughly 95 percent of the 390 adult ART sites also provide pediatric ART services. Given the critical need for pediatric ART services in Nigeria, the USG will utilize COP 12 as a platform from which to double the number of children enrolled in ART. Further, the USG will employ a mix of strategies to ensure retention of those currently on treatment. The number of children planned to be newly enrolled on treatment is 13,388 and 15,583 for FY12 and FY13 respectively. The number currently targeted for treatment will be 38,957 by the end of FY12 and 46,748 by FY13. The number of children supported by USG as well as the planned expansion coincides with USG commitments in the PFIP.

While significant gains have occurred in USG pediatric ART efforts, the need exists for more accurate data on the pediatric HIV epidemic and pediatric HIV services in Nigeria. Many opportunities exist to expand access to and strengthen the quality of ART services. USG-supported IPs and many sites already employ sound practices to strengthen USG efforts. In COP 12, the USG will provide support to a pediatric HIV care and treatment sub-group within the National Task Force on ART, strengthen national, state, and site-level data collection, and monitoring and evaluation systems to measure program outcomes and accomplishments. Work with the GON to develop sustainable national procurement capacity will ensure that all USG IPs provide pediatric services wherever adult services are available and promote the use of clinical criteria, in addition to age and CD4, for ART initiation in children. Such efforts reflect key findings and recommendations from the July 2011 assessment of USG-supported pediatric

efforts in Nigeria.

We have identified eight technical areas as priority areas for scale-up. These eight areas can be divided into two over-arching categories: those pertaining to continuity of care and those pertaining to strengthening the health system for improved pediatric services. Within the continuity of care category, USG efforts will focus on follow-up of mother-infant pairs, pediatric HIV testing and counseling, management of HIV-infected children, pediatric TB/HIV and retention, loss to follow-up, and linkages with other services. Within the health system-strengthening category, USG efforts will focus on laboratory (early infant diagnosis and CD4 testing), monitoring and evaluation (site-level data and documentation), and procurement (transition away from donor procurement of ARVs to the state-ministry procurement).

USG efforts for mother-infant pairs in COP 12 will design and implement a minimum package of services/support/data collection tools at primary health care centers to ensure quality service provision and measure mother/infant outcomes at 18-24 months of age. We will encourage USG sites to use fully standardized, national HIV-exposed infant registrars (EID registrars) to facilitate monitoring and evaluation. At the national-level, increased representation of MCH staff at national pediatric task teams will ensure linkage of guidelines, training, and implementation of prevention of mother-to-child transmission (PMTCT) to broader MCH goals. For pediatric HIV testing and counseling, the USG will continue testing all family members when one is HIV-positive, routine, op-out testing on inpatient pediatric wards, routinely test pediatric TB patients for HIV and make HIV testing available at the TB site, as well as the use of community outreach and support groups to promote testing and counseling. Further, the USG will strengthen procurement and supply chain systems for test kits (see the supply chain section for additional details), support development of guidelines and training materials for pediatric HIV testing and counseling as well as improved efforts to collect data on HIV testing of children at national, IP and site levels.

The USG will standardize the use of WHO clinical staging (in addition to CD4 count) for initiation of ART across all IPs for the management of HIV-infected children. The USG will ensure that all infected children less than 24 months old will start ART and that all children that require ART receive referrals for treatment. The USG will also develop a plan to standardize the inclusion of patient chart review to assess those children who qualify for ART to improve clinical monitoring. Pediatric TB/HIV efforts will focus on ensuring all HIV-exposed and infected children are routinely screened for TB using standard screening algorithm, practice routine intensified case finding for TB, and improve availability of correct pediatric TB fixed dose combinations. In COP 12, the USG will improve pediatric retention rates; decrease the loss to follow-up and linkages to other services that will include an increased use of support groups for women and children; improve linkages between PMTCT and pediatric treatment; and improve data collection and analysis. The USG will work with IPs to define a minimum group of feasible strategies for implementation at PHCs as PMTCT and treatment services are decentralized. Support groups for HIV-infected women, children, and adolescents represent a low-cost intervention that will be scaled up in COP 12. Further, efforts will continue to be made to strengthen linkages between adolescents and age-appropriate prevention with positives activities and support groups. Additionally, the USG will work with IPs at the site level to improve existing data collection and referral tools while also routinely reviewing and sharing the data from EID registrars, medical records, and national ART registers.

Beyond delivery of pediatric services, the USG will continue to provide technical and operational assistance and support to the GON in accordance to commitments made in the PFIP. In COP 12, the USG will support the GON to conduct a comprehensive pediatric ART program evaluation to estimate and document systematically the burden of pediatric HIV infection, progress made in pediatric ART coverage, and identify existing gaps and the unmet needs in the pediatric treatment program. The MOH, in collaboration with AIDSTAR-One and the USG, is currently conducting the National Pediatric HIV Treatment Assessment. Upon completion, the USG will support the MOH to ensure implementation of recommendations from the assessment. Further, the USG will support the GON to develop and

disseminate policy statements that support routine pediatric HIV testing and counseling (HTC) at service points across the three tiers of health facilities in addition to supporting the development of a national scale-up plan for pediatric treatment. The technical and operational capacity of the MOH to implement pediatric ART efforts has remained limited. In COP 12, we will strengthen GON (and other stakeholders) capacities through joint monitoring and supervisory visits to USG and non-USG supported pediatric ART sites in addition to supporting training opportunities for key pediatric ART program officers at the state and local levels. To improve pediatric ART data collation, reporting, and utilization, the USG will support the MOH to streamline and standardize pediatric HIV treatment and care indicators to accord with both PEPFAR indicators and global reporting requirements. The USG will also support the GON to streamline and standardize indicators to strengthen the monitoring and tracking of the quality of pediatric treatment. Current efforts to decentralize and integrate pediatric ART services have been slowed by a lack of human resources with requisite skills and confidence in pediatric HTC, treatment, and adherence counseling. In addition to the activities listed in the proceeding paragraphs, the USG will support MOH initiatives for task shift/sharing and will continue to engage the state and local governments to advocate for preferential distribution of skilled health personnel to critically-affected areas. Additionally, the USG will support and encourage streamlining of training for health care workers at the PHC level through an integrated training package.

CROSS-CUTING (SUPPLY CHAIN): The primary procurement and supply chain stakeholders in COP 12 period involve the USG and the MOH. The GF is a critical stakeholder through grants to National Agency for the Control of AIDS (NACA,) Planned Parenthood Federation of Nigeria (PPFN), and the Society for Family Health (SFH). Forecasting for ARV drugs and co-trimoxazole now occurs nationally on an annual basis. Nigeria has not yet instituted a pooled procurement system for laboratory commodities. However, the USG will support forecasting for CD4, EID reagents, and other supplies through the pooled procurement process in COP 12. ARVs and co-trimoxazole forecasting is based largely on eligibility criteria. The USG is contributing to forecasting efforts through technical and financial assistance to the MOH for the annual forecasting workshop and other procurement and supply management (PSM) related activities. A PSM group among IPs has been constituted to prevent stock-outs. IPs resupply their programs, use stocks from other partners, and rebalance stocks to avoid wastage through PSM. On a quarterly basis, logistics management information system (LMIS) data from implementing partners is reviewed in a joint meeting before ordering the next quarter's worth of ARVs and co-trimoxazole. Such action ensures that partners keep inventory within standard minimum and maximum levels. The LMIS data is largely collected through a standardized form that has been endorsed by the MOH. In COP 12, an electronic LMIS system will be developed and piloted to improve the visibility of the supply chain systems and to provide more real-time data for decision making.

The USG will address human resource challenges within the supply chain system by prioritizing facility level capacity building to improve pharmaceutical, laboratory, and test kit inventory control systems. In previous years, we sponsored training largely to pharmacists. However, in FY12, lab personnel will receive standardized training. Also, we seek to strengthen the capacity of the MOH through mentoring and workshops to forecast and conduct procurements according to supply plans and international procurement best practices. The Governance and Systems technical area narrative provides more detailed information on how the USG will promote sustainability and country ownership related to supply chain issues. Briefly, the USG intends to unify and improve the supply system to increase GON capacity to manage operations. The USG will simultaneously build the capacity of the MOH to manage its own supply system and build on that system (with infrastructure upgrades) to improve its reliability and security, which will allow GON systems to handle larger volumes of commodities. NAFDAC assesses quality of non-ARV pharmaceuticals and food products through a standardized quality assurance process resulting in issuance of certifications to manufacturers. The USG will support a selected number of local manufacturers to become WHO prequalified. This program supports pharmaceutical companies that produce medicines according to international standards. (We also describe this activity in greater depth in the Governance and Systems Technical Area Narrative.)

CROSS-CUTTING (PEDIATRIC ARV DRUGS): The cost of projected ARV drug needs for the pediatric population is $4.5 Million for FY12 and $5.4 Million for FY13. In collaboration with the GON and other stakeholders, the USG will review the logistics data for pediatric ARVs to reduce the number of ARVs on the pediatric drug list to a minimum (i.e., those that will meet the needs of the different age brackets). In past years, The Clinton Health Access Initiative (CHAI) has provided all pediatric ARV drugs for the country. This donation will end mid-2012. As outlined in the PFIP, the GON has committed to procuring a commensurate amount of adult, first line ARVs. As such, the USG will procure the more complicated pediatric ARV drugs. At this time, both the MOH and NACA cannot pool pediatric ARV formulations with other countries. However, the USG will work with the GON and relevant partners to minimize unnecessary and costly redundancies by increasing the use of Fixed Dose Combinations (FDCs) and ensuring the development of a rational list of pediatric ARVs. This will simplify drug forecasting and increase the efficiencies of procurement actions. Procurement of pediatric ARVs in FY 12 and 13 will be informed by the 2010 National ART treatment guidelines, which encourage earlier initiation of ART in children. The impact on the USG ARV budget will be marginal because the pediatric ARVs cost per patient year is relatively low compared to adults despite an increased need for pediatric ARVs and the assumption of the role of procuring pediatric formulations by the USG. About 85 percent of the children on ART receive FDCs, including 70 percent of this population who receive AZT based regimens while 30 percent who receive d4T-based regimens. This pattern is likely to persist during FY 12 and FY 13, and the USG and CHAI will continue to work with the appropriate authorities to optimize regimens for pediatric patients. In FY 12 and 13, the estimated percentages of children eligible to receive Lopinavir/Ritonavir based second line therapy are 4.4 percent and 5.1 percent, respectively, of the total number of children enrolled in ART based on WHO and national 2010 guidelines. The actual number of pediatric patients enrolled in ART fell short of expectations in FY11, as only about five percent of the total enrollments involved children through APR 2010 (forecast target: 10 percent). Lower numbers of clients posed particular challenges in procurement, because the volume of orders dictates the production related activities by the manufacturers. The FY12 and FY13 pediatric proportions of treatment targets are slightly scaled-down from 10 percent, through pediatric patients are targeted to account for 8 percent of the total patients enrolled on treatment with preferential scale-up of EID and pediatric ART.

All USG-supported ART implementing partners are involved in pediatric ARV drug forecasting and distribution. Furthermore, they participate in the USG pooled procurement mechanism for ARVs managed by SCMS. However, national forecasting and supply chain planning meetings to discuss issues related to drug selection, forecasting, procurement, and distribution remain ad-hoc. Currently, no specific work group at the national level oversees these activities. In COP 12, the USG will support the GON to assemble a standing working group on these areas with specific objectives and deliverables.

CROSS-CUTTING (LABORATORY): The USG has supported the GON to develop a National Medical Laboratory Policy (NMLP) and Implementation Plan. The USG will continue to collaborate with relevant stakeholders to ensure their implementation. In COP 12, we will place priority on development of a National Laboratory Strategic Plan (NLSP). The NLSP will address key laboratory system strengthening challenges, including the development of a tiered network of clinical/public health laboratories and quality management systems that will support the implementation of a sustainable laboratory accreditation program. The NLSP will also address current Human Resource for Health challenges in the laboratory program. The twenty pilot sites for WHO/AFRO accreditation will likely become ready for international assessment at the beginning of COP 12. We will support additional labs for accreditation readiness through the Strengthening Laboratory Management Towards Accreditation (SLMTA), training, and other capacity-building supports. The physical and management integration of PEPFAR supported labs with the mainstream labs will also receive priority in COP 12. This is a critical strategy to support government ownership and leadership of USG-funded laboratory programs, in addition to promoting integrated service delivery consistent with the Global Health Initiative (GHI). The USG has supported the GON to establish a National Laboratory Technical Working Group (NLTWG), which will serve as a platform to harmonize

laboratory activities across various disease controls programs, ensure a concerted effort at implementing the NMLP, provide unified coordination and planning of Lab programs, and inform development of policies and guidelines for tiered lab networks and harmonized service menu and equipment platforms at the different levels of care.

Laboratory equipment and commodity logistics remain a challenge as no national level laboratory supply chain management system exists. Reagent stock-outs persist , especially in non-supported laboratories. We have given priority to this area in COP 12. For the first time, the USG will pool procurement for CD4 count, in addition to EID and Viral Load assay reagents, through the SCMS implementing mechanism. The SCMS will also support capacity building at the national and state levels to develop the needed in-country capacity for a national laboratory commodities logistics system. These efforts will pave the way for harmonized equipment platforms.

We plan to expand laboratory services in accordance with the treatment scale up plan. To this end, decentralization of laboratory services to PHCs in focus states will receive priority in the COP. To ensure the effectiveness of this service decentralization, we will define and implement a minimum laboratory service menu for PHC Laboratories in collaboration with the MOH and the National Primary Health Care Development Board (NPHCDA). In addition, the targeted PHCs will link with secondary facilities (through a “hub and spoke” model) for specimen and/or patient referrals, laboratory quality service delivery mentoring, and monitoring and evaluation of the program. We also plan to pilot selected Point of Care Testing (POCT) platforms to further strengthen the laboratory service decentralization effort.

Laboratory services will receive appropriate upgrades and expansions based on identified needs in existing secondary and tertiary facilities to meet continuously increasing demand. The consistent laboratory monitoring of Pre-ART patients will be prioritized in addition to the implementation of Viral Load Assay network that will make access to viral load, when clinically indicated, possible across all the supported sites. To further improve EID of HIV, we will strengthen implementation of quality management systems in all the EID Laboratories, with specific focus on ensuring a “turn-around-time” of test results consistent with acceptable standards. In addition, we will introduce automated methods to expand sample testing capacity in selected laboratories. We will also assess additional laboratories and include them in the EID network based on defined criteria. We will establish a new EID Laboratory in the South East Zone to address the access gap that currently exists in the national EID Lab network.

In COP 12, the laboratory program will continue to support consistent delivery of quality laboratory services at all levels of care by expanding the USG-supported National External Quality Assessment (NEQA) program to include additional laboratories. The program will also partner with selected Schools of Health Technology to provide curriculum improvement, training laboratory infrastructure upgrading, and training of teachers to support quality pre-service training of health care workers that support service delivery at the PHC level.

We will support development of a robust laboratory information management system at all levels of care with linkages to networks to inform public health, laboratory policies, and management decisions. We seek to contribute to the strengthening of health systems and effective integration of HIV/TB/Malaria laboratory services, laboratory infection control, and bio-safety training.

CROSS-CUTTING (GENDER): Traditional, cultural, and social gender norms and behaviors contribute to public health problems such as domestic and sexual violence and increasing rates of sexually transmitted infections (STIs), including HIV/AIDS. In COP 12, the USG will further mainstream gender sensitive approaches into the delivery of ART services such as increasing gender equity in the delivery of ART. Currently, the USG has more women on treatment, which remains consistent with the disease epidemiology. USG efforts will ensure provision of services to all within a particular familial unit such as testing all family members when one is HIV-positive, routine, opt-out testing on in-patient pediatric wards,

routinely testing TB patients for HIV, and making HIV testing available at TB treatment sites. Further, the USG will encourage IPs to increase and expand utilization of support groups for women, children, and adolescents as a forum for psycho-social support, ensure ART retention, reduce loss to follow up, and promote linkages to other health services.

CROSS-CUTTING (STRATEGIC INFORMATION): The USG has a strong history of collaboration with the GON and other stakeholders to improve monitoring and evaluation efforts for adult and pediatric ART. The USG has supported the harmonization of monitoring and evaluation indicators and tools that support the development of the five-year Nigerian National Response Information Management System (NNRIMS) and Operational Plan, the Annual Joint National Data Quality Assessments (DQA), and various national technical working groups in the development of national indicators for the PFIP. Other achievements include institutionalizing monitoring and evaluation training at two universities and organizing the Nigerian Health Management Information System (NHMIS) consensus workshop. The USG also supported the ANC Sentinel Survey and the Integrated Biological Behavioral Surveillance Survey (IBBSS). However, the USG continues to experience challenges arising from poor leadership at national, state, and local government levels, inadequate resources for programs, parallel reporting systems resulting in conflicting national reports, and lack of adequate data collection tools and systems. Additionally, utilization of data and information among policy makers within the GON remains suboptimal. The USG has initiated training of policy makers at federal and state levels on data use for programming.

COP 12 efforts will focus on country ownership and sustainability. Key to effective implementation of USG activities involves establishment of effective data and information management systems. The GON has adopted the District Health Information System (DHIS) as the national platform for electronic reporting. The USG will support GON efforts to utilize the DHIS as the reporting platform for the National Health Management Information System (NHMIS). We will devote efforts to building capacity towards country ownership, and the ability to oversee and manage the system through the MEASURE Evaluation mechanism. The USG will collaborate with the GON to implement the use of DHIS 2.0 as the electronic platform for the NNRIMS 2.0, as well as work with IPs to adopt the system for monthly reporting from facilities. “Lead IPs” will work with state governments to build capacity for the use of electronic reporting systems. The USG will continue to work with partners on activities to strengthen the use of data for strategic planning, decision making, improving quality of care, and research. The USG will collaborate with the GON to build capacity of HIV/AIDS Division at the MOH to conduct qualitative population-based surveys and surveillance activities aimed at informing the current state of the HIV epidemic and response.

Technical Area Summary Indicators and Targets

Future fiscal year targets are redacted.

Indicator Number	Label	2012	Justification
P1.1.D	P1.1.D Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	n/a	Redacted
	Number of pregnant women who were tested for HIV and know their results	1,423,908	
P1.2.D	P1.2.D Number and percent of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery	80 %	Redacted
	Number of HIV-positive pregnant women who received antiretrovirals (ARVs) to reduce risk of mother-to-child-transmission	46,704	
	Number of HIV-positive pregnant women identified in	58,380	

	the reporting period (including known HIV-positive at entry)		
	Life-long ART (including Option B+)	21,484	
	Newly initiated on treatment during current pregnancy (subset of life-long ART)		
	Already on treatment at the beginning of the current pregnancy (subset of life-long ART)		
	Maternal triple ARV prophylaxis (prophylaxis component of WHO Option B during pregnancy and delivery)	15,412	
	Maternal AZT (prophylaxis component of WHO Option A during pregnancy and deliverY)	4,203	
	Single-dose nevirapine (with or without tail)	5,604	
P6.1.D	Number of persons provided with post-exposure prophylaxis (PEP) for risk of HIV infection	5,000	Redacted

	through occupational and/or non-occupational exposure to HIV.		
	By Exposure Type: Occupational	3,000	
	By Exposure Type: Other non-occupational	150	
	By Exposure Type: Rape/sexual assault victims	1,850	
P7.1.D	P7.1.D Number of People Living with HIV/AIDS (PLHIV) reached with a minimum package of 'Prevention with PLHIV (PLHIV) interventions	n/a	Redacted
	Number of People Living with HIV/AIDS reached with a minimum package of 'Prevention of People Living with HIV (PLHIV) interventions	711,576	
P8.1.D	P8.1.D Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the	n/a	Redacted

	minimum standards required		
	Number of the target population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required	953,083	
P8.2.D	P8.2.D Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required	n/a	Redacted
	Number of the target population reached with individual and/or small group level HIV prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence	317,694	

	and/or meet the minimum standards required		
P8.3.D	P8.3.D Number of MARP reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	n/a	Redacted
	Number of MARP reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required	667,732	
	By MARP Type: CSW	26,709	
	By MARP Type: IDU	20,032	
	By MARP Type: MSM	33,387	
	Other Vulnerable Populations	587,604	
P11.1.D	Number of individuals who received T&C services for HIV and received their test results during the past 12 months	4,726,364	Redacted
	By Age/Sex: <15 Female		
	By Age/Sex: <15 Male		

	By Age: <15	236,318	
	By Age/Sex: 15+ Female		
	By Age: 15+	4,490,046	
	By Age/Sex: 15+ Male		
	By Sex: Female	3,308,455	
	By Sex: Male	1,417,909	
	By Test Result: Negative		
	By Test Result: Positive		
C1.1.D	Number of adults and children provided with a minimum of one care service	2,843,600	Redacted
	By Age/Sex: <18 Female		
	By Age/Sex: <18 Male		
	By Age: <18	597,156	
	By Age/Sex: 18+ Female		
	By Age: 18+	2,246,444	
	By Age/Sex: 18+ Male		
	By Sex: Female	1,080,568	
	By Sex: Male	1,763,032	
C2.1.D	Number of HIV-positive individuals receiving a minimum of one clinical service	889,470	Redacted
	By Age/Sex: <15 Female		
	By Age/Sex: <15 Male		
	By Age: <15	88,947	

	By Age/Sex: 15+ Female		
	By Age: 15+	800,523	
	By Age/Sex: 15+ Male		
	By Sex: Female	595,945	
	By Sex: Male	293,525	
C2.2.D	C2.2.D Percent of HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis	80 %	Redacted
	Number of HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis	711,576	
	Number of HIV-positive individuals receiving a minimum of one clinical service	889,470	
C2.3.D	C2.3.D Number of HIV-positive clinically malnourished clients who received therapeutic or supplementary food	n/a	Redacted
	Number of clinically malnourished clients who received therapeutic and/or supplementary food during the reporting period.	53,368	
	Number of clients who		

	were nutritionally assessed and found to be clinically malnourished during the reporting period.		
	By Age: <18		
	By Age: 18+		
C2.4.D	C2.4.D TB/HIV: Percent of HIV-positive patients who were screened for TB in HIV care or treatment setting	90 %	Redacted
	Number of HIV-positive patients who were screened for TB in HIV care or treatment setting	800,523	
	Number of HIV-positive individuals receiving a minimum of one clinical service	889,470	
C2.5.D	C2.5.D TB/HIV: Percent of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment	6 %	Redacted
	Number of HIV-positive patients in HIV care who started TB treatment	53,368	
	Number of HIV-positive	889,470	

	individuals receiving a minimum of one clinical service		
C5.1.D	By Age: <18	196,348	Redacted
	By Age: 18+	249,897	
	Number of adults and children who received food and/or nutrition services during the reporting period	446,245	
	By: Pregnant Women or Lactating Women	80,324	
T1.1.D	By Age/Sex: <15 Female	4,492	Redacted
	By Age/Sex: <15 Male	5,157	
	By Age/Sex: 15+ Female	106,802	
	By Age/Sex: 15+ Male	49,908	
	By Age: <1	100	
	By: Pregnant Women	100	
	Number of adults and children with advanced HIV infection newly enrolled on ART	166,359	
T1.2.D	Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART)	522,396	Redacted
	By Age/Sex: <15 Female	14,105	
	By Age/Sex: <15 Male	16,194	
	By Age/Sex: 15+	335,378	

	Female		
	By Age/Sex: 15+ Male	156,719	
	By Age: <1	313	
	T1.3.D Percent of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy	85 %	
	Number of adults and children who are still alive and on treatment at 12 months after initiating ART	141,405	
T1.3.D	Total number of adults and children who initiated ART in the 12 months prior to the beginning of the reporting period, including those who have died, those who have stopped ART, and those lost to follow-up.	166,359	Redacted
	By Age: <15	8,484	
	By Age: 15+	132,921	
H1.1.D	Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests	344	Redacted
H1.2.D	Number of testing facilities (laboratories) that are accredited	10	Redacted

	according to national or international standards		
H2.1.D	Number of new health care workers who graduated from a pre-service training institution or program	1,200	Redacted
	By Cadre: Doctors	16	
	By Cadre: Midwives	48	
	By Cadre: Nurses	96	
H2.2.D	Number of community health and para-social workers who successfully completed a pre-service training program	440	Redacted
H2.3.D	The number of health care workers who successfully completed an in-service training program	114,345	Redacted
	By Type of Training: Male Circumcision	0	
	By Type of Training: Pediatric Treatment	0	
NG.357	Number of PEPFAR-supported sites graduated to GoN for continuing support	0	Redacted

Partners and Implementing Mechanisms

Partner List

Mech ID	Partner Name	Organization Type	Agency	Funding Source	Planned Funding
10004	Association of Public Health Laboratories	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	487,342
10015	National Blood Transfusion Service of Nigeria	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	5,157,141
10019	Safe Blood for Africa Foundation	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	940,000
10101	Excellence Community Education Welfare Scheme (ECEWS)	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	1,475,472
10103	Axios Foundation Inc.	NGO	U.S. Department of Health and	GHP-State	591,549

			Human Services/Centers for Disease Control and Prevention		
10104	American Society of Clinical Pathology	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	292,405
10105	Clinical and Laboratory Standards Institute	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	292,405
10107	University of Nigeria, Nsukka, School of Social Work	University	U.S. Department of Health and Human Services/Health Resources and Services Administration	GHP-State	360,000
10110	Population Council	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	698,058
10111	Vanderbilt University	University	U.S. Department of Health and Human	GHP-State	2,471,468

			Services/Centers for Disease Control and Prevention		
10113	Johns Hopkins University Bloomberg School of Public Health	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	1,075,096
10114	AIDS Prevention Initiative in Nigeria, LTD	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State, Central GHP-State	36,603,799
10115	University Research Corporation, LLC	Private Contractor	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	1,190,417
10116	Pathfinder International	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	313,913
10243	Pro-Health International	Implementing Agency	U.S. Department of Health and Human Services/Centers	GHP-State	98,423

			for Disease Control and Prevention		
10263	American Society for Microbiology	Private Contractor	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	633,544
10328	Partners for Development	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	1,332,224
12467	Salesian Mission Inc	FBO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	114,057
12831	African Field Epidemiology Network	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	3,553,060
12885	United Nations Children's Fund	Multi-lateral Agency	U.S. Department of Health and Human Services/Centers for Disease	GHP-State	500,000

			Control and Prevention		
13190	Institute of Human Virology, Nigeria	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	3,036,000
13564	Federal Ministry of Health, Nigeria	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	13,476,399
13667	Center for Integrated Health Programs	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	26,591,088
13713	Medical Laboratories Science Council of Nigeria	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	487,342
13753	National Primary Health Care Development Agency	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and	GHP-State	7,099,140

			Prevention		
13785	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	GHP-State	2,600,860
14040	U.S. Pharmacopeia	Implementing Agency	U.S. Agency for International Development	GHP-State	1,207,600
14050	Johns Hopkins University Bloomberg School of Public Health	University	U.S. Agency for International Development	GHP-State	400,000
14054	University of North Carolina	University	U.S. Agency for International Development	GHP-State	2,845,814
14055	Management Sciences for Health	NGO	U.S. Agency for International Development	GHP-State	4,240,000
14064	IntraHealth International, Inc	NGO	U.S. Agency for International Development	GHP-State	4,555,299
14115	Management Sciences for Health	NGO	U.S. Agency for International Development	GHP-State	9,851,825
14161	TBD	TBD	Redacted	Redacted	Redacted
14162	TBD	TBD	Redacted	Redacted	Redacted
14169	TBD	TBD	Redacted	Redacted	Redacted
14170	TBD	TBD	Redacted	Redacted	Redacted
14231	FHI 360	NGO	U.S. Agency for International Development	GHP-State	2,209,681
14233	TBD	TBD	Redacted	Redacted	Redacted

14250	KNCV Tuberculosis Foundation	NGO	U.S. Agency for International Development	GHP-State	2,433,077
14298	Deloitte Consulting Limited	Private Contractor	U.S. Agency for International Development	GHP-State	2,172,149
14302	TBD	TBD	Redacted	Redacted	Redacted
14303	TBD	TBD	Redacted	Redacted	Redacted
14348	Save the Children UK	NGO	U.S. Agency for International Development	GHP-State	1,548,058
14383	U.S. Department of Defense (Defense)	Other USG Agency	U.S. Department of Defense	GHP-State	11,536,529
14384	Sesame Street Workshop	NGO	U.S. Agency for International Development	GHP-State	360,000
14444	TBD	TBD	Redacted	Redacted	Redacted
14445	TBD	TBD	Redacted	Redacted	Redacted
14446	The Mitchell Group	Private Contractor	U.S. Agency for International Development	GHP-State	2,079,095
14503	TBD	TBD	Redacted	Redacted	Redacted
14505	FHI 360	NGO	U.S. Agency for International Development	GHP-State	46,350,198
14535	Cheikh Anta Diop University	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	487,342
14575	Pact, Inc.	Private Contractor	U.S. Agency for International	GHP-State	4,139,591

			Development		
14583	Chemonics International	Private Contractor	U.S. Agency for International Development	GHP-State	2,700,000
14589	Creative Associates International Inc	NGO	U.S. Agency for International Development	GHP-State	2,160,000
14595	Management Sciences for Health	NGO	U.S. Agency for International Development	GHP-State	4,329,012
14596	TBD	TBD	Redacted	Redacted	Redacted
14599	University Research Corporation, LLC	Private Contractor	U.S. Agency for International Development	GHP-State	360,000
14658	TBD	TBD	Redacted	Redacted	Redacted
14663	FHI 360	NGO	U.S. Agency for International Development	GHP-State	180,000
14664	Heartland Alliance for Human Needs and Human Rights	NGO	U.S. Agency for International Development	GHP-State	1,735,819
14666	TBD	TBD	Redacted	Redacted	Redacted
14668	TBD	TBD	Redacted	Redacted	Redacted
14676	TBD	TBD	Redacted	Redacted	Redacted
14678	TBD	TBD	Redacted	Redacted	Redacted
14683	Gembu Center for AIDS Advocacy, Nigeria	NGO	U.S. Agency for International Development	GHP-State	1,730,805
14757	Central Contraceptive Procurement	Private Contractor	U.S. Agency for International Development	GHP-State	428,489
14768	Partnership for Supply Chain Management	Private Contractor	U.S. Agency for International Development	GHP-State	99,265,818

14788	United Nations Children's Fund	Multi-lateral Agency	U.S. Agency for International Development	GHP-State	179,999
14833	TBD	TBD	Redacted	Redacted	Redacted
14836	TBD	TBD	Redacted	Redacted	Redacted

Implementing Mechanism(s)

Implementing Mechanism Details

Mechanism ID: 10004	**Mechanism Name: Association of Public Health Laboratories (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	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 487,342	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	487,342

Sub Partner Name(s)

(No data provided.)

Overview Narrative

In 2012 APHL will continue to support Nigeria in building national capacity for a sustainable public health laboratory system through; improved laboratory infrastructure; strengthening of the tiered referral system; development of human resources; and implementation of the framework for a laboratory accreditation process.

APHL will provide a senior laboratory advisor who will provide expert technical assistance to the Nigeria laboratory programs to improve quality and access to laboratory services in the country. The senior laboratory advisor will support activities on an as-needed basis and will specifically support the following activities: 1) Development and drafting of National Medical Laboratory Strategic Plan. APHL will support the core-group in drafting the documents and will provide the expertise and forum for a stakeholders meeting to formalize the documents; 2) Finalization of the HIV Rapid Test Kit Phase II Evaluation report and roll-out of new algorithm; 3) Strengthening of the Nigeria Central Public Health Laboratory; and 4) Strengthening Laboratory Management Towards Accreditation (SLMTA) activities through funds for

workshops and mentoring (technical assistance)
APHL will support a 'twinning' initiative between Nigeria Central Public Health Laboratory (NCPHL) and Connecticut State Public Health Laboratory in the U.S. This initiative will provide the technical expertise to strengthen the role of NCPHL in the system and ability to provide quality services and is also an opportunity for sharing of best practices. Support the reference labs in country for proper set up and Support the implementation of LIS. Activities will include procurement of supplies to support them

Cross-Cutting Budget Attribution(s)

Human Resources for Health	153,384

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**10004**		
Mechanism Name:	**Association of Public Health Laboratories (APHL)**		
Prime Partner Name:	**Association of Public Health Laboratories**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	487,342	0
Narrative:			
APHL will support a senior laboratory advisor who will provide expert technical assistance to the Nigeria			

laboratory programs to improve quality and access to laboratory services in the country. This person will support activities on an as-needed basis and will specifically support the following activities: 1) National Medical Laboratory Strategic Plan development; 2) Finalization of the HIV Rapid Test Kit Phase II Evaluation report and roll-out of new algorithm; 3) Strengthening Laboratory Management Towards Accreditation (SLMTA) activities, as needed. APHL will provide technical assistance to strengthen laboratory testing in Nigeria. This will include: supporting the Nigeria Central Public Health Reference Laboratory and strengthen it's role in the system and ability to provide quality services ('twinning' activity with Connecticut State Public Health Laboratory in the U.S.); and support for the SLMTA program in providing technical assistance and funding for workshops as needed. This budget will also fund the procurement of equipment and supplies to support the above-named activities. APHL will support the training of NQAT for test kits evaluations, Support the reference labs in country for proper set up and implementation of tiered system. Support the implementation of LIS.

Implementing Mechanism Details

Mechanism ID: 10015	**Mechanism Name: NATIONAL BLOOD TRANSFUSION SERVICE**
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 Service of Nigeria	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 5,157,141	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	5,157,141

Sub Partner Name(s)

(No data provided.)

Overview Narrative

1)NBTS will continue to implement activities to entrench the global framework for action on blood safety in

Nigeria, to ensure a sustainable pool of regular VNRBDs to meet Nigeria's blood needs, through promotion of youth activities, improving community participation with FBOs,Local NGOs and CBOs . 2)The HLP with tertiary hospitals will be intensified with training and basic equipment support, while sites offering HTC and comprehensive HIV services are encouraged to refer eligible safe blood donors to NBTS centres.Blood safety will be an integral part of comprehensive care. 3)Institutional capacity building of the NBTS will involve improvement/expansion of facilities, development and production of training manuals and policies, skills update for master trainers and stepdown training of other HCWs. 4)Supply chain components will be strengthened,with priority given to cold chain storage and transport systems, equipment selection, specific training and maintenance, to ensure testing standards and supplies' security.5)The NBTS will continue her pursuit of autonomy, via policy development, advocacy and legislation.6)Technical assistance is required to establish blood component production capability in 2 regional NBTS centres. 7)An appropriate MIS platform will be deployed to enable a robust M&E system in all areas of programming. 8)The NBTS will pursue a comprehensive quality management system towards achieving ISO certification by 2015. 9) A media driven SBCC strategy will be employed to promote VNRBD, improve public awareness of blood safety, and change current hospital dependence on paid/family replacement donors

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	10015		
Mechanism Name:	NATIONAL BLOOD TRANSFUSION SERVICE		
Prime Partner Name:	National Blood Transfusion Service of Nigeria		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HMBL	5,157,141	0

Narrative:

1)NBTS will continue to implement activities to entrench the global framework for action on blood safety in Nigeria, to ensure a sustainable pool of regular VNRBDs to meet Nigeria's blood needs, through promotion of youth activities, improving community participation with FBOs,Local NGOs and CBOs . 2)The HLP with tertiary hospitals will be intensified with training and basic equipment support, while sites offering HTC and comprehensive HIV services are encouraged to refer eligible safe blood donors to NBTS centres.Blood safety will be an integral part of comprehensive care. 3)Institutional capacity building of the NBTS will involve improvement/expansion of facilities, development and production of training manuals and policies, skills update for master trainers and stepdown training of other HCWs. 4)Supply chain components will be strengthened,with priority given to cold chain storage and transport systems, equipment selection, specific training and maintenance, to ensure testing standards and supplies' security.5)The NBTS will continue her pursuit of autonomy, via policy development, advocacy and legislation.6)Technical assistance is required to establish blood component production capability in 2 regional NBTS centres. 7)An appropriate MIS platform will be deployed to enable a robust M&E system in all areas of programming. 8)The NBTS will pursue a comprehensive quality management system towards achieving ISO certification by 2015. 9) A media driven SBCC strategy will be employed to promote VNRBD, improve public awareness of blood safety, and change current hospital dependence on paid/family replacement donors

Implementing Mechanism Details

Mechanism ID: 10019	**Mechanism Name: Safe Blood for Africa Foundation**
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	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	

G2G: N/A	Managing Agency: N/A

Total Funding: 940,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	940,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

SBFAF will conduct activities that will continue to provide insight into the knowledge, attitudes, perceptions, behaviors, practices, cultural norms, and sources of information about blood donation. This information will provide the necessary mechanism required to develop more strategies for appropriate behavior change communication to boost donor recruitment and retention. A media driven social behaviour change communication (SBCC) strategy will be implemented to promote voluntary non-remunerated blood donation (VNRBD) across the country through addressing identified factors undermining VNRBD. There will be support and promotion of youth club activities in order to develop and maintain a sustainable pool of regular voluntary non-remunerated blood donors. The hospital linkage program activities with tertiary hospitals will be intensified and linkages will be made with sites offering HTC and comprehensive HIV services to refer eligible safe blood donors to NBTS centres and to ensure that blood safety is included in the comprehensive services. Mentoring, training and re-training of NBTS staff in existing NBTS centers will be provided to give additional support in operational areas. Community participation and support in the promotion of voluntary blood donation will be supported in the effort to promote sustainability of the blood safety program. Support will be provided to the NBTS in its pursuit to gain autonomy. This will be in the form of policy development, advocacy and full participation in stakeholder's fora. SBFAF will provide training on blood component production and technical assistance in the set up and running of a blood component laboratory in the country.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Child Survival Activities
Military Population
Mobile Population
Workplace Programs

Budget Code Information

Mechanism ID:	**10019**		
Mechanism Name:	**Safe Blood for Africa Foundation**		
Prime Partner Name:	**Safe Blood for Africa Foundation**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HMBL	940,000	0

Narrative:

SBFAF will conduct activities that will continue to provide insight into the knowledge, attitudes, perceptions, behaviors, practices, cultural norms, and sources of information about blood donation. This information will provide the necessary mechanism required to develop more strategies for appropriate behavior change communication to boost donor recruitment and retention. A media driven social behaviour change communication (SBCC) strategy will be implemented to promote voluntary non-remunerated blood donation (VNRBD) across the country through addressing identified factors undermining VNRBD.
There will be support and promotion of youth club activities in order to develop and maintain a sustainable pool of regular voluntary non-remunerated blood donors.
The hospital linkage program activities with tertiary hospitals will be intensified and linkages will be made with sites offering HTC and comprehensive HIV services to refer eligible safe blood donors to NBTS centres and to ensure that blood safety is included in the comprehensive services.
Mentoring, training and re-training of NBTS staff in existing NBTS centres will be provided to give

additional support in operational areas. Community participation and support in the promotion of voluntary blood donation will be supported in the effort to promote sustainability of the blood safety program. Support will be provided to the NBTS in its pursuit to gain autonomy. This will be in the form of policy development, advocacy and full participation in stakeholder's fora. SBFAF will provide training on blood component production and technical assistance in the set up and running of a blood component laboratory in the country. SBFAF will provide technical assistance to ensure appropriate MIS platform is deployed to enable a robust M&E system in all areas of NBTS programming. SBFAF will provide capacity building in the development of an external quality assurance system and to ensure that the NBTS domesticate same.

Implementing Mechanism Details

Mechanism ID: 10101	**Mechanism Name: 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	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,475,472	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	1,475,472

Sub Partner Name(s)

(No data provided.)

Overview Narrative

ECEWS will support the achievement of the partnership frame work implementation plan and overachieving goal of PERFAR II which is to entrench sustainable programs and increase host government involvement in the fight against HIV/AIDS and other priority interventions in the global health initiative. ECEWS will continue to support and partner with the host government and communities in

implementing sexual prevention activities, HIV Testing and Counseling, Adult and pediatric care and support services, TB/HIV services, OVC services and Strategic Information. ECEWS will focus on health system strengthening and information use for decision making among stakeholders. Gender issues especially relating to the girl-child will be emphasized in ECEWS programming for fy12 and fy13. ECEWS plans to provide HTC services to over 87,895 individuals including MARPs by the end of fy13, Umbrella care and supports services to 49126 including 14870 HIV Infected persons and 7036 OVC. Fy13 will witness an estimated increase in reach by 30%. ECEWS will work with USG and GON to include ECEWS-supported facilities in the District Health Information System 2 (DHIS2). ECEWS will be an active participant on the USG SI Technical Working Group, supporting PEPFAR in developing and maintaining a unified national data platform for HIV services in Nigeria. ECEWS will be an active participant in the State M&E TWGs, supporting capacity building activities; the development and implementation of the States' Strategic Plans. ECEWS will participate in relevant National TWGs to share and adopt best practices and lessons learnt. Program implementation will be guided be Nationally approved guidelines and tools and contribute to the overall PEPFAR Nigeria goal.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	19,391
Education	48,000
Food and Nutrition: Commodities	26,667
Human Resources for Health	185,884
Water	59,795

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing gender equity in HIV/AIDS activities and services

Military Population
Mobile Population
TB
Family Planning

Budget Code Information

Mechanism ID:	10101		
Mechanism Name:	ECEWS		
Prime Partner Name:	Excellence Community Education Welfare Scheme (ECEWS)		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	244,000	0

Narrative:

ECEWS currently provides adult care and support services in 24 sites including 14 facility and 10 community sites targeting adults and adolescents especially girls, women and MARPs identified via ECEWS HTC program. Services are provided in a continuum and include clinical services [Basic Nursing care, pain & other symptom management, Nutritional assessment and support, OI prophylaxis and treatment, Provision of multivitamins ,STI counseling and management, PwP, TB/HIV services and access to lab services], provision of Basic care kits, Home based care, psychosocial support, PHDP and other counseling services. ECEWS plans to serve 7190 PLHIV in COP 12.
ECEWS BC&S program targets high burden status which fits into the overall PEPFAR and country strategy and emphasizes strong linkages between community and facility based services. Integration of HIV/AIDS services into the already existing health system, provision of standardized services of PHCs with strengthened linkages for community, defaulter tracking bi-directional referrals system are some of ECEWS strategies in improving client retention. ECEWS BC&S program has strengthened linkages with HTC and TB/HIV services for prompt referral of HIV+/co-infected persons as well as referrals linkages with other partner supported PMTCT and ART services. PLWA in care are linked with other partners and GON for food support, IGA, RH/FP while they are all encouraged to participate in support groups. Support groups will be assisted to develop and activate food banks to assist indigent clients and this will be co-ordinate with host community support. All HIV positive clients will receive CD4 counts at least every 6 months. Cotrimoxazole prophylaxis will be provided according to National guidelines. ECEWS will support integration of syndromic management of STIs and risk reduction interventions into care. All enrolled into care will receive risk assessment and behavioral counseling to achieve risk reduction. ECEWS will promote the use of nationally approved tools and SOPs in providing Palliative care and

CHBC services to clients across supported sites. Site M&E officers will be trained on Data analysis and use in decision making to promote ownership and sustainability.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	468,000	0

Narrative:

ECEWS; an indigenous partner provides a full spectrum of OVC services and care to 3070 OVC aged 0 – 17yrs, including children who have lost one or both parents to HIV/AIDS, who are directly affected by the disease or live in areas of high HIV prevalence in 13 community based sites in Akwa Ibom and Cross River States. In COP 12, ECEWS will target serving 6,118 OVC through partnership with 10 PLHIV CBOs within the target communities to provide need based services in a family centred approach to households of OVC using the CSI tools. Services will include provision of Preventive care kits (LLITNS, water purifiers & instructions, water vessels), support for IMCI, NACS, school attendance and performance monitoring, provision of educational materials and block granting of textbooks, home visits for HBC services. Kids/adolescent clubs for HIV preventive messages, counselling, reproductive health issues and building of life skills.

ECEWS also provides other services including free birth certificates for OVC in care and linkage of CBOs to Child Protection Network (CPN), strengthen protection of OVC by sensitization of CBOs and other stakeholders on relevant conventions and policies on the rights of the child and IGA/HES. ECEWS in collaboration with SMWA and Social Development has provided shelter and protection services for homeless OVC.

Organisational capacity of partner CBOs have been built on leadership and governance, financial management, human resource management and strategic information culminating in the receipt of PEPFAR small grant for provision of educational support to OVC in care by a supported CBO. ECEWS in collaboration with USAID Markets also trained Care Providers on micro-enterprise and homestead farming fundamentals and step down trainings conducted for all supported volunteers. The project will continue to build the economic capacity of caregivers to provide for the needs of their children; retaining them in school, and working with local governments and community to establish strong child welfare and protection systems.

Supportive supervision and routine QI visits have been carried out to enhance service delivery according to national guidelines and standards of practice. National M&E tools are used in reporting OVC data across supported CBOs in target communities.

ECEWS currently collaborates with FMWAs and SMWAs in monitoring and reporting of OVC activities, with regular feedback to host communities for ownership and sustainability.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Care	HVTB	41,994	0

Narrative:

ECEWS TB/HIV services are provided in line with the NSF II and national guidelines in 7 facility based sites in Akwa Ibom State. ECEWS plans to identify, provide CPT and link for DOTS and ART 150 HIV infected TB patients in COP 12. In the last 12 months, 207 HIV infected TB patients were identified, provided with CPT and linked to TB DOTS and ART. ECEWS has intensified TB case finding via administration of WHO TB symptom checklist on 84% of PLHIV currently in care.TB infection control committees have been constituted and are currently implementing facility specific infection control plans. ECEWS has completed minor renovation to enhance TB infection control in UNIUYO Medical Centre. ECEWS collaborates with NTBLCP and GLRA to ensure adequate provision of TB drugs, CPT, reagents and consumables to supported sites.
ECEWS continues to partner with PEPFAR IPs to facilitate QA programs to ensure quality of services. ECEWS master trainers and NTBLCP team trains and work with TB DOTS staff to ensure that HIV testing and sputum microscopy services provided are qualitative and according to national TB infection control and bio safety practices. TB diagnostics QA program; joint supervision visits with the SMoH and FMoH, selective review of completed smear examinations and panel testing are conducted periodically. ECEWS prints and utilizes nationally approved DCT tools in the provision and documentation of services across sites. ECEWS will participate in national TB-HIV TWG meetings and trainings and share reports based on the revised TB/HIV indicators.
ECEWS currently utilizes a two-way referral system with appropriate completion monitoring. Community sites are linked with facilities and home based care services are provided to co-infected clients. ECEWS will strengthen linkages and referrals for TB/HIV services and community TB care (CTBC) services will be provided for co-infected. ECEWS plans to strengthen linkages and referrals for TB/HIV services and community TB care (CTBC) services will be provided for co-infected clients. Tracking teams will be used for TB treatment defaulters as such reducing incidence of Multi Drug Resistant (MDR) and Extensively Drug Resistant (XDR) tuberculosis.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	19,000	0

Narrative:

ECEWS currently provides paediatric care and support services for 45 HIV exposed and 284 HIV infected children across 14 Health facilities in Akwa Ibom and Cross River States. Plans are to provide services to 591 paediatric clients in COP 12. Continuum of services to be provided are Clinical services including access to EID and CD4 estimation, OI management, BCKs and other support services. ECEWS recruitment strategies include intensified HTC Program for mothers and children during immunization, PITC at MCH clinics and outreaches to TBAs targeting HIV exposed infants for EID services. All

paediatric clients are provided with TB screening and linkage to DOTs, while eligible HIV infected children are linked to ART services. ECEWS provides basic nursing care, OI prophylaxis and management , antimalarial, antihelminths, antipyretics, pain management, NACS, TB screening, access to Lab services, LLITNs, water purifiers, weighing pans, MUAC tapes for supported sites for management of HIV infected children.
ECEWS targets adolescent clients with PHDP and also link clients to OVC program for community services. ECEWS currently integrate the PDCS program into the broader MCH services and procure food supplements/RUTF for malnourished clients. Community food bank is being promoted in supported sites.
ECEWS has strengthened linkages with other facility and community sites to provide holistic services to the clients in a continuum including linkages to IgA, food support, kids club, adolescent PLHIV support groups etc. Private health facilities with high client turn over will be engaged to provide free HTC and HIV care services. ECEWS provides supportive supervisions to care providers and emphasises the use of nationally approved care & support SOPs and tools for documentation and reporting..
ECEWS promotes adherence counselling during visits, Defaulter tracking and enhances easy transition of Paediatric clients into adult care and support program for clients turning 16 years old. ECEWS will scale up EID services access to all sites and will promote paediatric ART uptake in line with overall PEPFAR goals. ECEWS participates in National care and support TWGs to promote synergy and experience sharing.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	30,000	0

Narrative:

ECEWS currently supports a standardized HIV indicator reporting systems across 57 sites in Akwa Ibom, Cross River and Abia States; harmonization of data collection and reporting across sites with other donor-supported activities in line with the principle of “One M&E Framework” and in accordance with the national guidelines. ECEWS will work with USG and GON to include ECEWS-supported facilities in the District Health Information System 2 (DHIS2). ECEWS will be an active participant on the USG SI Technical Working Group, supporting PEPFAR in developing and maintaining a unified national data platform for HIV services in Nigeria. ECEWS will be an active participant in the State M&E TWGs, supporting capacity building activities; the development and implementation of the States’ Strategic Plans.
Funding will be used to provide IT infrastructure which will include laptop computers and internet modems for 14 facility-based sites to facilitate and enhance timely and qualitative data collection, aggregation and reporting. One M&E Focal Person will be selected each from all 57 supported sites and trained along with LACA M&E Officers across 17 L.G.As in 3 target states on data collection,

aggregation, analysis and reporting across the relevant National Data Capturing Tools for supported Technical Program Areas and on the use of IT for electronic documentation, analysis and reporting/dissemination of site-level data to all relevant stakeholders.
Monthly central M&E meetings will be held across the 3 focus states for all site M&E Focal Persons in collaboration with the states' SACA for the purpose of data collation and analysis.
ECEWS S.I Team along with SACA and SMoH M&E Staff will conduct regular joint monitoring and supervisory visits to all sites in order to build relationships and capacities within the states as part of DQA activities.
Program performance assessment across all supported technical areas will be performed to provide evidence-based decisions for program quality, impact, and effectiveness. ECEWS will also work with site administrators and staff to improve their knowledge and understanding of the data from their sites to enhance site information use for decision making and planning.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	292,313	0

Narrative:

ECEWS will target 11,692 individuals including youths (aged 10-24) especially girls and vulnerable children who engage in casual sex with multiple partners, widows, divorced/separated and married couples who engage in multiple sexual relationships.
Program implementation will focus on structural, behavioral and biomedical interventions utilizing a combination prevention intervention. CP interventions will focus on strategies like Community awareness campaigns, Peer education model, non-curriculum school-based approach and promotion of HTC. Mainstreaming of intervention activities via HIV abstinence clubs and FBO group meetings will be prioritized for sustainability. Using evidence based age appropriate & population specific curricula, targets will be reached with risk reduction counseling and education; [FLHE manual for lower secondary school, NYSC Adolescent RH/HIV prevention manual for upper secondary school and AHI training manual for adolescents' friendly health services].
An adapted version from the CRS faithful House manual will be utilized to reach other populations in Faith Based Organizations. Interventions will target to delay sexual debut and enhance adoption of secondary virginity as well as reinforce relevant life skills among in-school youths, while promoting mutual fidelity, partner reduction and HTC among young adults and married couples.
Programs are currently implemented in 10 schools and 10 churches in Akwa Ibom, Cross River and Abia states and has reached a total of 2378 individuals in the last 12 months
ECEWS will promote the use of standardized manuals and tools with supportive supervision and refresher trainings provided to reinforce messaging. Referrals will be made for counseling and testing for all beneficiaries while appropriate linkages with condom service outlets and OVC programs will prioritize

for relevant services.

Program monitoring plans will emphasis the use of appropriate combination prevention mix in reaching targets and evaluations will seek possible behavior change and adherence to risk reduction plans.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	148,781	0

Narrative:

ECEWS will target to provide HTC to 23, 616 individuals and 60, 000 individuals in fy12 and fy13 respectively in Akwa Ibom, Cross River and Abia States. ECEWS currently targets MARP populations, STI and TB suspects/patients, children, couples and general population in Akwa Ibom, Cross River and Abia States (HIV prevalence of 10.9%, 7.1% and 7.6% respectively, sentinel survey 2010). In the past twelve (12) months, 21,464 individuals have been counseled and tested for HIV in focus states. ECEWS adopts the provider- Initiated and client- initiated approaches in testing and counseling MARPs and the general population .PITC is provided in TB and STI clinics, ANC settings (where PMTCT services are absent), outpatient and inpatient wards. Home based testing will be provided for partners and family members of HIV-positive patients. Client–Initiated testing and counseling is adopted at stand-alone sites and by outreach/mobile teams to MARPs. Couples HTC and pediatric testing will be scaled up across ECEWS supported sites via targeted outreaches to high prevalence communities and health facilities to promote the test to treat strategy.
PITC and client initiated approaches have resulted in testing of 12,614 and 8,790 individuals respectively in the last 12 months. 14 HCWs were trained on HTC using the national curriculum, while refresher training was provided to previously trained forty (40) HCWs. ECEWS employs the nationally approved serial testing algorithm across all supported sites. STI/TB suspects and HIV positive persons identified via HTC are being referred using a 2 way referral system and clients are provided with escort services for intra facility referrals. A referral directory is deployed in all supported sites and follow-up calls and home visit are used to track client not yet enrolled into care. Population specific BCC materials and condoms are distributed during community mobilization campaigns and outreaches to markets, parks, religious groups and brothels based on clients' individual needs. This activity is aimed at creating demand for HTC. ECEWS quality assurance program includes the use of nationally approved SOPs, Supportive Supervision, Client exit and counselor reflection forms , DTS and EQA.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	231,384	0

Narrative:

ECEWS will target 6,611 individuals (female sex workers and their clients, transport workers, police,

soldiers, STI suspects/patients, female students in higher institution and PLWH) in Akwa Ibom, Cross River and Abia states for sexual prevention intervention. Targets are major drivers of the epidemic in Nigeria and are engaged in transactional sex and multiple concurrent partnerships with FSW having limited ability to negotiate for safer sex. Program implementation will focus on structural, behavioral and biomedical interventions utilizing a combination prevention intervention. ECEWs will employ evidence based adapted peer education plus model for intervention with sex workers, transport workers, uniformed service personnel and youths. Strategies will include community awareness campaigns, peer education model, risk reduction counseling, and promotion/provision of HTC and syndrome management of STIs. HCWs will be trained using the FMOH syndrome management of STI guideline to provide STI counseling and treatment to target populations. MARPs will be linked or provided with HTC. Risk reduction strategies will include partner reduction, negotiation for safer sex and consistent and proper use of condoms. HIV awareness campaigns will be intensified to increase risk perception among beneficiaries and increase demand for HTC, care and treatment. Using appropriate mix and dose of combination prevention intervention 8057 individuals including 830 commercial sex workers have been reached in the last 12 months. Condom availability is enforced across service outlets via the use of LMIS in procurement and supply chain management. Program monitoring visits, review meetings, observation of peer sessions and mentoring on condom demonstration and distribution and proper documentation are major strategies used to promote quality assurance. ECEWS will promote the use of standard tools to aid implementation of the combination prevention intervention with Job aids on risk reduction counseling and standard PEP manuals to guide peer educations. Supportive supervision and refresher trainings will be supported to reinforce messaging and access to condoms and BCC materials will be enhanced via strengthening of existing service outlets.

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: Axios Foundation Inc.	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 591,549	**Total Mechanism Pipeline: N/A**

Funding Source	Funding Amount
GHP-State	591,549

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The focus of COP12 is the expansion of activities and sustainability of the project achievements. The detailed activities include the following: proficiency panel schemes for HIV serology and CD4 will be extended to from 81 to 200 laboratories supported by PEPFAR. In addition, it is planned that 81 labs currently subscribed to HIV serology and CD4 will be expanded to include chemistry and hematology proficiency panels. Following the establishment of a regular calendar of panel testing for HIV serology and CD4, as well as the additional chemistry and hematology panel schemes, a feedback loop will be established in collaboration with MLSCN that addresses poor performing laboratories (corrective action). AXIOS will address all gaps identified by laboratory assessors in preparation for accreditation of the National EQA center (NLEQAC) early in the COP year so that formal accreditation can be sought through Step - wise Laboratory Quality Improvement towards Accreditation (SLIPTA) in the first half of the project year. AXIOS in COP12 will be responsible for the distribution of EID DNA PCR, viral load and TB proficiency panels to all registered laboratories. AXIOS will develop and implement the plan for in -country production of proficiency panels starting with HIV serology and CD4 in COP12. A complete costing guide for developing a second EQA site, developed by AXIOS, will serve as a resource for MLSCN's future EQA endeavors. AXIOS will also increase the current support for Rapid Test Kits Post Market Validation testing from four cycles per year to eight cycles per year by supporting logistics of the national QA team. AXIOS will also support other evaluations/validations of test kits and surveillance to be conducted by government of Nigeria.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	1,200

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Workplace Programs

Budget Code Information

Mechanism ID:	10103		
Mechanism Name:	Lab QA		
Prime Partner Name:	Axios Foundation Inc.		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	591,549	0

Narrative:

COP 2012 is the fifth and final year of funding for the National EQA center development project. The fifth year of the project will be dedicated to obtaining WHO/AFRO accreditation of the NEQA center and assisting MLSCN in the assumption of full management responsibilties of the Center. Budget provides for expansion of proficiency panels from 2 to 4 and also also be responsible for the distribution of EID DNA PCR, Viral load and TB proficiency panels. The COP12 budget provides for the continued acquisiton of panels from external sources for the four panels while working towards preparation for the eventual production of the panels starting with HIV serology and CD4 panels. Addtionally, AXIOS' effort will be directed toward documenting the lessons learned in the development of the Center and creating a workplan for the creation of a second EQA center in Nigeria. In COP 2011 Axios was assigned responsibility for the support of RTK Post Market Validation testing. The COP 2012 budget provides for the increased support including logistics support to members of the national QA team for this validation testing process from four cycles per year to eight cycles per year.AXIOS to also support other test kit evaluations/validations and other surveillance activities that will be conducted by GON

Implementing Mechanism Details

Mechanism ID: 10104	**Mechanism Name: HHS/CDC Track 2.0 ASCP**
Funding Agency: U.S. Department of Health and	Procurement Type: Cooperative Agreement

Human Services/Centers for Disease Control and Prevention	
Prime Partner Name: American Society of Clinical Pathology	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 292,405	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	292,405

Sub Partner Name(s)

(No data provided.)

Overview Narrative

ASCP worked with the University of Jos to revise their medical lab science program curriculum. This curriculum is finalized and has been implemented at the University; however, the lab science department requires final supplies to deliver the curriculum content, namely LCD projectors and corresponding laptop computers to drive them. ASCP proposes to acquire five of each to outfit the department's lecture halls to support the conclusion of the Pre-Service program with the University of Jos. Continue to provide TA and evaluate the Implementation of pre-service curriculum. With the finalized medical lab science curriculum implemented at the University of Jos (the pilot institution), there will be a roll-out to 5 other universities. ASCP proposes to conduct an initial stakeholders meeting to garner curriculum roll-out buy-in, conduct sensitization, and do preliminary assessments of capacity gaps and needs. This meeting would bring program directors and faculty staff from the universities together with representatives from the NUC, Ministry of Health, and CDC. ASCP will support curriculum improvement for schools of health technologies. Develop the education unit of the MLSCN to sustain the program. Build capacity for grant, research writing and publications for faculty staff and USG core lab staff. ASCP will contribute to Nigeria's laboratory accreditation initiative by building capacity in SLMTA facilitators through two SLMTA Mentorship Training workshops to increase the pool of SLMTANs from 7 to 50. The 50 mentors will be trained to roll out to increase the capacity of Nigerians in laboratory accreditation preparedness program. ASCP will continue to support basic trainings in chemistry, hematology, CD4 and phlebotomy for laboratory scientists and technicians.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

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**
Governance and Systems	HLAB	292,405	0

Narrative:

Through COP09 and COP10, ASCP worked with the University of Jos to revise their medical lab science program curriculum. This curriculum is finalized and has been implemented at the University; however, the lab science department requires final supplies to deliver the curriculum content, namely LCD projectors and corresponding laptop computers to drive them. The ASCP proposes to acquire five of each to outfit the department's lecture halls to support the conclusion of the Pre-Service program with the University of Jos.

Continue to provide TA to University of Jos to evaluate the Implementation of Pre-service curriculum. With the finalized medical lab science curriculum implemented at the University of Jos (the pilot institution), CDC-Nigeria has identified 5 other universities for a roll-out. ASCP proposes to conduct an

initial stakeholders meeting to garner curriculum roll-out buy-in, conduct sensitization, and do preliminary assessments of capacity gaps and needs. This meeting would bring program directors and faculty from the universities together with representatives from the NUC, Ministry of Health, and CDC. Develop the education unit of the MLSCN for the improvement of curriculum for training Medical Laboratory scientists. Build capacity of 28 for grant, research writing and publications for faculty staff and USG core lab staff. ASCP will work with schools of health technologies to improve the curriculum for training other categories of medical laboratory workers. ASCP will also contribute to Nigeria's laboratory accreditation initiative by building capacity in SLMTA facilitators through two SLMTA mentorship training workshops. Nigeria currently has 23 labs going through the SLMTA program and there are plans to eventually roll out SLMTA to 300 labs across the country. To support these labs, ASCP will train 50 mentors to build capacity and develop more trained personnel to roll out the program. ASCP proposes to support the training of 50 SLMTA mentors through two non-consecutive two-week workshops that will train 25 participants each. ASCP will continue to support basic trainings in chemistry, hematology, CD4 and phlebotomy for laboratory scientists and technicians.

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	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 292,405	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	292,405

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Clinical and Laboratory Standards Institute (CLSI) began supporting the Ministry of Health

(MOH)/CDC-Nigeria in 2008. CLSI works strategically to provide accreditation preparedness and capacity building assistance aligned with MOH and CDC/PEPFAR goals. Our Goals are to expand and strengthen National Laboratory Quality/comprehensive, standardized document System; build the capacity of the regulatory body (Medical Laboratory Science Council of Nigeria-MLSCN) 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; and work with the strengthening laboratory management towards accreditation (SLMTA-Nigeria) team to complete the rollout process for 23 PEPFAR supported laboratories. CLSI, with MLSCN will continue development of laboratory operational quality management to ensure sustainability of Quality Management Systems (QMS), achieve laboratory accreditation status and continued expansion of QMS and accreditation for all tiers. To further support the Global Health Initiative's goal of country ownership/strengthening, additional QMS workshop will be scheduled to train cohort of in-country laboratory mentors. Building capacity of local laboratory personnel ensures the continuation of accreditation activities, allowing a timely exit of the technical assistance providers. Funding levels directly determine number of training sessions/mentorships CLSI can conduct. A more intensive program-expanding number of laboratory interventions, increases rate of accreditation success. Collaboration between Lab Coalition partners and MLSCN on training/mentorships is a cost effective way to ensure broad application of technical assistance to rapidly achieve program goals.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	2,924

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Workplace Programs

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
Governance and Systems	HLAB	292,405	0

Narrative:

"Quality laboratory services play a crucial role in public health in both developed and in developing countries by providing reliable, reproducible, and accurate results, for disease detection, diagnosis and follow-up of treatment." CLSI anticipates a continuation of its laboratory and management strengthening activities in Nigeria during the 2012 COP funding year.

CLSI will work closely with CDC Nigeria to provide technical experts to MOH and the MLCSN to conduct activities that are described below for lab strengthening and country ownership:

• Beginning in September 2012, or as funds become available, CLSI will plan a laboratory Quality Management/Capacity Building workshop on Validation/Verification and QC.

• CLSI will provide necessary CLSI standards, guidelines and best practice documents for dissemination in Nigeria.

• CLSI will support mentorships with the MLSCN and/or designated laboratories.

• To further support the Global Health Initiative's goal of country ownership and strengthening, an additional QMS workshop will be scheduled during the year to train a cohort of in country QMS laboratory mentors.

• Two 12-month CLSI memberships for CDC Nigeria designees: including Infobase (CLSI's electronic access to over 200 CLSI approved and proposed consensus documents).

• CLSI will sponsor two individuals to attend the Leadership Conference in March 2013, and subsequent visits to clinical laboratories to observe best practices.

• CLSI will continue to provide consistent support and advisement remotely to facilitate self-assessment and CQI for accreditation preparedness. 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 Details

Mechanism ID: 10107	**Mechanism Name: American International Health Alliance Twinning Center**
Funding Agency: U.S. Department of Health and Human Services/Health Resources and Services Administration	Procurement Type: Cooperative Agreement
Prime Partner Name: University of Nigeria, Nsukka, School of Social Work	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 360,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	360,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

AIHA is a nonprofit organization working to advance global health by helping communities and nations with limited resources to build sustainable institutional and human resource capacity. Through twinning partnerships and other programs, AIHA provides technical assistance using the knowledge and skills of experienced physicians, nurses, social workers, administrators, educators, allied health professionals, and civic leaders. Established in 1992 to initially support health twinning partnerships between the United States and the countries of Central and Eastern Europe and the former Soviet Union, AIHA's programs address critical public health and development issues such as HIV/AIDS and other infectious diseases, maternal and child health, primary care, emergency and disaster preparedness, and health professions

education and development. Through the Twinning Center nearly 40 twinning partnerships and initiatives have been established in 10 countries in sub-Saharan Africa, and in the Russian Federation in support of PEPFAR. As in all AIHA partnerships, the Twinning Center focuses on the creation of peer-to-peer, voluntary relationships between healthcare and related institutions, including schools of the health professions. Current outcomes for AIHA Nigeria for FY 11 include 150 Para Social Workers trained after the initial pilot phase of PSW, which included a Proof of Concept I & II as well as trainer, facilitator and supervisory trainings. At conclusion of the pilot phase, PSW I, 6 month supervisory period, and PSW II were conducted and trained 150 this fiscal year. The goal of AIHA is to continue to build sustainable human resource capacity which is a crucial element in contributing to the Human Resources for Health Indicators in Nigeria.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**10107**
Mechanism Name:	**American International Health Alliance Twinning Center**
Prime Partner Name:	**University of Nigeria, Nsukka, School of Social Work**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	360,000	0

Narrative:
The first Nigeria Twinning Partnership was initiated in September of 2008 which is funded by CDC Nigeria aimed to: To strengthen the capacity of Nigerian Social Work Educational Institutions to provide knowledge and skills necessary to ensure the provision of comprehensive social services for Orphans and Vulnerable Children in Nigeria. Partners include University of Nigeria Nsukka- School of Social Work; Federal School of Social Work Emene- Enugu; and constituents from both the United States and Tanzania. The goal is to improve the health and well being of the vulnerable children and families in your communities by creating a work force of Para Social Workers. Para Social Workers are local people who have been trained to provide para professional support to vulnerable families. The training gives people skills to identify, assess, and link to the care system and provide ongoing support based on local, national and international standards of care. Para Social Workers learn basic principles of social work; child and human development; and HIV management. To be certified as a Para Social Worker (PSW), a trainee needs to complete a six month training regimen, which includes an initial 8 day PSW I training, 6 month supervisory/evaluation period and a follow up 5 day PSW II training. The goal of AIHA in FY 12 is to train 220 PSW for FY 2012 at the local level to address the pressing needs of the community. The overall goal is to contribute to congressional mandate of 140,000 new health care workers which can meet local demands for care necessary for orphans and vulnerable children in Nigeria. In doing so, we will expand to an additional institution within the central region, specifically Benue State. This state has one of the highest statistics of OVC in Nigeria and therefore demand reiterates the need to train PSW in this region. University of Calabar will also be considered for expansion, dependant on increase of funding. AIHA will also access needs with regard to the trainings halls at each facility.

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	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 698,058	**Total Mechanism Pipeline: N/A**

Funding Source	Funding Amount
GHP-State	698,058

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Population Council shall continue to provide HVAB, HVOP,HTC and CHTC to Most at risk populations (MARPs) and their partners and other vulnerable populations in communities. Population Council will use a combination of behavioral, biomedical and structural strategies both at individual and community levels to provide comprehensive prevention services to MARPs and will report numbers of individual reached in accordance with current monitoring indicators. Council's service delivery is targeted at the MARPs: Men who have sex with men (MSM), Injecting drug Users (IDU), Client of female sex workers (CFSW), vulnerable populations and partners of MARPs. To achieve the HTC target and maintain quality in the number of services that will be provided in communities, service providers must be knowledgeable and skilled.HTC services at the community will include a functioning referral system to identified health facilities at primary level like primary health care facilities and private institutions. The services will ensure that HIV positive patients and clients are linked to care and treatment services, and that HIV negative clients and patients are linked to prevention services. Population Council will report monitoring and evaluation activities and data collection collected regularly and routinely with standardized MIS tools. Population Council will conduct regular supervision to sites/fields and will ensure and maintain data completeness and accuracy through this process. Population Council will provide a comprehensive progress report on the following PEPFAR HTC indicator as requested by CDC. As part of supervision, regular on-site monitoring and supervision shall be conducted in order to ensure data quality.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **No**

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors

Mobile Population

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**
Prevention	HVAB	27,767	0

Narrative:

POPULATION COUNCIL is required to describe in detail the strategies employed to provide comprehensive prevention services with the AB funds received. In particular, they should pay attention to the combination prevention approach they employed as outlined in the National HIV/AIDS Prevention Plan 2010 – 2012 which should include Behavioral, Bio-medical and Structural Interventions. They will be expected to describe in detail the population groups and the drivers of the epidemic they target with their mix of interventions. The report should include results achieved against FY12 targets on NGI P8.1.D (general population reached with comprehensive combination prevention interventions) and P8.2D (general population reached with AB interventions), challenges encountered if any and measures taken to overcome the challenges. The partner will be expected to address in detail what quality improvement interventions they have included in their programs as well as a description of their monitoring and evaluation tools.

The partner should also address collaborations with Government of Nigeria (whether at federal, state or local government level) and other partners; efforts at integration with other programs such as HCT, PMTCT, Blood Safety, Continuum of Care and Treatment and Reproductive Health (including Family

Planning, Maternal Newborn and Child Health); referrals and linkages with other services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	40,896	0

Narrative:

PopCouncil should provide comprehensive progress report on: HIV Testing and Counseling (HTC) services carried out to MARPs at Service Delivery Points (SDPs) offering HTC services and at TB DOT sites and determine percentage contribution to the overall FY12 HTC target; couples' testing and counseling (CHTC) activities; number of health workers trained on HTC and CHTC; number of sites providing HTC services according to national and international standards; Quality assurance (QA) measures on counseling and testing components of its service delivery and M&E activities carried at the sites. Detail report should include those tested positive to HIV and disaggregation of the population served by gender, age (<15 and 15+) and type of SDP (hospital-based, stand-alone and mobile).The partner should also address the impact, if any, of collaborations with Government of Nigeria (whether at federal, state or local government level) and other partners; efforts at integration with other programs such as Continuum of Care and Treatment and Reproductive Health (including Family Planning, Maternal Newborn and Child Health); referrals and linkages with other services. In addition, PopCouncil should mention strategies adopted to ensure sustainability of programs at all levels of service delivery and involvement of local communities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	629,395	0

Narrative:

POPULATION COUNCIL should describe in detail the strategies employed to provide comprehensive prevention services with the OP funds received. In particular, they should pay attention to the combination prevention approach they employed as outlined in the National HIV/AIDS Prevention Plan 2010 – 2012 which should include Behavioral, Bio-medical and Structural Interventions. They will be expected to describe in detail the population groups and the drivers of the epidemic they target with their mix of interventions. The report should include results achieved against FY12 targets on NGI P8.3D (MARPs reached with comprehensive combination prevention interventions), challenges encountered if any and measures taken to overcome the challenges. The partner will be expected to address in detail what quality improvement interventions they have included in their programs as well as a description of their monitoring and evaluation tools.

POPULATION COUNCIL should also describe collaborations with Government of Nigeria (whether at federal, state or local government level) and other partners; efforts at integration with other programs such as HCT, PMTCT, Blood Safety, Continuum of Care and Treatment and Reproductive Health

(including Family Planning, Maternal Newborn and Child Health); referrals and linkages with other services.

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	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 2,471,468	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	2,471,468

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The VU/FGH strategy for COP12 will focus on integration of program areas to create a sustainable functional HIV/AIDS service delivery units in all supported facilities. VU/FGH is committed to fulfilling the following objectives:

1) Strengthen existing facilities and systems to effectively provide quality HIV-related service delivery in operational states.

a) Increase access to PMTCT services through the engagement of public and private health facilities in Niger, Kwara, and four additional high HIV burden contiguous states.

b) Upgrade existing PMTCT sites to comprehensive care and treatment centers to support surrounding primary health care facilities.

c) Establish results-based financing systems with health facilities to engender site ownership and responsibility in delivery of services.

d) Strengthen utilization of strategic information to guide decisions in service delivery.

2) Increase clinical and health management knowledge, skills of health-care workers and health administrators

a) Train and retrain health care staff in HIV Prevention, Treatment, Care and Support.

b) Train site, LGA and state government workers on effective monitoring and evaluation.

c) Monitor quality of service delivery and effectively mentor site staff in service provision.

3) Establish and strengthen communication and coordination between health facilities and communities

a) Strengthen linkages between communities and facilities to improve adherence, retention rates and minimize stigma.

b) Create a community support system that will help identify health needs, complement HIV care and enhance quality of life of PLWHAs.

c) Link primary health care centers with secondary facilities to increase access.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Commodities	247,147
Food and Nutrition: Policy, Tools, and Service Delivery	72,350
Human Resources for Health	123,573

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

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
Child Survival Activities
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	163,954	0

Narrative:

In COP12 FGH will continue provision of services to clients with emphasis on community based care and support built on strengthened community support systems. FGH HBC teams will continue to provide community services as well as linkage to the facilities where the patients are accessing treatment around all 11 comprehensive sites. FGH will expand services to 16 additional sites in 4 contiguous states where the burden of the epidemic is high or likely to exceed the national average, if additional funds are available.

Goals include:
1. Improved care and quality of life for (PLHIV) and their families: VU/FGH will continue provision of high quality comprehensive facility and community-based adult care and support services to PLHIVs and their families, enhance patient retention and continuum of care within community support systems. Food by prescription (FBP) program will continue to be part of the standard of care in all FGH supported sites through the provision of therapeutic or supplementary food to malnourished HIV-infected clients. VU/FGH will continue treatment support services across all supported centers to provide BCP, adherence, PwP, HBC, etc through continuous patient engagement.
2. Increased community support for (PLHIV):
VU/FGH Care programs will leverage on state-run programs on malaria and economic strengthening activities, encourage new clients to join support groups at the facility or community levels, will map

locations of clients to engage in services through a tiered CSS structure by engaging active support group clients to support provision of sustainable care services, strengthen existing (HBCW) by encouraging support group members to join CSS teams to enhance monitoring and follow-up of clients missing appointments or experiencing difficulty in treatment adherence.
3. Increased number of trained health care workers and volunteers in care and support: VU/FGH will Increase the number of HBCWs & community workers to further extend services from comprehensive centers to the communities. HBCWs workers will be trained to improve client tracking, provide adherence support and basic home nursing care.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	84,106	0

Narrative:

VU/FGH will continue to partner with CBOs to support OVC services in Niger and Kwara states. FGH will expand services to 4 additional states where the burden of the epidemic is high or likely to exceed the national average if funding permits.

The goals of FGH OVC program include:

1. Improved access to OVC service areas: VU/FGH will continue provision of orphans and vulnerable children (OVC) services to enrolled children in Kwara and Niger states on a prioritized case-by-case basis in the following areas: 1) Healthcare; 2) Nutrition; 3) Psychosocial; 4) Education; 5)Legal/birth registration; 6) Economic strengthening; and 7) Shelter (extreme situations only).
2. Increased collaboration and involvement of local government in OVC efforts: VU/FGH will partner with state governments to leverage available resources for OVC services. Opportunities in microfinance and other economic strengthening activities will be sought with the National Poverty Eradication Program.
3. Delivery of quality care and support services to OVC: VU/FGH will work with CBO partners to establish an OVC monitoring and evaluation system. VU/FGH will orchestrate routine quality control visits to evaluate OVC program performance, accurate record keeping, referral linkages, and compliance with standard operating procedures.
4. Increased knowledge of OVC care and support services among community workers and volunteers: VU/FGH will provide training or re-training in implementation of OVC services including monitoring and evaluation of program activities. VU/FGH will provide training and re-training of selected partner CBO and OVC volunteers in implementation of OVC services including monitoring and evaluation of program activities. Once new CBO is selected, VU/FGH will provide additional information including CBO assessment, capacity, training plans and, where applicable, linkages that will be established.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Care	HVTB	92,955	0

Narrative:

In COP12, VU/FGH will continue implementing the strategy of the Three 'I's: provision of isoniazid preventive therapy (IPT); intensified case finding for active TB; and TB infection control, especially in ART settings, following national guidelines. Other activities will include multi-drug resistant (MDR) TB case identification following National TB and leprosy Control Program (NTBLCP) guidelines, patient referrals to designated MDR-TB treatment facilities, strengthening TB laboratory and chest x-ray services, and basic infrastructure renovations at DOTS and TB laboratory sites.

Program objectives include:

1. Improve service delivery in TB-HIV care to eligible clients: VU/FGH will continue to symptomatically screen all adult and pediatric HIV-infected clients for TB during routine HIV care and treatment visits and create an active referral system between ART and TB DOTS clinics to link patients to care and treatment. VU/FGH will enhance TB diagnosis in all PHC-DOT centers using available technology in co-infected, predominantly smear negative patients including provision of LED FU microscopes at selected comprehensive sites. VU/FGH will monitor treatment completion rates, defaulter patterns and case detection rates in FGH-supported DOTS sites through linkage of NTBLCP recording systems and the PMM system of ART care and treatment.

2. Increase capacity and knowledge of TB-HIV service delivery: VU/FGH will continue to improve the capacity of health facility staff to diagnose, treat, and monitor TB among HIV-infected individuals by upgrading onsite laboratory and DOTS services in all supported sites. VU/FGH will integrate TB/HIV training curriculum into routine activation training based on IMAI/ IMCI curriculum. VU/FGH will train and retrain facility staff in assessment and implementation of TB infection control per national guidelines at all sites

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	20,736	0

Narrative:

VU/FGH will continue provision of comprehensive, high quality, facility- and community-based pediatric care and support to HIV infected clients in all 11existing treatment sites. FGH will expand services to 16 additional sites in 4 contiguous states where the burden of the epidemic is high or likely to exceed the national average if additional funds are available.

1. Improved care and quality of life for PLHIVs (pediatric) and their families: VU/FGH will continue provision of high quality comprehensive facility and community-based pediatric care and support services in all treatment sites comprising of: periodic clinical and laboratory monitoring, growth monitoring,

prevention and treatment of opportunistic infections, pain management, psychosocial and spiritual support, nutritional assessments and counseling and home-based care visits.VU/FGH will continue to provide clients with basic care kits including monthly refills of consumable kit contents and emphasize Prevention with Positives (PwP) services as a routine component of clinicalcare.VU/FGH will continue to enroll additional sites to the national (EID) program in accordance with national EID scale up plan.

2. Increased coverage and community support to PLHIVs Peads and families. HIV positive clients and their families focusing on integration of pediatric care and support with health and development programs.VU/FGH will support implementation of adolescent friendly services, such as integration of syndromic management of STIs with ongoing HIV care activities and promotion of risk reduction and PwP activities.VU/FGH will identify and enroll pediatric clients living with HIV through PMTCT program, immunization days, PITC, community outreach. FGH will train care givers on empowerment through IGA, leveraging government programs, NAPEP, microfinance schemes etc

3. Increased knowledge in pediatric care and support among healthcare workers and families: VU/FGH will train or re-train healthcare workers in child basic care and support services including elements of positive living package. VU/FGH will also train HBCWs to support services in communities

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	504,496	0

Narrative:

During the period covered, VU/FGH will concentrate on supporting routine diagnostics for monitoring clients on ARVs and conduct internal and external QA activities consisting of quarterly site monitoring visits using standardized monitoring tools developed by the USGPEPFAR. VU/FGH will register all comprehensive laboratories and PMTCT sites with National Laboratory External Quality Assurance Center (NLEQAC) for Proficiency Testing (PT).
Strengthened laboratory facilities to support HIV/AIDS related activities.
a) VU/FGH will continue supporting routine HIV/AIDS-related laboratory service-delivery activities in established comprehensive and satellite sites through continuous training and mentoring.
b) VU/FGH will continue participating in USG-PEPFAR coordinated LTWG to ensure harmonization of other IPs and GON-supported laboratory programs and get on national and international accreditation.
c) VU/FGH will continue to work with PEPFAR LTWG to develop common lab equipment platform appropriate for each laboratory level to ease equipment procurement, usage, maintenance and minimize reagents wastage.

d) VU/FGH will conduct internal QA activities consisting of quarterly site monitoring visits using a standardized monitoring tool.
e) VU/FGH will support provision of laboratory services for HTC in new PMTCT sites.
f) VU/FGH will register all comprehensive laboratories with Medical Laboratory
Science Council of Nigeria to continue progress in meeting requirements for acquiring national accreditation.
g) VU/FGH will provide standardized training on quality system management (QSM) to laboratory scientists in the sites to prepare for national and international (WHO-AFRO) accreditation.
h) VU/FGH will continue supporting production and performance of internal quality assurance dried tube specimen (DTS) for HIV serology.
i) VU/FGH will perform routine preventive and periodic maintenance of laboratory equipment for optimal performance. VU/FGH will sign contract with equipment vendors for routine maintenance and servicing.
j) VU/FGH will incorporate Point-of-Care (POC) HIV Monitoring for Primary Health Centers/PMTCT sites using Cyflow miniPOC device.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	70,000	0

Narrative:

FGH will continue to support strategic information activities for providing the necessary evidence-base to guide program implementation in FGH states of operation. FGH will expand services to 16 additional sites in 4 contiguous states where the burden of the epidemic is high or likely to exceed the national average if additional funds are available.

1. Established Reporting and Monitoring and Evaluation (M&E) systems in all sites: FGH will train staff and support use of national M&E tools at sites, adopt the use of DHIS platform as the national reporting system in service delivery points. FGH will continue to strengthen states to utilize HIV/AIDS data, train site staff at LGA and PHCs on use of HIV/AIDS program monitoring tools as well as provide continuous mentoring and feedback.
2. Improved data quality and sustainable M&E efforts: VU/FGH will work in line with GoN SI polices and guidance to support PFIP and fulfill all obligations of USG and national government reporting requirements.
3. Improved service quality through compliance monitoring and performance measurement: VU/FGH will conduct periodic review of program monitoring and service quality data to help support design and implementation of high quality and sustainable programs. FGH will train site staff on CQI activities and build their capacity to implement and integrate QI activities into routine activities in HIVcare.

4. Improved utilization of available program data for Evidence-based decision in planning and program Improvement (Operations Research): VU/FGH will continue to utilize program data to identify effective strategies, the gaps in programming, new innovations that can improve access or quality of services and to establish the cost effectiveness or otherwise of the current interventions.

5. Improved national Surveillance and research activities: VU/FGH will continue to avail its services to the GoN in the design and conduct of large population-based surveys to help define magnitude and monitor trend of HIV infection in the country, studies among high-risk population groups that involve determination of size of MARP groups as well clinic-based studies for monitoring drug–resistance among patients receiving antiretro-viral therapy.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	0	0

Narrative:

VU/FGH will continue to provide in-service training for health care facility staff in the following areas:
1. ART Adult: Train and retrain doctors nurses, pharmacists, technicians, CHEWS, medical records staff and other health workers in various aspects of HIV/AIDS service delivery including task-shifting of responsibilities to lower cadre health workers.
2. ART Pediatric: Train two doctors and four nurses on pediatric HIV care in VU/FGH supported facilities.
3. TB/HIV: VU/FGH will continue to improve capacity of health facility staff to diagnose, treat, and monitor TB among HIV-infected individuals by upgrading onsite laboratory and DOTS services. FGH will integrate TB/HIV training curriculum into routine activation training for treatment and PMTCT sites based on IMAI/ IMCI curriculum.
4. BC&S: HBCWs workers will be trained on improved client tracking, adherence support and basic home nursing care, including child basic care and support services and positive living package.
5. PMTCT: FGH will build capacities of health workers in delivery of PMTCT services. TBAs will continue to be trained on provision of HTC services and referral of HIV-infected pregnant women to the nearest VU/FGH treatment site.
6. Lab: FGH will provide standardized training on quality system management to laboratory scientists in the sites to prepare for national and international accreditation.
7. HTC: VU/FGH will partner with LGA PHC coordinators to train, coordinate and implement targeted community HTC strategy. VU/FGH will implement quality assurance/quality control (QA/QC) program that provides on-site evaluation, proficiency testing, and linkage to a reference laboratory.

8. SI: VU/FGH will train staff and support use of national M&E tools at sites, and adopt the DHIS platform as the national reporting system in service delivery points. VU/FGH will continue to strengthen states to utilize HIV/AIDS data, train site staff at LGA and PHCs on use of HIV/AIDS PMM tools as well as provide continuous mentoring and feedback.
9. OVC: VU/FGH will provide training in implementation of OVC services, including program M&E activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	77,582	0

Narrative:

FGH 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).
FGH will provide prevention programs in collaboration with experienced community-based organizations NGOs(SYDOCK)in Kwara and peer educators to reach commercial sex workers (CSWs) and other individuals along the Olorun Kanbi community along Ilorin Jebba Road transport road, Lambata community in GAWU transport road, including truck drivers and those who engage in transactional sex at overnight motor parks. It is anticipated that seroprevalence among this group exceeds 20%. The number of targeted truck stops will be maintained at 2sites FGH will also targets out-of-school youth via community centres and organized activities supported through OVC programming. Condoms and other prevention programming will be balanced with AB prevention messages for youth in these settings.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	238,588	0

Narrative:

VU/FGH will continue to focus on providing high quality provider-initiated HIV testing and counseling services (HTC) to adult and pediatric patients in all supported facilities. All new clients will receive HTC services in line with the national testing algorithm.

HTC program objectives include:

1. Increase knowledge of HIV status through effective testing and counseling services: VU/FGH will

maintain ongoing HTC service-delivery activities at comprehensive and satellite sites in line with the Nigerian HTC Guidelines. These include Provider initiated HTC at health care facilities, Opt-out HTC for patients receiving treatment for TB at sites with TB-DOTS centers, Point-of-service testing in the antenatal care (ANC) center and inpatient wards, outreach HTC targeting MARPS and couple testing and counseling. VU/FGH will implement Couples HIV Testing and Counseling (CHTC) services to encourage partner reduction and fidelity in concordant HIV negative couples and reduce HIV transmission in sero-discordant couples.

2. Increase enrollment into care and treatment through established referral systems and ownership of HTC programs: VU/FGH will strengthen referral systems by partnering with state HIV/AIDS care agencies to map all available state care and treatment services. This information will be utilized in all PHCs to link HIV-positive patients to care and treatment services, and HIV negative-patients to prevention services. VU/FGH will actively utilize site-based referral forms and registers to track proportion of clients successfully linked to care and treatment.

3. Strengthen local capacity for delivery of quality HTC services: VU/FGH will partner with LGA PHC Coordinators to coordinate and implement targeted community outreach HTC strategy among MARPs. This will include several quality assurance (QA) methods to create efficient HTC programs ensuring quality service delivery in collaboration with the state ministries of health/SACAs. VU/FGH will implement a quality assurance/quality control (QA/QC) program that provides on-site evaluation, proficiency testing, and linkage to a reference laboratory.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	305,084	0

Narrative:

FGH will support risk reduction and safer sex promotion activities among HIV-positive clients, partners, and members of their households. The comprehensive package of prevention interventions will include provider and counsellor delivered prevention messages, family planning counselling, STI management and treatment, and testing of partners and children. Lay counsellors within the community, including peer educators will be mobilized for more in-depth counselling on key prevention issues such as: sexual risk reduction, disclosure, adherence, reduction of alcohol consumption, and partner testing. Condoms and information on proper condom use will be available in community settings of MARPs..These services will be linked to facility based PwP interventions. FGH supported sites will integrate prevention with positives (PwP) activities including: adherence counselling; syndromic management of STIs in line with National STI control policy and guidelines; risk assessment and behavioural counselling to achieve risk reduction; counselling and testing of family members and sex partners; counselling for discordant couples; and IEC materials and provider delivered messages on disclosure.

Site level trainings for Nurses& CHEWS in STI syndromic management will be carried in Kwara & Niger states& supported PHCs. Peer educators & PLWHAs will be trained by FGH CLO/C&S program Officers and NGO subcontractors using a curriculum developed by FGH CLO focusing on truck stop and commercial sex settings as well as a manual on interpersonal communications, General training will include risk stratification, disclosure and couple counselling, proper condom use, and syndromic STI management training for health care workers.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	339,300	0

Narrative:

FGH will build on its past successes of collaboration with the Nigerian government through the NPHCDA, NACA and participation of state governments to provide PMTCT services to the rural and under-served populations using a cluster-model approach by saturating PHC service delivery points around a Hub-secondary health facility. All the existing 11 hub sites and over 100 satellite sites will continue to provide PMTCT services. In addition, FGH will expand services to 16 additional sites in 4contiguous states where the burden of the epidemic is high or likely to exceed the national average, if additional funds are made available in COP12. VU/FGH will continue to engage private health clinics to provide non-profit PMTCT services to a large proportion of underserved population as well as leverage on the existing community health structures to improve PMTCT service uptake, retention, linkage to treatment and mainstreaming with other reproductive health services.
The goals of FGH PMTCT program include:
1. Increased PMTCT coverage and effectiveness: VU/FGH will adopt a family-centered approach for HTC of pregnant women, increase child testing at pediatric service delivery points, including use of Immunization days.

2. Increased collaboration with community leaders and local partners to create demand for services: VU/FGH will involve community leaders and local organizations to establish and strengthen community-based health committees, linkages, improve male involvement and engender ownership.

3. Capacity building for Healthcare providers: VU/FGH will build the capacities of the different cadres of health workers involved in the delivery of PMTCT services. TBAs will continue to be trained on how to provide HTC and refer HIV positive pregnant women to the nearest FGH treatment site.

4. Integration with Reproductive Health and other services: We will integrate PMTCT services with reproductive health, malaria program and other services in line with the Global Health Initiative principles. These services will be available at all hub sites in order to provide our clients with a qualitative and robust

maternal and child health package.
As part of our strategy to increase the uptake of HTC at antenatal clinics in supported PMTCT facilities, we shall defray/absorb antenatal booking/registration fees for all pregnant women. In addition, we shall ensure that communities served by the health facilities are adequately informed of this benefit/privilege through local media outlets and strategically placed IEC materials.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	147,054	0

Narrative:

ARVs will be sourced by SCMS for VU/FGH ART patients.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	333,942	0

Narrative:

As of COP 11, VU/FGH supports care and treatment services in seven comprehensive sites in Niger state, Kwara state and the Federal Capital Territory, and their feeder PHCs. In COP 12, four additional PMTCT sites will be upgraded to bring total number of comprehensive sites to eleven. Upon availability of additional funds, in COP12 VU/FGH will add 16 number of comprehensive sites in 4 contiguous high HIV/AIDS burdened states.
VU/FGH will continue to provide antiretroviral therapy (ART) per national guidelines, collaborate with the state ministries of health to train a core group of trainers on provision of quality HIV/AIDS comprehensive services and continue to mentor healthcare staff in service quality improvement.
Objectives of FGH treatment program are:

1. Access to quality ART and improved adherence to treatment for HIV-infected individuals: VU/FGH will support provision of uninterrupted ART following national guidelines to HIV-infected adults in 27 comprehensive centers. Patient adherence and partner support will be enhanced by the community component of the program (see Adult Care and Support for more detail).

2. Strengthen local capacity in ART delivery and sustainability of services: FGH will continue to support the state ministries of health in training core group of trainers on ART and decentralization, utilizing the Integrated Management of Adult Illnesses (IMAI) curriculum for implementation and support of services in VU/FGH supported sites. In addition to training, VU/FGH will implement a performance-based funding mechanism to increase site ownership and responsibility of HIV/AIDS services, empowering and rewarding health care facilities for quality service delivery.

3. Improve ART service delivery through decentralization at PHC facilities: VU/FGH will decentralize drug pick-ups and task-shifting responsibilities to PHC level to improve patient compliance, expand access and minimize burden at comprehensive facilities. VU/FGH will strengthen mentoring roles of staff at the comprehensive facilities thereby maximizing staff output, and enhancing communication between facilities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	93,671	0

Narrative:

VU/FGH will continue to support child-friendly pediatric treatment services in seven comprehensive treatment sites in Niger state, Kwara state and FCT. In COP 12, four existing PMTCT sites will be upgraded to comprehensive facilities thereby bringing the total number of comprehensive sites to eleven. Subject to availability of additional funds, VU/FGH will provide HIV treatment and care services to 16 additional sites in 4 high HIV/AIDS burden contiguous states.
Program Objectives for pediatric treatment are:
1. Improve access to Anti-Retroviral Therapy (ART) for eligible HIV-infected children: VU/FGH will continue to provide ART per national treatment guidelines to HIV-infected pediatric clients at 11 care and treatment sites. VU/FGH will identify and enroll pediatric clients living with HIV through the PMTCT program, provider-initiated counseling and testing services, and targeted community outreach.

2. Improve adherence to treatment and retention of HIV-infected children on antiretroviral therapy: VU/FGH will improve retention of enrolled pediatric clients through monthly adherence counseling, youth-friendly support groups and linkage to OVC programs. VU/FGH will assure uninterrupted ART services by establishing electronic reminders, creating effective client tracking systems and providing regular adherence counseling to clients and their caregivers.

3. Increase knowledge and skills in pediatric HIV/AIDS care and treatment among national healthcare workers focusing on best practices: VU/FGH will train and re-train clinical site staff in accordance with national guidelines and in line with principles outlined in the Integrated Management of Childhood Illnesses (IMCI) concept.

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 Bloomberg School of Public Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,075,096	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	1,075,096

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Zamfara Akwa Ibom HIV/AIDS Project (ZAIHAP) as currently being implemented by Jhpiego has the overall goal to establish sustainable approaches for the reduction of morbidity and mortality due to HIV/AIDS among vulnerable populations. Also has the mandate to scale-up PMTCT and HCT programs using the platforms of integrated health services and community outreach.ZAIHAP approaches are in line with the country current strategic objectives.ZAIHAP in COP 12 among other things will continue to strengthen the capacity of care providers to implement quality HIV services and to expand primary prevention of HIV services to other sites based on the current trend of HIV in the two project states.

ZAIHAP will continue to work with the State Ministry of Health (SMoH) and State Agency for Control of AIDS (SACA) to coordinate HIV activities and also support activities that will increase access to the use of high quality PMTCT services at facility and community levels.ZAIHAP particularly in Zamfara state will continue to provide leadership role as the lead IP to support the state to coordinate its PMTCT activities, support the state to establish and nurture the state owned PMTCT program

HIV testing and counseling using the opt-out approach will be provided to all pregnant women at the time of antenatal booking. HIV positive pregnant women will be provided with a complete course of ARV prophylaxis based on either option A or B as supported in the national PMTCT guideline.

All HIV positive women will be counseled on appropriate infant feeding option using national PMTCT guidelines .All HIV exposed infants will be supported to access Early Infant Diagnosis (EID) and also linked postpartum to the nearest pediatric ART treatment and OVC services sites.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	80,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's legal rights and protection
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 Bloomberg School of Public Health**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVCT	293,616	0
Narrative:			
In COP 12, four additional high volume potential HTC sites have been identified. HTC services will be scaled up to these sites from the two project states.HTC fund will be expended in very minimal			

percentages to cover the following various costs: Personnel, Fringe Benefits, Program Activities, Other Direct Costs and Indirect Costs

Just as it was in COP 11, 90% of the total HTC fund will cover different program activities that will ensure ongoing HTC service delivery in all its supported sites. The activities will include but not limited to the following categories to support different programs including: training; Supplies (Educational Materials and Supplies); Rental Short Term (Conference Room); Rental Equipment; Meeting costs (Lunch-Coffee Breaks); Printing; Conference Registration (Tuition); Participant Costs (Travel expenses); General Contracts (Translation Services, Design Services; Courier/Delivery Services

HTC will contribute an insignificant amount to personnel salaries and fringe benefits because of its low funding level. Below are the lists of some key HTC activities proposed for COP 12:

? Conduct HTC related trainings to enhance the quality of HCT services provided: HTC, Couple Counseling, Infection Control and Quality Control/Assurance trainings .Trainings will be spread across the year and carried out in collaboration with other partners implementing at ZAIHAP locality to share cost especially to pay for the hall and to pay the consultants.

? Support and establish PITC as a model in all the new sites and strengthens PITC in all the old sites

? Conduct outreach targeting MARPs around the communities where ZAIHAP HTC services are located

? Establish in the new sites and strengthens in the old sites QA/QC activities

? Update and produce job aids (cue charts) for HTC and ensure its availability and usage at all the newly supported and old sites

? Strengthen couple counseling activities in all the supported sites by training providers on couple counseling and follow-up with supportive supervisory visits to all the sites regularly to ensure quality of service is maintained

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	781,480	0

Narrative:

In COP 12, the significant part of MTCT budget will be dedicated to support service delivery and PMTCT scale up plans, a minimum of seven new high volume potential PMTCT sites have been identified. PMTCT services will be scaled up to these sites in the two project states .In addition, some potential PHCs have equally been identified for the scale up exercise

MTCT fund will be expended in different percentages to cover the following costs: Personnel, Fringe Benefits, Program Activities, Other Direct Costs and Indirect Costs

Just as it was in COP 11, 44% of the total MTCT fund will cover different program activities which will include but not limited to the following categories to support different programs including: trainings, attending meetings etc.: Supplies (Educational Materials and Consumables); Rental Short Term (Conference Room); Rental Equipment; Meeting costs (Lunch-Coffee Breaks); Printing; Conference

Registration (Tuition); Participant Costs (Travel expenses); General Contracts (Translation Services, Design Servs); Courier/Delivery Services The most significant and the largest source of ZAIHAP program level funding based on COP 11 was MTCT funds, this will also have to contribute significantly to the personnel's salaries and fringe benefits. The remaining funds will be used to cover other program activities Trainings to support quality PMTCT service delivery especially at the newly proposed sites will be spread across the year and will be carried out in collaboration with other partners that implements in ZAIHAP locality to be able to share some costs especially consultants' honorarium, hall rental and some other costs that can be easily shared Some aspect of this fund will also be used to cover some key activities like:cost of trainings,cost of minor renovation at some of the new sites,cost of puchase at least 6 low cost point of care CD4 for some of the new and old PMTCT to improve the quality of PMTCT services . As part of our strategy to increase the uptake of HTC at antenatal clinics in supported PMTCT facilities, we shall defray/absorb antenatal booking/registration fees for all pregnant women. In addition, we shall ensure that communities served by the health facilities are adequately informed of this benefit/privilege through local media outlets and strategically placed IEC materials.

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: AIDS Prevention Initiative in Nigeria, LTD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 36,603,799	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
Central GHP-State	12,410,577
GHP-State	24,193,222

Sub Partner Name(s)

(No data provided.)

Overview Narrative

In COP12, APIN will provide comprehensive HIV Care and treatment program in 38 treatment sites across 10 states of the federation. With the renewed focus on high burden populations and low coverage states APIN will activate expansion sites in Benue, Borno, Oyo and Yobe states. By the end of COP12 APIN planned to have activated 100 PHCs for the provision of PMTCT services. APIN also plans to provide integrated HTC services in DOTS centers in Lagos and Benue states. During COP11, APIN refocused its OVC and Prevention program implementation strategy by engaging thirty-six (36) Non-governmental organizations (NGOs) and community based organizations (CBOs) to provide these services at the community level in addition to the facility based services being provided in the treatment sites. Twenty-one (21) of these CBO/NGOs provide OVC services while eleven (11) provide AB services and while fourteen (14) will implement Other prevention services. A core component of APIN implementation strategy is Health system strengthening. As lead IP for SI in Borno, Lagos, Oyo and Plateau States and lead APIN for PMTCT in Lagos, Oyo and Plateau states, APIN will continue to engage those states to build their capacity in developing, implementing and monitoring the delivery of qualitative comprehensive HIV prevention, care and treatment programs.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Sub Recipient**
3. What activities does this partner undertake to support global fund implementation or governance? **(No data provided.)**

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	600,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

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:	**10114**		
Mechanism Name:	**HHS/CDC Track 2.0 APIN**		
Prime Partner Name:	**AIDS Prevention Initiative in Nigeria, LTD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	5,662,684	0

Narrative:

In COP 12 and 13, APIN will provide care and support services to 142,959 PLHIV and PABAs. APIN provides a minimum package of care and support services using a multi-disciplinary, family-centered approach and in accordance with National guidelines. These services include clinical care, provision of basic care kit, community home-based care (CHBC), Positive Health Dignity and Prevention services, psychosocial and spiritual supports. Clinical care includes nursing care; pain management; OIs and STIs prevention, diagnosis and treatment; and laboratory monitoring. A basic care kit (containing insecticide treated bed net, water vessel and purifier, IEC materials and soap) is distributed at the facilities and communities, to ensure availability to patients and their families. Positive Health Dignity and Prevention

services include assessment and counseling on sexual risk reduction, ART adherence, alcohol/substance abuse, partner testing, syndromic management of STIs, and family planning/pregnancy intention. Patients are provided with or referred for family planning, cancer screening and other services, as appropriate.
APIN will continue to facilitate PLHIV support groups both in the facilities and communities, including the establishment of new community-based ones. APIN will liaise with CBOs to coordinate the community-based group, improve access to care for PLHIV and their families, and deliver services in the communities through a continuum of care, in line with national guidelines. The support groups, collaborating with site teams, will follow-up patients (with telephone calls and home visits), help in defaulter tracing, and establish/strengthen linkages and referrals to economic strengthening programs to address issues around poverty. These strategies will contribute to patient retention in care, especially pre-ART patients. Efforts will be made to reduce stigma and discrimination against PLHIV in the community through awareness creation. Cross-referrals between treatment facilities and community services (including wrap-around services e.g. income generating activities, spiritual support etc.) will be strengthened using national referral tools.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	962,912	0

Narrative:

In COP 12 & 13, APIN will continue to provide qualitative comprehensive OVC services to most-at-risk children (0 – 17yrs) who have lost one or both parents to AIDS, or those affected by the disease, or who live in areas of high prevalence and maybe vulnerable to the disease or its socio-economic effects. APIN will continue to partner with CBOs that will provide a complement of the 6 + 1 services to 12,248 OVC in COP 12 using the family-centered approach. These services include education and vocational skills training, health care, psychosocial support, shelter, protection, food and nutrition, and economic empowerment of care givers and older OVC. The goal is to support the provision of a safety net for these children by and strengthening their families' capacity to care for them. Active involvement of community structures will be promoted, thereby fostering ownership and sustainability of the program.
APIN will support the economic strengthening (ES) of caregivers, older OVC, households and communities by collaborating with SMEDAN (Small and Medium Enterprises Development Agency of Nigeria), a GoN agency. Linkages to ES organizations e.g. Mashiah Foundation, a collaborating FBO in Jos, will also be strengthened.
There will be training and retraining of these CBOs staff and community volunteers on quality service delivery and proper documentation of all OVC activities. The CBOs will be provided with the harmonized national OVC tools, and the activities of these CBOs will be periodically monitored to ensure compliance to national guidelines and standards of practice.

APIN will support the Federal Ministry of Women Affairs & Social Development (FMWASD) and the state counterparts, in collaboration with American International Health Alliance (AIHA), to conduct a situation analysis of the social welfare workforce in two (2) states with high HIV prevalence (Benue and Plateau) and help address identified gaps. The expertise of AIHA in the training of social and para-social workers will be leveraged to train OVC desk officers in the states and LGAs as well as community mobilizers. This will also help to achieve better coordination, monitoring and reporting of all OVC activities in their states/LGAs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	1,140,302	0

Narrative:

TB/HIV services will be provided to 8,849 patients in line with the 3I's. TB diagnostic capacity has been enhanced with the provision of fluorescence microscopes and digital x-ray machines. More sites will receive this support in COP 12 and 13. All TB/HIV co-infected patients will receive ART following national, regardless of CD4 count. They will be provided CPT, and the use of IPT will be piloted at Sacred Heart Hospital, Abeokuta. To prevent nosocomial infection, national guidelines on TB infection control are implemented at the sites.

HTC is provided for TB suspects/patients at co-located DOTS centers in APIN-supported sites. APIN has piloted universal access to HTC for TB suspect/patients in Oyo state and is in the process of replicating this in Lagos state. This will be supported in Benue state (COP 12) and Plateau state (COP 13). HIV+ cases detected are referred to ART centers for evaluation. Cross-referrals between the DOTS centers and HIV clinics are being strengthened. APIN has provided logistics support for the distribution of TB commodities and NTBLCP supported with LMIS training in Oyo state for the national roll-out of the 6-month treatment regimen, contributing to improved supply chain management system and availability of TB drugs. This training will be provided for more states in COP 12 and 13, beginning with Benue state. Support for MDR-TB activities will include institution of routine surveillance, in line with the national expansion plan for DR-TB. The TB national and SW zonal reference labs will be supported to enable them function at bio-safety levels 3 and 2+ respectively, and to improve their quality system management for accreditation. To improve diagnosis of TB and MDR-TB, GeneXpert will be provided to 5 sites in collaboration with NTBLCP.

APIN will collaborate with CBOs to implement community TB care (CTBC) in order to increase case detection and treatment success. ACSM activities will be carried out to create awareness, community involvement and participation.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	2,536,760	0

Narrative:

APIN will provide care and support services to …exposed children through a continuum of care for the next two years. These services will include clinical/nursing care, pain management, OIs diagnosis/prophylaxis, nutritional assessment and support, end-stage care, baseline hematology, chemistry, CD4 count. These children will be provided with CTX prophylaxis, screened for TB via clinical, laboratory and radiological diagnostics. Families of enrolled children will be provided with basic care kits including water vessel, water guard, ITN, soap, ORS, latex gloves, and IEC materials. APIN will collaborate and strengthen the capacities of support groups, CBOs, to deliver care and support services, including the provision of community and HBC services. All HIV exposed infants will be given NVP soon after delivery. APIN will strengthen the linkage between facility and community OVC services to promote retention of children through collaboration with CBO. RUTF will be provided to prevent malnutrition and LTFU. HIV-infected children will be identified through HCT, PMTCT and TB programs. Expansion of more PITC outlets at all points of care and integration into the MNCH will contribute to scale of pediatric treatment. Introduction of genealogy forms will ensure the children of HIV infected adults are identified and tested. APIN will also involve Private for profit and non-profit organisations in the scale up activities. The programme will identify, renovate suitable places within the clinic as play rooms equipped with age appropriate toys and literatures. Health care workers will be trained to provide care and support services to HIV-infected/affected children. APIN will encourage facility-based support groups to decentralize and function as smaller units at various locations within the community. Formation of adolescent support group will be encouraged including training on adolescents care, PwP. The programme will provide reagents/kits, train and support lab. Scientist, technicians and non laboratorians with the appropriate skills to collect DBS specimens for EID. APIN will support and build the capacity of the FMOH, SMOH, SACA, LACA on pediatric care and support.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	4,758,794	0

Narrative:

During COP11, in addition to the existing 11 sites and 43 Oyo State DOT Centers; APIN assumed management responsibility for 7 Harvard sites (UMTH, UNTH, FMC Makurdi, OLA, FMC Nguru, SSH and Nursing Home Maiduguri). During this period APIN activated 100 PHCs and also took over management responsibility of 5 former Africare sites – Police Hospital, Falomo, St. Joseph Catholic Clinic, Kirikiri, Ancila Catholic Hospital, Iju, PHC Sango, Agege and AHI all in Lagos.

By the end of COP11, APIN would have taken over the management of remaining Harvard transition sites of ABUTH, JUTH and its 13 satellites. In COP2012, APIN will provide support for laboratory development at 32 treatment sites (9 tertiary care, 23 secondary sites), 100 PMTCT and 43 DOT sites.

APIN will upgrade equipment platforms in all PCR labs to automated systems for DNA PCR and Viral load. APIN will collaborate with the USG to develop the framework for these labs to support other IPs without the capabilities. The three (3) APIN supported DRM labs will be integrated into the national DRM program. Primary health care facilities are closely partnered with secondary and tertiary care facilities, allowing for baseline and periodic evaluation. The primary facilities provide limited lab monitoring with basic clinical, hematologic and CD4 assays using largely point-of-care technologies.
In furtherance of the PEPFAR II goals, APIN will continue to collaborate with the SLMTA team to prepare the five (5) participating labs towards attaining the WHO-AFRO accreditation. In addition, APIN will collaborate with SLMTA to register and prepare five (5) more labs for accreditation. APIN will also continue to work with the MLSCN to get all APIN labs accredited nationally.
APIN will continue to support the LIS at the labs with technical support from Harvard, using FileMaker Pro data software a program has been developed to support data generation, capturing and analysis. APIN will strengthen its Biomedical engineering unit by building the capacity of engineers to reduce equipment down time. In addition, APIN will collaborate with SCMS to implement pooled procurement of Lab commodities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	1,057,673	0

Narrative:

During COP11, in addition to the existing 11 sites and 43 Oyo State DOT Centers; APIN assumed management responsibility for 7 Harvard sites (UMTH, UNTH, FMC Makurdi, OLA, FMC Nguru, SSH and Nursing Home Maiduguri). During this period APIN activated 100 PHCs and also took over management responsibility of 5 former Africare sites – Police Hospital, Falomo, St. Joseph Catholic Clinic, Kirikiri, Ancila Catholic Hospital, Iju, PHC Sango, Agege and AHI all in Lagos.
By the end of COP11, APIN would have taken over the management of remaining Harvard transition sites of ABUTH, JUTH and its 13 satellites. In COP2012, APIN will provide support for laboratory development at 32 treatment sites (9 tertiary care, 23 secondary sites), 100 PMTCT and 43 DOT sites.
APIN will upgrade equipment platforms in all PCR labs to automated systems for DNA PCR and Viral load. APIN will collaborate with the USG to develop the framework for these labs to support other IPs without the capabilities. The three (3) APIN supported DRM labs will be integrated into the national DRM program. Primary health care facilities are closely partnered with secondary and tertiary care facilities, allowing for baseline and periodic evaluation. The primary facilities provide limited lab monitoring with basic clinical, hematologic and CD4 assays using largely point-of-care technologies.
In furtherance of the PEPFAR II goals, APIN will continue to collaborate with the SLMTA team to prepare the five (5) participating labs towards attaining the WHO-AFRO accreditation. In addition, APIN will

collaborate with SLMTA to register and prepare five (5) more labs for accreditation. APIN will also continue to work with the MLSCN to get all APIN labs accredited nationally.
APIN will continue to support the LIS at the labs with technical support from Harvard, using FileMaker Pro data software a program has been developed to support data generation, capturing and analysis. APIN will strengthen its Biomedical engineering unit by building the capacity of engineers to reduce equipment down time. In addition, APIN will collaborate with SCMS to implement pooled procurement of Lab commodities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	0	0

Narrative:

APIN as lead Implementing Partner for PMTCT in Plateau, Lagos and Oyo States, will work with the State and Local Government to strengthen their capacity, towards increasing PMTCT coverage in conformity with the National Strategic Health Development Plan (NSHDP).This is in line with the GHI utilizing HSS.
APIN will build the capacity of different cadres of Health care workers in partner sites to provide both HIV and non HIV services to address existing manpower gaps in service delivery, including primary, secondary and tertiary sites across Government, Private and faith based facilities by conducting trainings in administration, finance, Monitoring and evaluation, Quality improvement and HIV medicine.
APIN will support weak or none existent sites systems for sourcing, procuring, storing and distributing drugs and commodities which were at sites. The National Health Survey (NHS) assessment indicates that the pharmaceutical management system has mixed performance results in Nigeria and implementation of drug related policies lags behind. APIN will strengthen the state systems by supporting the Government to appropriately select and access procure, store, distribute, appropriately products for HIV and none HIV services.
APIN will continue to scale up the provision of comprehensive HIV care in treatment services in secondary Health facilities as well as expand PMTCT services to PHCs in a cluster model in States where it is lead IP.
Through its partners on the MEPI Grant to support Medical education Programs in the country, APIN is currently supporting review of the various curriculums that are used in training at these institutions to reflect current information especially in HIV Medicine and infectious Diseases APIN will draw on this experience to support Pre-service training of undergraduate Medical students and schools of Nursing and Midwifery.
APIN will continue to advocate to management of its partner institutions to absorb staff that were being supported by the Program into the government pay roll. This has already commenced in some of the

partner tertiary and secondary health facilities and several of them will still be transited in the COP year.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	0	0

Narrative:

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMBL	43,715	0

Narrative:

In COP12 APIN will provide blood safety services in 33 treatment centers. APIN will work in collaboration with the National Blood Transfusion Services (NBTS), and Safe Blood for Africa Foundation (SBFA) to build the capacity of health care workers in these sites to provide qualitative blood safety services. This will be done by conducting training of trainers in collaboration with NBTS and SBFA on appropriate clinical use of blood and other topics. This pool of trainers will be supported to step down the training at their various sites. APIN will also continue to support the hospital linkage program of the NBTS for appropriate screening of blood with EIA for the four (4) TTIs. APIN will continue to make advocacy to management of APIN supported tertiary institutions to collaborate with NBTS in ensuring that the practices of family replacement donors is completely replaced by voluntary non remunerated donors. Site management will also be encouraged to promote best practices, pay more attention to upgrading infrastructure for blood banking at their facilities, support training to effectively link up with the NBTS and contribute to the nationally coordinated blood banking system.
In COP11 APIN collaborated with other stakeholders to participate in a forum where issues on blood safety APIN were discussed. One of the outcomes was an activity that pooled samples of transfused blood from different sites and centrally tested for transfusion transmissible infections (TTIs) to determine the percentages of TTIs detected in transfused blood. This has formed an evidence based advocacy tool to convince policy makers on the importance of EIA for screening for the four (4) TTIs instead of the prevalent use of RTKs in donor testing. In COP12 APIN will support eleven (11) blood banks with EIA capabilities for screening for the four (4) TTIs. APIN will continue to work with NBTS to support Social mobilization and health promotion messaging through media driven campaign for donor recruitment. Facilities will be supported to carry out outreaches with linkage to community based HTC for blood donation awareness and recruitment.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMIN	94,146	0

Narrative:

APIN will continue to implement injection safety in all supported sites in 9 states (Borno, Benue, Enugu, Kaduna, Lagos, Plateau, Ogun, Oyo and Yobe). This activity provides the initiation of intensive training program in injection safety practices for HCWs at all APIN sites. APIN will continue to build the capacity of sites in collaboration with AIDSTAR to provide HIV/AIDS care and treatment activities in a medically safe environment. During COP11, APIN conducted a series of trainings including a TOT on the 'newly' approved infection prevention, control in clinical setting, with hand hygiene and phlebotomy components. This TOT was further stepped down by all the sites with support from APIN.
APIN will support sites to make provision for referral of staff for access to post exposure prophylaxis (PEP). PEP will be provided through ART drug activities. APIN will support the USG Health Care Waste Management (HCWM) strategy by adopting the integrated approach to expiry management at all facilities. APIN will collaborate will other stakeholders to develop and implement the HCWM framework. APIN will also support advocacy for the approval of the HCWM plan, policy and guidelines. Proper waste management will be encouraged at each site through the use of biohazard bags, suitable sharps containers, and the use of incinerators. This activity will support procurement and maintenance of incinerators where applicable within funding limit. APIN will also work with AIDSTAR to procure and distribute injection safety commodities to all sites.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	512,987	0

Narrative:

During COP11, APIN refocused its Abstinence and Be faithful implementation strategy by engaging eleven (11) Non-governmental organizations (NGOs) and community based organizations (CBOs) to provide services at the community level. These NGOs and CBOs (CAHLI Jos, CCC Jos, TMVF Maiduguri, SWAAN Enugu, Karale Lagos, Humanity Lagos, PAC Ogbomosho, AHI Lagos, Patriots Abeokuta, AHP Makurdi and AFI Ifo, Ogun State) are spread across six (6) states of Borno, Enugu, Lagos, Ogun, Oyo and Plateau.
In COP12 APIN will implement AB activities at community level utilizing the minimum prevention package strategy as contained in the National Prevention Plan. The goal of the program is to provide a comprehensive package of prevention services to individuals reached through a balanced portfolio of prevention activities, including abstinence and be faithful messaging (HVAB).
APIN will build the capacity of the NGOs and CBOs to target the general population using a combination of biomedical, behavioral and structural interventions. 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 in our treatment sites. APIN will collaborate with PLWHA support groups at these sites to build their capacity to implement AB activities among its members and surrounding

communities. As in previous COP years, APIN will continue to focus on improving the integration of prevention activities into the HIV care and treatment settings.
A key age group for HVAB activities is youth/young adults aged 15-24 years as this encompasses the highest prevalence age group. Age-appropriate abstinence only messaging and secondary abstinence messaging will be conveyed to this group particularly focusing on those orphans and vulnerable children receiving both facility and home-based support. APIN targets to reach 61,558 individuals from the general population with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	1,335,966	0

Narrative:

In COP12 APIN will continue to support the provision of comprehensive HIV counseling and testing (HTC) services in 76 facility-based and 5 stand-alone centers in 10 states while expanding services to high burden locations within the states. APIN will adopt the test-to-treat strategy and focus on MARPs, clients and their partners presenting to the health care facilities will be offered PITC at all service delivery points, testing of exposed children and family members of PLWHA.
To further increase coverage, APIN will scale up CHCT and pediatrics HTC. APIN will continue to integrate HTC into TB DOTS centers in Oyo and Lagos State and expand to Benue state in COP12. HTC will also be offered to patients receiving TB services at each of the APIN sites. APIN will use mobile HTC to reach high prevalence and hard to reach communities.
To ensure improved quality of service at the sites, APIN will continue to strengthen referrals and linkages, provide strong M&E and conduct Regional HTC Quality assurance meetings with the counselors.
Individuals identified as positive at APIN sites will be referred to PMTCT and ART clinics for treatment and palliative care services. APIN sites will continue to 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.
Condoms will be made available at all HTC sites in conjunction with the delivery of ABC messages. The Society for Family Health (SFH) will supply condoms. APIN will continue to promote task shifting by training and utilizing lay counselors to provide quality HCT services at the community level. HTC services will also be integrated into other HIV prevention, care, and treatment services both in facilities and communities and also into other health services like SRH, MNCH and STI, home-based HTC for partners and families of PLHIV or TB. Where necessary, refresher training will be conducted for counselors using the National HIV training curriculum. HIV testing is performed with rapid test assays and same day results are given using the National testing algorithm.
APIN will continue to support the quarterly National HCT Task Team meetings.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	552,034	0

Narrative:

During COP11, APIN refocused its Other Prevention implementation strategy by engaging fourteen (14) NGOs/CBOs to provide services at the community level in addition to the facility based services being provided in 18 treatment sites. These NGOs and CBOs (Mashiah, HALT AIDS, ARFH, CAHLI Jos, CCC Jos, TMVF Maiduguri, SWAAN Enugu, Karale Lagos, Humanity Lagos, PAC Ogbomosho, AHI Lagos, Patriots Abeokuta, AHP Makurdi and AFI Ifo, Ogun State) are spread across six (6) states of Borno, Enugu, Lagos, Ogun, Oyo and Plateau.

In COP12, APIN will continue to implement COP activities at both the facility and community levels utilizing the minimum prevention package strategy as contained in the National Prevention Plan. APIN partners will target (MARPs), including outpatient STI patients, border traders (like Saki), fashion designers, young male market agents, and motor mechanics. APIN will also target high risk communities like Kuramo and provide intervention and educational materials based on community-specific risks. 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.

APIN will continue to focus on improving 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 GOPD, SRH, MNCH and STI services. The target for Condom and other prevention is 30,058 individuals.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	0	0

Narrative:

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	2,202,158	0

Narrative:

Currently, APIN support comprehensive PMTCT program at 43 service outlets in 9 states. "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) for the next two years. APIN will achieve this through scale up of services to PHCs, strengthening decentralization, Provider Initiated Testing and Counseling (PITC); Integration of PMTCT services into maternal and child welfare clinics immunization clinics (MNCH); Introduction of genealogy forms; Involvement of Private for profit and non-profit organisations. APIN will adopt the "hub and spoke" model to strengthen referral system and linkages using the National referral form. Health care workers will be trained and supported to offer HCT, infant feeding counseling and PMTCT using the revised National guidelines. Post-test counseling services on prevention of HIV infection will be encouraged. APIN will support couple counseling by encouraging pregnant women to bring their husband. Family planning and cervical screening of all pregnant women will be supported. The program will address stigma, male norms and behaviors through identification, sensitization and education of members of NURTW, Okada riders association and others in collaboration with CBOs. SOP which addresses special concerns of the adolescent will be developed. Emphasis will be on community PMTCT which supports the development of network of secondary or primary PMTCT clinics, including TBAs. APIN will collaborate, support and build the capacity of all stakeholders state LACA, SACA, SMOH, involved with the delivery of PMTCT services through regular meetings, trainings and workshops. APIN will support reduction of LTFU through use of adherence counseling tool. Mentoring of clinicians and other health workers will be done by program officers using the program monitoring tool. Regular training of the health workers from the states and Local government areas on timely data collection, collation and reporting will be conducted. Data collected will be used in conjunction with funders to improve service delivery. APIN will provide HTC to 110,108 pregnant women and ARV prophylaxis to 3,612 HIV+ve pregnant women.

As part of our strategy to increase the uptake of HTC at antenatal clinics in supported PMTCT facilities, we shall defray/absorb antenatal booking/registration fees for all pregnant women. In addition, we shall ensure that communities served by the health facilities are adequately informed of this benefit/privilege through local media outlets and strategically placed IEC materials.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	2,220,957	0

Narrative:

Pharmacovigilance :

1. Our adverse drug events (toxicity) forms have been superimposed with the NAFDAC PCV forms, this will improve capturing Pharmacovigilance information, and Pharmacovigilance committee has been set up at all facility to improve awareness, documentation and management

2. Our training modules include one for pharmacists, to be adopted for training of pharmacists across

Nigeria, as well as technicians' training module that will train dispensers and other healthcare workers in drugs logistics and reporting.
3. The purpose of the Drug Information Center (DIC) is to serve health care professionals throughout Nigeria by answering critical questions on drug use and its possible side effects. The DIC routinely responds to inquiries regarding appropriate therapy for specific patients; adverse reactions to drugs; efficacy of drugs; drug interactions; intravenous additive incompatibilities; biopharmaceutic and pharmacokinetic parameters of drugs; dosing in renal failure; and information on new drugs. It serves as a hotline for public access to drug information; thus plays a vital role in providing outstanding health care to the citizens of Nigeria.
B. Strengthen Supply Chain Management
In line with the goal to strengthen PEPFAR supported system, APIN will:
Quantify for all ARVs, OIs and Lab consumables that are used across the APIN sites; help make requisitions, distribute, track and send quarterly reports of all drugs and consumables.
APIN already has a virtual system to track and monitor all its commodities at the APIN Central Warehouse and at the site level. APIN will support the GON in setting up the virtual stock management system at federal central medical stores. APIN will work closely with GON to take over the management of federal medical stores in Oshodi.
APIN will also offer technical support to GON sites and some FBOs in the area of quantification, forecasting and reporting of ARVs and labs consumables. This will help strengthen the system. In addition, APIN will continue to strengthen its relationship with the states and help in the collection of data using the NNRRIMS platform.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	12,326,529	0

Narrative:

During COP11, APIN assumed management responsibility for 7 Harvard sites (UMTH, UNTH, FMC Makurdi, OLA, FMC Nguru, SSH and Nursing Home Maiduguri), in addition to the initial 7 Harvard transitioned sites – NIMR, LUTH, UCH, Adeoyo, Eleta, GH Ogbomosho and GH Ijebu-Ode and the start-up 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. During this period APIN activated 100 PHCs and also took over management responsibility of 5 former Africare sites – Police Hospital, Falomo, St. Joseph Catholic Clinic, Kirikiri, Ancila Catholic Hospital, Iju, PHC Sango, Agege and AHI all in Lagos.
By the end of COP11, APIN would have taken over the management of remaining Harvard transition sites of ABUTH, JUTH and its 13 satellites. In COP2012, APIN will provide support for treatment at 32 treatment sites (9 tertiary care, 23 secondary sites), 100 PMTCT and 43 DOT sites. This activity will

provide ART services to a total of 74,321 eligible adult patients by the end of the reporting period. Treatment will also be provided for eligible pregnant women at the secondary facilities and the PHCs. APIN will continue to scale up treatment services focusing on high burden low coverage populations. We will also support early detection and treatment while increasing focus on the treatment of children and women.

APIN will continue to use the hub and spoke model for service delivery. APIN will also continue to support the decentralization program of the GON which promote the 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. We will also strengthen our monitoring for treatment failure. Harmonization of data collection for M&E will be coordinated with USG and GON efforts. APIN will continue to employ the use of electronic clinic and lab records to provide data for high-quality patient management and centrally coordinated program monitoring.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	1,196,182	0

Narrative:

APIN currently provide pediatric treatment at 43 service outlets in 9 states. This includes 3 facilities previously supported by Africare in Lagos. APIN plan to increase pediatric treatment in the next two years is through scale up of services to PHCs, strengthening decentralization process, identification of pediatric HIV infection through Provider Initiated Testing and Counseling (PITC); Integration of pediatric services into maternal and child welfare clinics immunization clinics (MNCH) at all pediatric service outlets; Introduction of genealogy forms to ensure the children of HIV infected adults are identified and tested; involvement of Private for profit and non-profit organisations to ameliorate the hardship encountered due to incessant industrial strikes by government owned health facilities. Adolescent are usually missed in the care for HIV services and these are most vulnerable group. APIN already has the adolescent support group at NIMR; this will be replicated at other sites. In addition, counselors and other health care workers will be trained on the care for adolescents in HIV, PwP. Standard Operating Procedures (SOP) which addresses special concerns of the adolescent will be developed. Tracking teams inclusive of patients and support groups will be strengthened at all sites. ART eligible children will be provided ART and followed every 6 months for CD4% enumeration. Adherence counseling tool, containing sets of critical issues to be discussed with the patients will be developed for use by counselors and pharmacist. Mentoring of clinicians and other health workers at site level will be done by program officers in Pediatric care and treatment as well as other service delivery using the program monitoring tool. Regular training of the health workers from the states and Local government areas on timely data

collection, collation and reporting will be conducted. Data collected will be used in conjunction with funders to improve service delivery. To ensure sustainability, APIN will collaborate, support and build the capacity of all stakeholders LACA, SACA, FMOH, SMOH, involved with the delivery of Pediatric services through regular meetings, trainings and workshops.

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	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,190,417	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	1,190,417

Sub Partner Name(s)

(No data provided.)

Overview Narrative

In FY12, URC will enhance efforts to transition responsibility of HIV services to the states' MOH and empower officials to take over supervision of health care workers and monitoring of services in collaboration with other partners. In addition, we will encourage state governments to increase their financial contribution in line with the partnership framework by procuring laboratory reagents and supplies to augment the PEPFAR funded supply. These efforts will extend to the LGA who are responsible for PHCs. Consistent with the national decentralization agenda, HACCI will build HCW capacity in PHCs to provide PMTCT services according to the new guidelines, provide ARV refills for patients initiated on ART in the hubs, and manage simple OIs and side effects of ARVs. The project will also initiate IPT for PLHIV in whom active TB has been excluded. HIV education, PITC for TB patients, and cotrimoxazole preventive therapy for co-infected patients will be integrated into services at DOTS centers. All service points will intensify efforts to screen for TB and refer suspected cases for diagnosis and treatment. HACCI

will continue to implement comprehensive HIV services and work closely with government counterparts to improve health worker supervision, extend referral systems and enhance program monitoring to improve enrollment, retention, and clinical outcomes. Community volunteers mobilize and educate community members about HIV, create demand for services, help reduce stigma and promote ownership. We will increase volunteer linkages with community structures and health facilities to enable them to be sustainable HIV champions. Finally, we will work with the Enugu and Ebonyi MOH to develop strategies and approaches to integrate HIV services with general health care services.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	1,191

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Child Survival Activities
Mobile Population
Safe Motherhood
TB
Workplace Programs
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	51,686	0

Narrative:

In FY 12, HACCI will provide care and support services aimed at optimizing the quality of life for HIV-infected clients through the provision of comprehensive services including clinical care including medical needs assessment and provision of necessary interventions; psychological support services including counseling and disclosure support; prevention services including behavioural risk assessment and the promotion of ABC messages and measures; social support services such as alcohol and substance abuse assessment and counseling; improvement of food security by conducting nutritional assessment and counselling as well as provision of supplements; and general health support services including health education at both the household and community levels. HACCI will conduct trainings and refresher trainings for 35 HCWs in order to build and maintain their capacity to provide quality care and support services. In addition, HACCI staff will provide regular site mentorship visits to promote and entrench best practices. Client retention will be achieved by utilizing empowered support group members and home based care volunteers through weekly monitoring and review of clients' clinic attendance, the follow-up of identified instances of missed appointments and referal of clients through telecommunication, bi-directional referral forms and tracking. Periodic clinical audits will be carried out to monitor the quality of care. We will strengthen linkages between supported facilities and tertiary hospitals providing HIV care and treatment services to improve access for patients requiring specialist services. We will continue to facilitate the formation of PLHIV support groups as an avenue to provide psychosocial and other support to PLHIV and their families. Select members of support groups will be mentored to serve as adherence counsellors and expert patients to help educate and support newly diagnosed patients enroll and stay on treatment. To facilitate sustainability and ownership HACCI will conduct quarterly joint monitoring and supervisory visits with the state Ministry of Health officials to build their capacity to autonomously carry out such supervision after the completion of the project.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	36,000	0

Narrative:

The goal of the project in its last activity year is to enable the Enugu State Government and target communities to continue to provide needed services to OVC and their families. Since the beginning of the OVC program in 2009, the project has used a rights-based approach to equally serve 125 male and

female OVC aged 0-17 years in Awgu, Aniniri and Oji River LGA of Enugu State. The project has an excellent working relationship with the OVC focal person in the Enugu State Ministry of Women Affairs. We also work very closely with the social welfare officers of Awgu, Aninri and Oji River Local Government Areas. HACCI also has strong relationships with the MOH and MOE and has been working together with these ministries in support of the OVCs currently enrolled in our program. These strong relationships with government counterparts will facilitate the transition towards the State and communities overseeing the care of targeted OVC. The project will further its efforts to build the capacity of the government counterparts as well as the communities and caregivers to provide OVC care and support. The project will continue to aid communities to establish and strengthen systems to support OVC. The HACCI-trained OVC community volunteers will continue to receive coaching from project staff to reinforce what was originally learned during training sessions. These volunteers were selected in consultation with their communities' leaders and contribute to the sense of ownership of the program as the HACCI project comes to a close. The child protection committees formed during COP11 will continue to raise awareness about OVC needs, monitor abuse and provide protection for all OVCs in the communities in a sustainable manner. The project will continue to build the economic capacity of caregivers to provide for the needs of their children; retaining them in school, and working with local governments and community to establish strong child welfare and protection systems. HACCI will build upon linkages established between the communities and the facilities through the community volunteers and a strengthened referral system. HACCI will continue to strengthen the relationship between OVC volunteers/caregivers and PHCs to ensure OVC receive needed child survival health care services. PHC staff will continue adolescent programs for infected and affected children. The project will ensure OVC receive HCT services and if found positive, be enrolled in HIV care, support and treatment.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	66,758	0

Narrative:

In FY 12, HACCI will further our partnership with the Enugu and Ebonyi state MOH to strengthen collaboration between TB and HIV at the state, LGA and health facility levels to ensure that all TB patients have access to HIV services and PLHIV have access to TB diagnostic and treatment services. At facilities, co-location of services will occur where possible and safe; where co-location is not possible or unsafe, the project will strengthen linkages between HIV and TB DOTS clinics. HIV education, PITC for TB patients, and cotrimoxazole preventive therapy for co-infected patients will be integrated into services provided by DOTS clinics. All persons evaluated for TB at the supported TB clinics will receive HCT services as part of routine care. At HCT, Pre-ART and ART clinics, all PLHIV will be routinely screened for TB using a screening questionnaire at every clinical encounter. This will facilitate early identification and treatment of TB cases. Clients with positive TB screens will be linked to diagnostic

services for AFB microscopy. Smear negative cases will be referred to radiology to ensure that PLHIV with TB are not missed during clinical evaluations. Diagnosed TB patients will be treated according to the national guidelines. IPT will be provided to PLHIV in whom active TB has been excluded and TB infection control measures will be strengthened. HACCI will reinforce initial training of facility medical officers on IPT and the diagnosis of sputum smear negative TB with regular mentorship. Emphasis will be on administrative and environmental control measures as well as the appropriate use of personal protective equipment. To facilitate community level ownership, HACCI will train existing community volunteers to promote TB sensitization and case detection. Volunteers will speak to family members during home visits and to group gatherings about TB. They will educate them about the symptoms and encourage them to go to TB DOTS clinics for evaluation when they present symptoms. Where feasible, volunteers will escort suspected TB cases to clinics for evaluation. The project will strengthen referral networks by motivating support group members to accompany new clients and ensure completion of the referral process.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	837	0

Narrative:

In FY12, HACCI will support the GON to increase enrollment in pediatric services to close gaps in coverage. We will work with CHAI and other partners to link our PMTCT sites to the national EID network to facilitate early diagnosis of HIV infected children. The project will strengthen linkages between PMTCT sites and care and support sites ensure children diagnosed through EID are promptly enrolled in care and treatment. We will also work with members of adult support groups to test their children for HIV and enroll those who test positive. To promote integration with routine pediatric care, nutrition services and MCH services, we will use provider-initiated HCT targeting of children in pediatric wards, child welfare and under 5 clinics to identify and enroll HIV positive children. We will strengthen referral linkages between child welfare clinics, labor wards, postnatal clinics and comprehensive sites to ensure children identified at these points of service are enrolled in care and support services. HACCI will further support the creation and maintenance of children's play/support groups at PHCs. Cotrimoxazole prophylaxis will be provided according to national guidelines and children will also be linked to OVC services based on need. Another aspect of the pediatric care and support program is to conduct community outreach programs in markets and schools to sensitize, test, and enroll HIV positive adolescents. HACCI will continue to address ongoing prevention needs for all clients including assistance with disclosure, counseling for intimate partners of sexually active adolescents, ongoing risk reduction counseling, provision of condoms, and lifestyle counseling and STI screening for sexually-active adolescents. For all those who are enrolled in pediatric care and support services, we will provide a need-based package of services including clinical care, basic care kits, preventive services and psychosocial support. Clinical care will include OI prophylaxis and management, growth monitoring and immunization, assessment and

management of pain and other symptoms, and nutritional assessment and treatment. PWP is a key component of care and support and will be continued.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	504,496	0

Narrative:

HACCI will intensify efforts to transfer the five fully-equipped laboratories in the comprehensive sites to the responsibility of the Enugu and Enonyi MOH. We will encourage the state to take over increasing responsibility for lab services and be actively involved in the maintenance of equipment and forecasting of lab reagents. The goal of the HLAB program is to achieve accreditation of the supported labs by the end of the project. Project staff will continue to work with the Enugu and Ebonyi Ministries of Health and the laboratory scientists/technologists in charge of supported laboratories to institutionalize an internal improvement process, which addresses gaps in requirements and maintains accreditation standards. This process will ensure all the supported laboratories have all necessary documentation, perform annual and semi-annual laboratory audits, continue to participate in proficiency testing for CD4 count and TB microscopy, advocate directly with the SMOH to hire and post more laboratory scientists/technologists to the laboratories, and work with the management of the respective hospitals and the chief laboratory scientists/technologist to ensure the laboratory space meets minimum requirements. Trained laboratory scientists, working with the HACCI-supported laboratories, will continue to receive on-site training and mentoring to ensure they acquire the required confidence and independence to continue services in the absence of HACCI project staff at the end of the project. The project will reinforce the supervisory capacity of chief laboratory scientists to take over the mentorship of lab staff. Regular evaluation of lab technicians on their technical skills and achievement of minimum standard knowledge necessary to perform analysis using the provided equipment platform will help chief laboratory scientists to determine training needs. The project will also analyze and strengthen the system of sending blood samples from stand alone PMTCT sites and PHCs providing ARV refills to be analyzed in the comprehensive sites and then promptly sent back to the facilities to ensure sustainability of the system.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	40,000	0

Narrative:

In FY 12, HACCI will continue its efforts to increase facility-level reporting through the national system. Specifically, the project will support health care workers to better document the services they render using national data tools. HACCI subscribes to the “three ones” principle and is using the GON’s M&E

platform: the District Health Management Information System (DHIS). Furthermore, HACCI will continue to place the GON's National HIV Strategic Plan at the centre of its SI efforts. HACCI will also work with the MOH in Enugu and Ebonyi states to strengthen the reporting system from the health facilities to the LGAs and then to the state MOH in line with the national HMIS system. The Enugu MOH has been using the national platform and the DHIS since 2006 through the support of the DFID-funded PATHS project. HACCI bought into the existing system and is working with the MOH to strengthen it. HACCI recognizes the need to maintain an accurate database of patients receiving HIV care and treatment services in Nigeria and will support the implementation of a web-based national data system that will uniquely identify clients by category of services provided. HACCI will actively participate in the planning and implementation of this database. All patients receiving care in HACCI-supported facilites will be given unique ID numbers, and their information will be fed into the national database. Over the past 4 years, HACCI organized bimonthly M&E meetings, to which health facility staff, MOH officials, the state AIDS control agency and other partners were invited. The meetings were used to collate data, review results, discuss achievements, challenges, etc. In the final year of project, HACCI will continue to support the SI lead implementing partner to organize these meetings as another step toward eventually transitioning responsibility for organizing and coordinating meetings to the MOH. HACCI technical staff will continue to collaborate with state and national officials to conduct at a minimum quarterly DQA or field monitoring visits. These visits will serve to improve data quality, improve staff capacity and further prepare government to lead SI efforts by the end of the project.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	111,081	0

Narrative:

In FY12, HACCI will provide HCT in Enugu and Ebonyi states, which will target most at-risk individuals, couples, pregnant women and the general population in line with GON goals and aspirations. This will be done through provider-initiated testing and counseling that will be geared towards normalizing HIV testing. Provider testing and counseling will be carried out in supported health facilities in HCT sites and DOTs centers. It will target inpatient and other sick clients seeking non-HIV related services who often yield higher positivity rates. Outreach/mobile HCT will target high-risk populations including brothel and non-brothel based commercial sex workers, long distance drivers and MSMs while the family-centered approach will target the family members of HIV-positive clients. In addition, we will continue to promote client-initiated HCT through intensive community mobilization including participation in community gatherings such as women's and men's associations and cultural festivals. We will leverage GON resources to integrate HCT into routine health care services by working with government facilities to implement strategies to provide HCT to all their clients as a routine service. As HACCI plans for transfer of responsibilities to the GON, we will work with the MOH and LGAs to supervise and support referral

focal persons in sites and other HCT service delivery points to correctly refer, track, and follow up with clients to ensure they enroll in care or treatment services. Referrals will be documented in the referral register to facilitate monitoring of the effectiveness of the system. Finally, we will work with government counterparts to ensure they are prepared to provide quality HCT services through regular supportive supervision and monitoring of the quality of counseling to ensure services are provided in accordance with national guidelines and SOPs. Quality control measures include tracking records on available test kits, batch numbers and expiry dates; periodic inclusion of previously characterized samples or dry tube specimen (DTS); and use of proficiency testing using Panels for HIV proficiency from South Africa.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	178,800	0

Narrative:

In FY12, HACCI will continue to utilize the hub and spoke model of service delivery in all seven health districts in Enugu state and southern zone of Ebonyi state. The comprehensive sites, which provide adult and pediatric care and treatment as well as laboratory monitoring services, form the hubs and the primary cares sites form the spokes. Each hub will serve 3-5 spokes, thus allowing for better access to PMTCT services for pregnant women in rural areas. This effort will be expanded in FY12 to achieve better coverage and to improve access to PMTCT services for rural communities. We will intensify our community mobilization efforts to ensure that communities know about PMTCT, appreciate its importance and utilize PMTCT services. HACCI-trained and supported community volunteers will mobilize the population for PMTCT uptake, promote couples counseling and male involvement in PMTCT. We will work with community leaders and organizations so that every pregnant woman and her spouse know their HIV status and access appropriate services before delivery. We will collaborate with TBAs in targeted communities to facilitate access to PMTCT services for their clients. We will continue to train and mentor health care workers at secondary and primary health care facilities to provide PMTCT services according to their level of care and in line with the national task shifting and decentralization agendas, including supporting adequately staffed PHCs to provide ARV refills. We will do this in close collaboration with responsible officers in the MOH and the LGA Health Departments to promote transfer of skills and responsibilities in the areas of supervision, routine data collection, and monitoring service quality.

HACCI will continue to promote the integration and strengthening of PMTCT with MCH and RH services, which will serve as an entry point to other HIV services for women, their children, and increasingly, for male partners. HACCI also recognizes that minimizing unintended pregnancies is crucial to effectively eliminate new pediatric infections and will expand its effort to support the availability of FP services. We will work with the MOH and health facility management to co-locate or link PMTCT and FP services.

As part of our strategy to increase the uptake of HTC at antenatal clinics in supported PMTCT facilities, we shall defray/absorb antenatal booking/registration fees for all pregnant women. In addition, we shall ensure that communities served by the health facilities are adequately informed of this benefit/privilege through local media outlets and strategically placed IEC materials.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	89,272	0

Narrative:

In FY 12, URC will to serve adults and children with antiretroviral (ARV) drugs including those with advanced HIV infection, HIV infected pregnant women for PMTCT and rape victims. In line with the national ART guidelines and the national goal of streamlining the number of regimens, HACCI will procure AZT/3TC/NVP and TDF/FTC/NVP both as fixed dose combinations and as single drugs for use as first line drugs. Patients that fail will be switched to the second line of either TDF/3TC+LPV/r for clients on Zidovudine-based first line and AZT/3TC/LPV/r for clients that had tenofovir-based first line. We will also purchase TDF/3TC/EFV, TDF/FTC/EFV as well as ABC for PMTCT. These drugs will be purchased through the pooled procurement from SCMS. HACCI has participated in pooled procurement through SCMS since the beginning of the project, which has helped ensure regular availability of antiretroviral drugs. We will also continue to leverage adult second line and pediatric first and second line drugs from the Clinton Health Access Initiative (CHAI). The project will further support the national ARV program in procurement strategic planning by participating actively in national quantification exercises. We will share our lessons with the national program to help guide decisions in changes to ART guidelines. Finally, HACCI will reinforce its work with the MOH and LGAs to raise the performance levels of health care workers and deliver sustainable improvements in the management and technical skills of procurement practitioners and managers in Nigeria. At the site level, URC will work with clinicians, nurses, pharmacists and pharmacy technicians to document adverse drug reactions and report instances to the NAFDAC. We will monitor this data with the national program, which will also aide decision making related to changes in the ART guidelines.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	106,630	0

Narrative:

In FY12, working closely with the MOH, HACCI will continue to work in 7 health facilities located in the underserved areas of Enugu and Ebonyi states to consolidate the progress made in the provision of comprehensive HIV services. HACCI will further strengthen the referral systems to promote access to TB treatment and other needed services. The project will continue to build the capacity of health care workers employed in supported health facilities in the correct use of ARVs in line with current national

guidelines. Health care workers previously trained will be mentored and closely supervised to ensure they deliver high-quality services and improve their skills. Health care workers in selected PHCs will continue to be mentored to provide ARV refills, adherence counseling, management of minor side effects and OIs. To improve retention on ART and quality of care, HACCI will engage MOH counterparts to utilize the gap analysis framework which uses performance measurement data to identify and address deficiencies in program quality. The project also employs the chronic care model to increase and maintain high-level adherence and retention to reduce the risk of resistance and improve well being. Patients will be encouraged to use family and trusted relatives to improve adherence and the patient support base. HACCI will continue to use support group members and expert patients to strengthen adherence counseling in both facilities and communities. Adherence counseling is closely linked to treatment initiation and maintenance with initial, one month and six month counseling sessions. Close links will also be formed with HBC providers to maintain adherence within the home setting. We will maintain the mentoring of health workers and MOH counterparts to perform clinical audits and use clinical notes from patients' visits and pharmacy records to measure performance and clinical outcomes. The gap analysis framework will then be used to improve coverage, retention in care and clinical outcomes. To promote sustainability and ownership, HACCI will carry out quarterly joint supervisory visits of ART services with the state ministries of health.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	4,857	0

Narrative:

In FY12, HACCI will continue the provision of ART services in 7 comprehensive health facilities in Enugu and Ebonyi states to children with advanced HIV infection. HACCI along with government counterparts will continue to closely mentor health facility staff to ensure that quality services are provided for children. We will work with the MOH and LGAs to ensure that all supported sites increase early identification of children living with HIV/AIDS and improve referrals within and between health facilities to help prevent loss to follow-up. We will work to link PLHIV diagnosed in standalone HCT, PMTCT, TB/HIV service delivery points and under 5 clinics to care and treatment services. We will strengthen referral linkages between PMTCT sites and ART clinics to ensure that HIV positive infants identified through EID are enrolled early on treatment. We will also ensure that all supported sites are linked to the national EID network. To increase pediatric enrollment and scale up ART services coverage, new and existing PLHIV in adult care and treatment as well as support group members will be encouraged to bring their children to HCT sites for counseling and testing. Positive children identified from this effort will also be linked to care and treatment. Baseline investigations including CD4%, chemistry and hematology tests will be performed on all enrolled HIV-infected children before commencement of ART. To improve the quality of treatment, HACCI will utilize the gap analysis framework to reveal and address gaps in program quality

and the chronic care model to increase and sustain progress in adherence and retention. HACCI will work with facility-based referral focal persons and other health care workers providing HCT to ensure identified HIV positive children are enrolled and receive care and treatment services. Referral linkages will also be strengthened between HBC providers, OVC programs, other GON and community child welfare services and the health facilities to ensure that clients receive all necessary wraparound services. Lastly, we will work with health facility staff and the MOH to promote integration of pediatric ART with MCH services.

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	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 313,913	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	313,913

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The IPPCTN (Implementation of Programs for the Prevention, Care and Treatment of HIV/AIDS in Nigeria) project implementing in Edo (HIV Prevalence: 5.3%) and Kano (HIV Prevalence: 3.4%) states , with a month to go to the end of FY11 has surpassed its PMTCT and HCT FY11 targets by 13% and 2% respectively, having reached 7334 pregnant women with HIV Counseling and Testing (out of a set target of 6441) and 11672 of the general population with HTC (out of a target of 11415). It scaled up in the just concluded third project year to establish PMTCT services in 4 new sites increasing the total number of focal sites from 10 to 14. In Edo, a significant PMTCT coverage of the target population was reached in all

the Local Government Areas (LGAs) where focal sites were situated through outreach activities to other Primary Health Centres (PHCs). As the project plans for the two years ahead, the project in COP12 within the funding cap of US$500,000 will focus strategically on increasing PMTCT and HCT coverage in accordance with the national guidelines, strengthening sustainability efforts, and an end-of-project evaluation. In an effort to increase PMTCT coverage and based on past project experience, PMTCT service sites will be established at the PHC level in the 3 LGAs of Edo state and 5 LGAs in Kano state, within 24 additional PHCs. With accompanying intensive community mobilization efforts to reach youths, integrating HIV into RH/Family Planning, STI and Child health at focal health facilities will increase access to services by the targeted populace. Technical sustainability of the project will be achieved through the formation of a core team of trainers at each LGA for PMTCT and HCT that will include members of Community Based Organizations (CBOs).

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Sub Recipient**
3. What activities does this partner undertake to support global fund implementation or governance? **(No data provided.)**

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors

Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Mobile Population
Safe Motherhood
TB
Family Planning

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
Prevention	HVCT	131,453	0

Narrative:

Scale up for HCT: In order to reach 20,866 men women and youth for HCT services among the rural populace of Edo and Kano States with HIV prevalence rates of 5.3% & 3.4% respectively, the project will establish HCT units in 24 additional PHCs to provide PMTCT and 'provider initiated testing and counseling' HCT services (in accordance with the national guidelines and algorithm) while integratiing HIV into RH/FP services. Positive clients shall be provided with appropriate prevention messages and linked to appropriate support services like HCT for family members and sex partners, counseling for discordant couples and counseling on positive lifestyles/ disclosure. Negative clients shall be supported to remain negative and where appropriate, follow up tests shall be advocated. All HCT clients will be screened for TB using standard questionnaires and based on scores, appropriate referrals will be made for TB diagnosis and treatment. Patients attending STI clinics will have access to HCT while HCT clients will be screened for STI using a standard questionnaire and referrals made as appropriate. Quality of HCT and PMTCT service provision will be maintained through National Quality Assurance CT procedures and quarterly counselors meetings. As in FY11, advocacy teams will facilitate community sensitization and mobilization targeting youths. The project will ensure the Edo state SACA M&E officer is involved in all monitoring visits to focal facilities in the state and submission of monthly data. The logistics supply management system will be strengthened by facility electronic data transfer.
Sustainability: Declining funding levels over project years prevented actualization of involvement of community based organizations (CBOs) as outlined in the original FOA. In year 5 (COP12), the capacity of these CBOs in PMTCT/HCT and organizational development will be strengthened through structured

mentoring sessions. Through sub-granting, they will be involved in the strengthening of community systems to ensure quality supervision and coordination of PMTCT/HCT service provision, community sensitization and mobilization in the LGA.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	182,460	0

Narrative:

Planned strategies in Year 5 of the project will focuse on scaling up PMTCT for increased coverage, sustainability and evaluating impact made by the project in the last five years:
LGA coverage: In order to significantly increase PMTCT coverage (addressing all the four prongs) in the focal states, Pathfinder proposes expanding to 24 additional PHCs: 3 PHCs/LGA (as per the national PMTCT guidelines of the 'integrated cluster model') in 3 'new' LGAs in Edo state and 5 'new' LGAs of Kano state. These facilities will offer quality PMTCT services to mother-baby pair while also ensuring integration of HIV into RH/Family Planning services. Strategies to promote demand creation that were successfully utilized in the project include cost effective outreaches to other PHCs and private clinics, community dialogue with gate keepers, men and women of the potential beneficiary communities (facilitated by Advocacy teams) and pathway-dialogue with TBAs. The project exceeded its targets in the last project year despite numerous challenges (stigma to HIV, staff attrition, general strikes, elections, bad terrain) faced with project implementation in rural hard-to -reach areas. Decreased unit costs per patient by effective coordination, decentralizing project management to field level, effective referrals, tracking mother-infant pair mechanisms, cost effective logistics supply management systems, reduced commodity wastage, structured supervision visits and increased support from the communities are planned. 9,123 pregnant women for HCT will be the set target/year and an estimated 301 positive women linked to care and treatment programs. Project & Facility staff, Government, CBOs and communities will monitor project progress using national and NGI through existing PMTCT Facility Management Committees (Facility-Community Coalitions) and activated Ward Development Committees. A central PMTCT TOT training and step down trainings is planned using National PMTCT training curricula and facilitators for PHC, local government and CSO staff.
As part of our strategy to increase the uptake of HTC at antenatal clinics in supported PMTCT facilities, we shall defray/absorb antenatal booking/registration fees for all pregnant women. In addition, we shall ensure that communities served by the health facilities are adequately informed of this benefit/privilege through local media outlets and strategically placed IEC materials.

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 International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 98,423	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	98,423

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The HCT Expansion Plan for Nasarawa and Plateau States (HEPNAP) project aims to expand the access of HCT services in the rural areas of Plateau and Nasarawa States. The HEPNAP project has activities in 5 Local Government Areas (LGAs) in Plateau State and 5 LGAs in Nasarawa State. PHI will provide HCT and result to 15,623 individuals in FY 2012. ,build the capacity of 15 HCWs in HCT and 15 HCWs on CHCT and provide technical assistance for the prison HCT program in 3 prisons in Plateau and Nasarawa States. HEPNAP will utilize diverse approaches to provide HCT to populations most in need of the service at the community level. Pro-Health will partner with CBOs to provide HCT services to the target population- MAPS. In integrated health facility HCT sites, Provider Initiated Testing and Counseling (PITC) opt-in and opt-out approach will be used to reach patients in medical wards, ANC, TB and STI clinics. HEPNAP will continue to provide Couples HIV Testing and Counseling (CHTC) services to couples to encourage partner reduction and fidelity in couples who learn they are concordant negative and also to reduce HIV transmission in sero-discordant couples. Pro-Health will build on already established linkages with other PEPFAR and multilateral programs and actively follow up referred to ensure that referral is completed. Pro-Health will continue to engage State and Local Governments and leverage resources form Government of Nigeria (GON) and other donors/stakeholders to continue the expansion of HCT access. MAIN ACTIVITIES Provision of HCT services through the integrated health facility and mobile HCT outlets.- On-site supervision and monitoring for Healthcare workers and HCT and CHCT training for HCWs.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	8,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Military Population

Mobile Population

Family Planning

Budget Code Information

Mechanism ID:	**10243**
Mechanism Name:	**HHS/CDC Track 2.0 ProHealth**
Prime Partner Name:	**Pro-Health International**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	98,423	0

Narrative:

In FY2012, Pro Health International (PHI) will utilize a variety of services delivery models to provide HTC services to 15,623 individuals. In integrated health facilities HTC, Provider Initiated Testing and Counseling (PITC) opt-in and opt-out approach will be used to reach 5,623 patients in medical wards, ANC, TB and STI clinics. The mobile HTC approach will be used to reach 6,000 clients who are among the vulnerable and Most-at-Risk Populations (MARPs) especially Female Sex Workers (FSWs) and their clients, Uniform Service Men, Transport Workers and the Prison Inmates. Community outreaches will be

used to reach 4,000 clients living in communities where HTC services are either inaccessible or unavailable.

PHI will utilize the standardized national HTC data collection tools and adhere to the national testing algorithm. PHI will carryout the following activities in order to improve the efficiency and quality of HTC service delivery: monthly supervisory site visits to monitor adherence to quality standards and provide technical assistance to HCWs, monthly counselors meeting for experience sharing, client exit interviews to evaluate client satisfaction, and utilization of Dried Test tube Specimen (DTS) and proficiency testing for internal and external quality assurance respectively.

PHI will utilize the two-way referral approach to ensure that all HV positive clients are referred and linked to care and support services and that HIV negative clients are linked to prevention services. Referred HIV positive clients will be followed up by the HCWs, incentives (e.g transportation aid) for referral completion will be provided where necessary and linkages with programs providing care and support services will be strengthened to ensure referral is completed.

Monitoring and Evaluation activities will include bi-monthly site visits to monitor program implementation, routine data quality assessment, monthly data collation, data entry, data analysis and reporting for performance monitoring and decision making.

PHI will also train 15 Health Care Workers (HCWs) on HTC and Couples HTC (CHTC) each and support the prison staff in 3 prisons in Plateau and Nasarawa States to implement the Prison HTC program.

Implementing Mechanism Details

Mechanism ID: 10263	**Mechanism Name: Global Laboratory Capacity Strengthening Program**
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	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 633,544	Total Mechanism Pipeline: N/A
Funding Source	**Funding Amount**
GHP-State	633,544

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The major goal of this activity is local organizational and human capacity development in quality assurance and quality improvement of laboratory testing. The objectives are for American Society for Microbiology (ASM) to develop training programs provided to Nigerian laboratorians working in clinical health care facilities for improved diagnosis of tuberculosis (TB) and other HIV-related opportunistic infections (OIs). ASM will also improve the infrastructure of laboratories where these individuals currently work. Key expected intermediate outcomes include increased microbiological knowledge and retaining skills required to carry out quality-assured diagnosis of major infectious diseases. ASM will continue to explore partnership opportunities, both public-private and other kinds that help leverage funds, and the strategy, which involves transferring knowledge through onsite mentorship, is a cost-efficient manner to effect major changes. ASM will continue to work with Nigerian laboratory technical working groups at the central level to adapt training materials for Nigeria's particular circumstances, so as to ensure country ownership. Furthermore, ASM will work directly with the Ministry of Health's national reference laboratories for TB and OIs and national TB control program to transfer proper management expertise via onsite mentorship and training programs. ASM has an in-house M&E Specialist whose sole responsibility is to develop indicators to measure program activities. As part of the M&E strategy, the M&E Specialist will offer technical assistance to the Nigerian stakeholders in defining an M&E plan that is manageable and most appropriate for measuring program progress.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	25,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing women's access to income and productive resources

TB

Budget Code Information

Mechanism ID:	10263		
Mechanism Name:	Global Laboratory Capacity Strengthening Program		
Prime Partner Name:	American Society for Microbiology		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	633,544	0

Narrative:

Under COP2012, the American Society for Microbiology (ASM) technical experts (mentors) will continue to provide in-country support for microbiology and OIs, laboratory systems and strategic planning, standardization of protocols for cost effective testing, and good laboratory and clinical practice. ASM's major emphasis area will continue to be human capacity development. Of major emphasis under COP2012, ASM will look to expand training to regional laboratories. Other activities that will be followed up from the previous year will include: 1) improvement of training for simple OI diagnosis; 2) development of a comprehensive, integrated quality management system for basic microbiology, 3) review and improvements to the basic microbiology curriculum (and standard operating procedures (SOPs)) currently used in Nigeria, 4) assisting via onsite mentoring and guidance with providing technical support for development of a proficiency program for OIs to begin assisting with accreditation processes; 5) offering technical assistance for quality management systems (QMS) implementation for TB culture moving towards accreditation. ASM will continue to work closely with Nigeria's Lab Technical Working Group (LTWG) to ensure that these activities are coordinated with other organizations supporting HIV, TB and OI diagnosis and treatment in Nigeria. ASM will work through the LTWG to ensure that activities and deliverables are developed and implemented in a harmonized fashion. Expected outcomes include development of a local cadre of well-trained individual microbiologists, so that they can continue forward

with laboratory trainings at lower levels of the laboratory network, as well as assisting with maintaining achieved levels of diagnosis; in addition, each organization supported through this mechanism will be on track toward WHO-AFRO and/or international accreditation.

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	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,332,224	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	1,332,224

Sub Partner Name(s)

Daughters of Charity, Ikot Ekpene		

Overview Narrative

In July 2008, Partners for Development (PFD) won the “Counseling, Care and Antiretroviral Mentoring Project” (CAMP) in Nigeria. The goal of CAMP is to provide a comprehensive package of care for People Living with HIV/AIDS (PLHIV) including Adult and Pediatric Care and Treatment, Antiretroviral Treatment (ART), Care for Orphans and Vulnerable Children (OVC), Prevention of Mother to Child Transmission (PMTCT), and HIV Testing and Counseling (HTC). A year after implementing CAMP in Niger Delta states of Akwa Ibom and Delta, CDC approved PFD’s expantion to satellite sites for PMTCT, HTC and OVC in Bauchi and Benue states. In these states, PFD works through local community organizations and Primary Health Care (PHC) facilities. Delta and Akwa Ibom states each have a comprehensive care site: Assumption Clinic, in Warri, Delta state, and St. Joseph’s Center, in Ukana Iba, Akwa Ibom state. Both comprehensive sites provide outreach support to PHC facilities, particularly in for HCT and PMTCT. The comprehensive sites provide lab services, ART, and care and support to HIV positive clients. In the two

Delta region comprehensive sites, a combined PFD and Daughters of Charity (DoC) team work to mobilize community support and volunteers to carry out home-based care, prevention and OVC services. In the Benue and Bauchi sites, PFD works with community-based women's organizations (Women in Nigeria, WIN and Women Empowerment Initiative of Nigeria, WEIN, respectively) to support HCT and PMTCT provision through PHCs. The same women's organizations mobilize and train volunteers to provide OVC and prevention services. The project will continue to build the economic capacity of caregivers to provide for the needs of their children and working with local govt & community for child protectio

Cross-Cutting Budget Attribution(s)

Construction/Renovation	16,500
Economic Strengthening	18,000
Education	16,000
Food and Nutrition: Commodities	5,000
Gender: Reducing Violence and Coercion	10,000
Human Resources for Health	76,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

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

Military Population
Mobile Population
Safe Motherhood
TB
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	62,598	0

Narrative:

PFD will provide a package of quality, facility and home/community-based sustainable HBC services, including clinical, psychological, spiritual, social, and prevention reaching 1,453 PLHIVs/PABAs while building the capacity of partners to ensure quality treatment and care. The capacity of facility/community-health staff will be built to ensure provision of a minimum HBC package of services to PLHIV and PABA, including BCKs. In-service training for clinical staff will focus on ART using the national guideline for standard package of care and management of OIs (cotrim provision) and STIs. HTC will be expanded, particularly for family members of PMTCT clients. Client satisfaction surveys will be introduced for QI. Provision of BCKs, nutrition supplements and transport reimbursement will encourage PLHIV enrollment and retention in care and treatment sites.

In summary, the strategy to identify HIV-infected persons early, refer for pre-ART, and retain them for quality continuum of care all the way through end-of-life involves:
• Improving awareness of the need for quality care and support through PE community outreach, PLWHA visits, and other prevention messaging, particularly as part of PwP.
• Expanding facility/community-based HCT to screen and enroll HIV positive persons for pre-ART preparation, including couples and families of HIV positive persons.
• Building capacity of health care workers is improved through appropriate training and support in facility, community as well as home-based care settings in accordance with task shifting strategies for volunteers.
• Improved referral linkages between facility, community (PHC to hospitals and back), and HBC programs

to reinforce quality of care and support as well as integration of services with broader health services, including cervical cancer screening. Also, refer for non-HIV specific services such as IGA, FP/RH and PLHIV support groups.
• Reliable supplies of critical commodities such as BCKs are available at facilities and through community health workers.
• EID to catch infants early and follow through using a mother/child tracking system for defaulters, same day appointments, home visits to minimize LTFU and maximize adherence.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	76,500	0

Narrative:

PFD will during the FY 12, mobilize and train CBOs, caregivers and volunteers to provide direct services to 2,002 OVC through priority family strengthening approaches that reinforce families 'long-term' caring capacities as the basis of a sustainable response to children affected by HIV/AIDS. The aim is to boost household economic and food security, improve access to health care and schooling as well as encourage healthy parent-child relationship through key child protection interventions revolving around early childhood development, prevention for OVC, economic strengthening, and exit strategies for OVCs turning 18 and establishing linkages/networks. The project will continue to build the economic capacity of caregivers to provide for the needs of their children; retaining them in school, and working with local governments and community to establish strong child welfare and protection systems. PFD will empower CBOs as direct OVC service providers while exploring public-private partnerships. CBOs will mobilize community response through child protection committees at LGAs using household/community-focused, evidence-based, needs-driven and age/gender sensitive approach. Best practices will be shared with these committees/communities to ensure compliance with the FMWASD National Guidelines. CBOs will be trained to improve their organizational and technical capacity to engage and support social service systems established by GoN to create vital safety net for OVC. Community leaders and GoN will be engaged in negotiations involving EBG support to schools where OVC are enrolled.

Besides using Sesame Workshop model and materials for Kids Club activities, CAMP will explore use of Save the Children model for protection services and Christian Aid model for facilitation of Life Skills development. To create buy-in and support for OVC, CAMP will invite community leaders to meetings organized for CBOs, caregivers and volunteers. In addition to business skills training and linkage of caregivers and older OVC to microfinance services, PFD will consolidate community-led savings and loans activities for provision of credit to interested caregivers and volunteers. CBOs will be trained/mentored on data collection and reporting on OVC activities using National OVC M&E Data Collection and Reporting Tools. Monthly reports of activities will be sent to Department of Child

Development and FMWASD. PFD maintains membership with AONN in respective states.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	41,995	0

Narrative:

During FY 12, PFD will build capacity of state TB Control Program to integrate/provide quality TB/HIV co-infection services to 150 clients and establish a referral network between DOTS supervisors in the state DOTS centers so that HCT screening and linking clients for TB/HIV co-infection management services can be extended. Given the close interaction between HIV and TB, PFD will scale-up TB control programs in high burden and prevalence states of Delta and AKS to strengthen TB/HIV services in accordance with national strategy. In Delta state, PFD will work to improve services at government owned Eku TB Referral Hospital by scaling HCT and ART services for TB suspects and patients. In AKS, PFD will work with the State TBL Manager at the Comprehensive Treatment Centre where TB screening and diagnosis in PLHIVs will be intensified. The centre will recruit a TB microscopist who will take over the functions currently being undertaken by a TB DOTS Supervisor who visits the centre only to administer the drugs to eligible patients. MoUs have been signed to formalize collaboration between the State TB Control Program and PFD covering expansion of services to public facilities.

Key activities include: Capacity building for TB microscopist, strengthening lab services for accreditation, training on HCT for 5 DOTS supervisors in the LGA and strengthening referral networks between state DOTS Centers and SJRC as well as ensuring effective mentoring from the State TBL Manager. CAMP will provide logistic support for the quarterly TB/HIV review meetings at the centre to help generate quality data using the national TB and HIV M&E framework and tools to track progress towards stated targets.
The STBLCP supplies TB DOTS drugs (CPT/IPT) to the patients with co-infection. Patients on DOTS will be closely followed, for both clinical management of the co-infection, and for early detection of multi-resistant TB (MDR) and referred through community health workers. PFD's work will improve infrastructure for TB diagnosis, renovate TB facility, install necessary equipment for diagnosing and treating TB, train facility staff on TB treatment protocols, provide treatment services and train DOTS supervisors as HCT Counselors.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	3,373	0

Narrative:

In FY 12, a package of care and support will be provided to 71 HIV exposed infants/children at facilities, homes as well as communities through facility and community-based staff as well as caregivers and

PLHIV support groups to ensure adherence to drug regimens, preventive prophylaxis, palliative care, immunization, nutritional as well as growth and developmental support. The aim is to optimize quality of life for HIV exposed clients and their families. In the case of adolescents with HIV, services will include youth-friendly counseling on PwP, enrollment with support groups, and assistance with transitioning into adult HIV services. Routine pediatric care will be integrated with MNCH, prevention and treatment of OIs and other HIV-related complications, including malaria and TB treatment, diarrhea control through access to cotramoxazole, safe water, pain relief and nutritional assessment and support. EID will be scaled in conjunction with existing testing services such as PMTCT, family members of those on adult pre-ART or ART care and treatment, GOPD or other child-centered integrated services.

HIV positive children will receive care and support at both facility and home/community, using leaders of PLHIV support groups, health care workers, volunteers or caregivers. Each of these cadres will be trained and mentored to deliver appropriate clinical care and support services to children. Children enrolled for care will be followed up and monitored closely by these service providers. BCKs and clinical care and two or more other supportive services will be provided. To maintain higher retainer-ship by those involved in care and support services for HIV positive children, CAMP will provide economic empowerment that will enhance the nutrition, logistics. PFD program officers and adherence counselors will work with community volunteers to improve retention in care using defaulter tracking system. Caregivers will be tasked with monitoring patients in their homes regularly, including supervision to ensure improved quality of care. CHW will conduct monthly rounds to visit children with HIV/AIDS and offer support to their caregivers. This will be tracked and reported on with patients disaggregated by gender.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	257,121	0

Narrative:

In FY 12, PFD will ensure continued delivery of quality lab services at all sites in compliance with national/international standards, including purchase of equipment and commodities, and provision of quality assurance, staff training and other technical assistance. To ensure continuous delivery of quality lab services and compliance to national/international accreditation standards. PFD will work with CDC/Nigeria Lab Lead and collaborate with other PEPFAR IPs to provide refresher training to lab personnel at Assumption Clinic and Maternity, and Saint Joseph's Rehabilitation Center in Delta and Akwa-Ibom and satellite sites. The refresher training will focus on routine diagnosis and monitoring of clients, and QA, particularly on improving the proficiency levels in HIV Serology, automated CD4+ estimation and blood chemistry analysis; application of safety measures, use of PPE, proper waste

disposal; proper documentation, including use of worksheets, logbooks, temperature charts and corrective action forms; pipetting skills, blood collection techniques, sample transportation, reception, storage Inventory management of stock and lab reagents and procedures for OI testing (STI).

A system will be instituted for quick blood sample collection from satellite sites and easily transported to hub labs for analysis. PFD's Lab Scientist will organize quarterly review meeting for lab personnel in CAMP supported comprehensive and satellite sites and use this forum for information exchange and ensuring compliance to national standards. PFD will maintain on-going service and maintenance contracts with laboratory equipment and reagents suppliers to ensure functional equipment and quality reagent supply which are critical. PFD has engaged SLAMTA to conduct an assessment and upgrade labs in the two sites in preparation for national accreditation. One more additional laboratory is being proposed for preparation, making a total of 3 laboratories accreditation preparedness and presentation for national accreditation/ international accreditation.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	40,000	0

Narrative:

PFD will generate quality data and information by introducing robust monitoring and evaluation system which will facilitate ease of data collection, storage, retrieval, analysis and utilization at each service delivery point in harmony with PEPFAR and GoN national indicators.

Further, CAMP will continue data generation and information sharing with sub partners, SACA, NASCP and other stakeholders through the USG monthly and quarterly DCT reporting. To maintain quality and sustainability at quality data collection at new sites, relevant program guidelines, registers, forms and report formats will be introduced for easy and accurate data generation. CAMP's M&E team lead will also provide training on New Generation and National Indicators (NGI) and on use of the new DCT spreadsheet to M&E personnel at each service delivery point. This will help roll-out and harmonize consistency and accuracy of data collection and use. PFD will continue to support efforts aimed at joint data verification and quality assurance with GON and work in line with GON policies and guidance to support Partnership Framework Implementation Plan (PFIP). This will mean phased transition of reporting on the paper-based excel format into the National reporting DHIS Platform. First, PFD will adopt the use of DHIS software at its Abuja country office before training and introducing the same at the service delivery points. This more integrated and robust monitoring and evaluation system will facilitate ease of collection, storage, retrieval, analysis and utilization of real time data and information for HIV/AIDS service delivery. This will enhance national capacity to undertake the same activities on their

own when the project ends.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	158,537	0

Narrative:

PFD will deliver comprehensive prevention interventions targeting 6,341 beneficiaries through trained volunteer PEs as well as CBOs using combination of evidence-based approaches that integrate behavioral, biomedical and structural interventions to address HIV drivers. The minimum prevention package interventions use PEs to conduct activities in accordance with National HIV/AIDS Prevention Plan 2010 – 2012 targeting in-and-out-of school youths, particularly young adult men and women ages 18-30 who engage in concurrent partnerships to promote abstinence, delay of sexual debut, fidelity, reducing multiple partners in Bauchi, Benue, Akwa-Ibom and Delta States. With supportive supervision, prevention activities will be delivered though innovative community outreach, population awareness, school-based, and vulnerability issues-based interventions.

PFD's prevention team will organize periodic community outreaches at cluster sites for sexual prevention messaging, including HTC; train 30 PEs to reach peer groups using "PE Plus" model training manuals, focusing on gender dynamics -- women PEs to reach girls/women vulnerable to sexual abuse, violence and coercion; conduct PE sessions in schools and MARP communities at least thrice a month via groups of 10-25 persons reached with evidence-based 3 minimum interventions; organize influence groups to facilitate quarterly meetings that create enabling environment for behavior change and maintenance; form and strengthen HIV/AIDS Clubs as safety nets for behavior change maintenance and link to biomedical services such as HTC, condom messaging and distribution; carry out weekly program supportive supervision and quarterly M&E meetings with specific target groups to assess program approach, both in partners' offices and at intervention sites and use Prevention Intervention Tracking Tools (PITT v6.1.3) for QI - Comprehensive Prevention Intervention Data Entry sheet to track persons reached, strategies used and method to generate results based on 3 minimum intervention which addresses AB and COP.

8) Promote sustainability via integration/transition of resources to GoN at all levels.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	135,318	0

Narrative:

PFD will expand integrated HTC and other prevention services to reach 21,479 clients through PITC or client initiated approaches in a range of facility and community-based settings. The selection of HTC sites will be guided by knowledge of prevalence of HIV. Adopting the "test-to-treat" strategy, PFD will scale-up

PITC for all patients accessing health services (ANC, TB clinics, out-patients) at all points of services. Mobile HTC for high HIV prevalence communities and sub-populations and home-based HTC for partners of families of PLHIV or TB will be conducted following the index patient model. CAMP will also generate demand for HCT through community outreach using sentinel surveys showing higher HIV prevalence rates among subpopulations/MARPs, including uniformed men and women, female sex workers, truck drivers/okada riders, and MSM. PFD will coordinate with SMoH for RTKs and consumables.

Private medical facilities will be supplied with RTK for routine screening on patients reporting for consultation. Clients will receive results the same day with appropriate counseling for those who test negative, positive or are in window period. Those tested positive in out-reach or facilities will be referred to treatment sites for enrollment into care and support services with encouragement on partner notification and CT. Discordant couples will receive prevention education on minimizing risk of infecting partner using condoms. Capacity of health workers, including lab personnel will be improved to cope with increased workload and to ensure testing meets minimum standards. Forty counselors and testers will be trained on HTC/CHCT using national training manual. The latest guidelines on rapid testing algorithm, retesting, and QA/QC protocols will be emphasized. Proficiency testing will be conducted for testers to evaluate performance using approved tools/techniques. M&E tools, including data collection and analysis, will be introduced to monitor progress incorporating couples HTC and other new PEPFAR recommended indicators. Pre-printed logbooks and registers will be used to record test results and lot numbers.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	134,802	0

Narrative:

PFD will apply evidence-based interventions to avert new infections reaching 3,852 MARPs and general population in FY 12 with integrated HTC and condom services as well as refer to increase access to prevention as part of care and treatment, blood screening, infection control, PEP, and STI management in clinics for maximum impact on HIV incidence. MARPs, including alcohol users, at risk youth, mobile/migrant workers, truck drivers, the military and sex workers will be reached through trained PEs and CBOs with prioritized integrated behavioral, biomedical and structural interventions to address HIV drivers in accordance with National HIV/AIDS Prevention Plan. A sustainable BC strategy utilizing appropriate mix of interventions will be used to increase knowledge leading to adoption of safer sexual and RH practices among MARPs and general populations. Messages will be tailored towards BC based on needs and values of the groups. MARPs and general populations will be provided with opt-out HTC services and condoms at designated outlets.

CAMP will integrate prevention as part of care and treatment in facility and community-based settings in line with GHI principle; and promote positive health dignity and prevention. In clinics, 100% of transfusion-bound blood samples will be screened. In communities, COP program officers will utilize activities from at least three intervention prongs to reach individuals/groups using behaviors considered as drivers of HIV infections. These approaches include periodic community outreach, awareness campaigns, PE targeting MARPs, workplace interventions, referrals for STI management, and vulnerability issues interventions.

For QI, the program will continue using PITT v 6.1.3 tools - Comprehensive Prevention Intervention Data Entry sheet to track persons reached, strategies used and results based on three minimum interventions addressing AB and COP. M & E tools include attendance sheets, activity reports, and IEC/condom distribution forms. The “Make We Talk” participatory M&E templates will be adopted to assess level of KAP of specific targets to help assess the level of BC, ensure QI, and alert on emerging issues.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	172,260	0

Narrative:

PFD will expand/improve the quality of PMTCT services by building capacity of facilities to decentralize, integrate, scale-up, link as well as coordinate with GoN to reach 8,613 pregnant women and their eligible infants with sustainable PMTCT services. The strategy will include the activation of 16 new public/private PHC facilities and building staff capacity to integrate PMTCT into ANC services to maximize enrollment in line with GoN policy and knowledge of HIV prevalence; Linking new facilities and treatment sites to enroll and manage exposed infants via referrals; Supporting EID at facilities via PICT (out-out) for children, couples and families; Ensuring training manuals, guidelines, SOPs and M&E tools are shared and used; Strengthen links/referrals between ANC and comprehensive sites to increase HTC - send samples for CD4 count tests; Refreshing ANC staff on PMTCT, infant feeding/counseling, FP couseling, prophylaxis for mothers and newborns and EID; Adopting best practices in integration of MNCH/PMTCT interventions at PHCs covering a range of prevention, care and treatment services. These include clinical staging, treatment of acute OIs, using more effective ARV regimens, access to CD4 testing, enhanced prevention messages, retention and adherence of mother-infant pair, and palliative care and Intensifying HTC using PITC/opt-out model at the facilities while mobilizing the community to create demand, improve male involvement and couple TC.

PFD’s approach will also facilitate coordination between State/LGAs for co-supervision, mentoring, and sharing work-plans; integration with MNCH, FP counseling, malaria diagnosis and treatment, TB co-infection management as well as other illnesses, particularly for HIV positive mothers and infants;

support for logistics to ensure and provide test kits to avoid stakeouts of consumables; accurate data generation, reporting and feedback through M&E tools and materials to monitor progress and building mechanisms into PMTCT program to encourage long term retention, minimize LTFU and improve adherence via information systems strengthening at community-outreach/referral and facility levels.
As part of our strategy to increase the uptake of HTC at antenatal clinics in supported PMTCT facilities, we shall defray/absorb antenatal booking/registration fees for all pregnant women. In addition, we shall ensure that communities served by the health facilities are adequately informed of this benefit/privilege through local media outlets and strategically placed IEC materials.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	107,352	0

Narrative:

PFD will ensure continued supply and access to HIV commodities by creating a functional as well as effective pooled supply chain management system whereby resources from major stakeholders (GF, GoN, PEPFAR, UNITAID/CHAI) are leveraged to ensure a continuous availability of the needed commodities. With the current treatment guidelines, the cut off level to commence treatment for adult/adolescent is a CD4 count of 350 or less. This has increased the number of those who need ARV drugs. It is therefore expected that with PHLWA education, strengthened support groups, expansion of access to PMTCT and EID program, the demand for ARV and OI drugs will increase. ARV and OI medicine supplies to the two sites shall be closely monitored through the monthly reporting tools, which PFD's Logistics officer reviews regularly and gives feedback to the site pharmacists. Drug and commodity wastage will be kept to a minimum through inter-site and inter IP commodity exchange. CAMP has also established relationship with SACA of respective states to benefit from ARV, RTK and OI drug distributions, exchanges and trainings. PFD's adult first line ARV supply will continue to be through SCMS; adult second line and pediatric ARV is being leveraged from the Clinton Foundation; while OI drugs will be procured directly by PFD and distributed to sites but also leveraged from NASCP or SASCP of respective states whenever available.

PFD supports GoN in planning and procurement by participating in national quantification exercises. This year, PFD experienced one stock out for Niverapine suspension due to change in the national ART guidelines which increased consumption of the drug. To ensure no stock outs in FY '12, PFD will participate in the forthcoming PEPFAR Nigeria COP '12 ARV and cotrimoxazole quantification process. PFD will also closely monitor its stock and place timely orders using the Supply Chain Manager Pipeline and Quantized Software. Lastly, PFD will make sure pharmacists/logistics officers in all supported sites are trained to efficiently order for commodities based on need estimates.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Treatment	HTXS	127,907	0

Narrative:

PFD will scale-up treatment activities focusing on access and quality in line with GoN's decentralization plan reaching 866 clients with integrated ART that improves treatment outcomes as well as enrollment in community care and support services. Interventions will target high burden/prevalence communities (MARPs), unmet needs, and early detection and treatment, particularly of children and women.

An experienced Clinical Advisor (CA) will ensure provision of in-service, harmonized training to facility clinicians, particularly at the newly decentralized PHCs. The CA will make periodic onsite supervision as well as record review to ensure quality of treatment services. Each facility will use recording/tracking tools to evaluate clinical outcomes which will be reviewed by the CA on a monthly basis to improve quality of clinical outcomes. Patients on treatment will be linked to community/home-based services and referral systems through CHEWs to help monitor adherence to drug regimens, pharmacovigilence as well as retention in program. Patients will be tracked through these same cost-effective mechanisms for provision of comprehensive care and treatment package, including cotrimoxazole prophylaxis, PwP, viral load monitoring and TB screening. A pooled procurement system will be used for drugs and commodities.

Finally, PFDs strategy is to support GoN to implement relevant packages of priority, integrated adult treatment interventions and ensure adequate staffing at PHCs; coordinate with GoN-managed facilities to expand ART, PMTCT, HTC, HIV/TB and EID services to rural and MARP communities in accordance with GoN and international guidelines and SOPs; work with GoN and all other stakeholders to ensure the availability of drug supplies and lab commodities at PHCs; support GoN in training and monitoring of PHC staff to institutionalize QA and M&E at PHCs thereby ensuring consistent/accurate data collection using GoN tools and materials (registers, cards, and forms), data of which should feed into national reporting system and hold monthly meeting with State/LGA and facility health authorities for better coordination and address challenges pertaining to decentralization.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	14,461	0

Narrative:

In FY 12, PFD will build the capacity of ART clinicians in facilities on pediatric ART management using GoN guidelines thereby establishing and strengthening linkages between hubs/satellites and treatment sites to reach 70 children with quality and sustainable EID interventions as well as link them to other OVC services.Through facilities, every exposed child will be offered DNA PCR test from 6 weeks to determine

their HIV status. This is the entry point. HIV positive infants/children will be enrolled in care and monitored until they are qualified for ARV. Other children seen during routine clinic outlets with high index of suspicion will also be screened for HIV. ARV and cotrimoxizole prophylaxis will be provided as necessary for pre-ART enrolled positive infants and children. PFD's strategies will entail working with facilities to integrate pediatric HIV services by setting specific targets and resources to finance and train those engaged in service delivery; maximize opportunities for identification of exposed/infected infants/children at multiple entry points, including HTC via PITC of sick children in facilities and communities, MCH/ANC units, PMTCT, HBC/OVC programs on a referral basis; conduct joint training of health care workers with state health authorities in pediatric HIV/AIDS care and treatment and utilize CHEWs for follow-up of exposed infants after home delivery linking them for virologic HIV testing at 6 weeks and early antibody testing between 9-12 months of age; shift towards family-centered approach in PMTCT and EID service provision. An integrated approach will not only help prevent HIV infection in the infant, but also increase survival of the mother through treatment and improve overall family health. PMTCT will be the entry point into comprehensive family-focused services for women, their exposed infants and HIV infected family and household members and keep records of children for proper follow-up on clinic appointments and for HBC. CHEWs will be trained on adherence counseling which is reinforced at every clinic visit to mothers or caregivers of children. Caregivers, volunteers and PLHIV will be trained to carry out follow-up, care and support services.

Implementing Mechanism Details

Mechanism ID: 12467	**Mechanism Name: Salesian Mission -Life Choices Nigeria**
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 Inc	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 114,057	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	114,057

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Life Choices Nigeria – VCT Project aims to increase the number of people that know their HIV status. The project achieves this by increasing access to VCT services, by counseling and testing youth and adults and by improving quality of service delivery in the already existent VCT set-ups on a yearly basis. This project is being implemented at the Salesian Akure Health Center in Ondo State within a period of five years. The project works toward decreasing fear and stigma of HIV/AIDS at grass-roots level which will increase the willingness of people to be tested.

This project contributes to the objective of the Ondo State Action Committee on AIDS (ODSACA) reducing the HIV prevalence rate by 25% every four years by 2013. With this in mind, the project was developed in order to fill the gaps identified in the existing system.In FY 2012 the project spefically aims to test 18,104 clients and reach 2000 youth and adults with HIV prevention AB messages in Akure, Ondo State, Nigeria.

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	1,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing gender equity in HIV/AIDS activities and services
Military Population

Mobile Population

Budget Code Information

Mechanism ID:	**12467**
Mechanism Name:	**Salesian Mission -Life Choices Nigeria**
Prime Partner Name:	**Salesian Mission Inc**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	114,057	0

Narrative:

In FY12, 7000 clients will receive VCT services via the mobile VCT unit. Life Choices will conduct group information sessions to minimize pre-testing counseling session as to reach larger number of clients. All clients will receive strong messages about the benefits of abstaining, to be faithful to one negative partner and information about the consistent use as well as the limitations of condoms. All clients will be referred to prevention, care and treatment programs. Clients who are diagnosed as HIV positive will be provided with psychosocial support and referred to proper care and treatment. In FY 2012, 6000 children will get tested by coordinating efforts with a local mother child care service units. Special emphasis will made to test exposed or suspected of having been exposed to HIV. Couples HIV testing and counseling (CHTC): In FY2012, 1014 couples will get tested. CHTC services will be conducted to encourage partner reduction and fidelity couples who learn they are concordant negative. For sero-discordant couples efforts will be made to reduce HIV transmission. Couples will receive pre and post-test counseling together, and learn HIV test results together. During FY12, the project will organize awareness and mobilization campaigns prior to the roll-out of the mobile VCT services. These campaigns will incorporate culturally and age-appropriate HIV/AIDS prevention communication and will reach at minimum of 10,000 people.SMI will develop referral networks for the mobile VCT clients. Project counselors and health professionals will be trained to refer all clients to additional prevention, care and treatment programs. Life Choices will also provide each client diagnosed as HIV+ with 5 psychological support sessions (one-on-one). In addition to these sessions, youth needing further support will be linked with the Life Choices social worker to obtain further support and to access additional services.In FY 2012, the Life Choices-VCT Project will provide at least two trainings to reach 10 project staff to develop more quality counseling skills, strategies for improving the continuum for care for PLWHA and to ensure that health care facilities become more friendly in the delivery of their services.

Implementing Mechanism Details

Mechanism ID: 12831	Mechanism Name: African Field Epidemiology Network
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: African Field Epidemiology Network	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 3,553,060	Total Mechanism Pipeline: N/A
Funding Source	**Funding Amount**
GHP-State	3,553,060

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Goal: To strengthen, expand and ensure the sustainability of Nigeria's disease surveillance and response system mainly through workforce development by training.

Geographic coverage: Our target is to cover all 6 geopolitical zones of Nigeria through both long (2 years) and short course trainings (3 months).

Efficiency strategy
1. As much as possible recruiting Nigerian professionals to work within the project
2. Recruiting some of the graduates from the NFELTP to serve as mentors to residents
3. Establishment of a library for NFELTP, as opposed to giving each resident a set of personnel textbooks.
4. With the acquisition of a larger space for the training program, more meetings and activitis will be held onsite as opposed to using hired venues.

Plans for transitioning to partner government
1. Close partnership with the Federal Ministries of Health and that of Agriculture and Rural Development

2. Participation of the federal ministries in the NFELTP's steering committee
3. Planned participation of the federal ministries in developing a graduate retention and career plan.
4. Strenthening of field sites through various strategies and supply of essential materials such as furniture, computers

Monitoring and evaluation: Several methods including use of EPITRACK a software, and other methods of data collection.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	32,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Impact/End-of-Program Evaluation
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB

Budget Code Information

Mechanism ID:	**12831**
Mechanism Name:	**African Field Epidemiology Network**
Prime Partner Name:	**African Field Epidemiology Network**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	3,553,060	0

Narrative:

System barrier addressed: Nigeria is faced with a challenge of inadequate human resources for health services. The lack of adequately trained personnel is often the most significant rate-limiting step in providing quality health services and clinical services. In addition there is inadequate number of well-trained public health professionals (field epidemiologists, program managers, laboratory personnel, support staff, etc.). with the capacity to collect and use surveillance data and manage national HIV /AIDS and other programs, as well as validate/evaluate public health programs to inform, improve and target appropriate health interventions

How the barrier is addressed: This mechanism focuses on providing training for public health professionals through a 2 year masters' degree training program focusing on performance improvement for participants in the training. The 2 year training producers leaders in public health, who can head government bodies and other entities (private and public), where they directly influence public health policy and action. The training produce cadres of professionals at different levels of the health system that can support each other to improve public health practice in Nigeria.

Potential leveraged linkages/oppportunities identified: The NFELTP works closely with various departments within the FMOH and FMARD. These provide potential field sites where trainees are posted to build their skills. Collaborating universities- Ahmadu Bello and Ibadan provide lecturers to teach trainees and also accredit the 2 year masters' training.

Implementing Mechanism Details

Mechanism ID: 12885	**Mechanism Name: UNICEF**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: United Nations Children's Fund	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	

G2G: N/A	Managing Agency: N/A

Total Funding: 500,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	500,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The goal of the OVC program in PEPFAR is to mitigate the effect of HIV/AIDS in families infected and affected by HIV/AIDS. The range of OVC services that PEPFAR partners are providing to the families and children affected by HIV/AIDS include: Protection, Nutrition, Health ,Psychosocial support, Shelter and Care and Economic Strengthening. Protection involves the provision of services that addresses child identification, abuse, exploitation, neglect, and violence. A 2009 review of PEPFAR-funded child protection programs showed that very few had appropriate child protection services and policies that address violence against children. Yet any organization that works directly or indirectly with children should have clearly defined child protection policies and services to prevent and respond to child abuse, exploitation, neglect, and violence perpetrated by staff or volunteers associated with the organization and community members. This study will provide evidence base data for the provision of protection services to OVC by Government of Nigeria and PEPFAR. This study is timely and would result in data and information that would also help inform our pediatric health and psychosocial programs. A similar study has been done in Swaziland and Kenya and this has greatly influence their OVC programs. This funding is for completion of the ongoing child protection mapping activities as well as Violence Against Child (VAC) study.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **No**

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing women's access to income and productive resources
Child Survival Activities

Budget Code Information

Mechanism ID:	**12885**		
Mechanism Name:	**UNICEF**		
Prime Partner Name:	**United Nations Children's Fund**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	500,000	0
Narrative:			
The funds for this activity will be directed to the completion of the ongoing Child Protection mapping study as well as Violence Against Children (VAC) survey by UNICEF. UNICEF will coordinate with other UN agencies who have expressed interest in the survey			

Implementing Mechanism Details

Mechanism ID: 13190	**Mechanism Name: Institute of Human Virology Nigeria (IHVN)**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Institute of Human Virology, Nigeria	
Agreement Start Date: Redacted	Agreement End Date: Redacted

TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 3,036,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	3,036,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Community in ACTION (CIA) project is being implemented by the Institute of Human Virology Nigeria (IHVN) through a public private partnership with the National Primary Health Care Development Agency (NPHCDA) and Solina Health Ltd. (SHL) to integrate PMTCT and strengthen comprehensive health services at Primary Health Care (PHC) centres including their surrounding communities.
CIA works through PHC facilities as PMTCT care centers linked to secondary and tertiary centers providing more complex PMTCT services in Nasarawa, Benue, Niger states and Abuja. CIA will scale up to 44 PHCs and 16 secondary facilities in Benue and Niger states with a focus on integration of comprehensive PMTCT services and community-based interventions that will achieve virtual reduction in MTCT. CIA employs community resources for demand creation, client follow up and to expand access. For sustainability, capacity for PMTCT is built at national and sub-national levels by strengthening networks of PHCs and the coordination roles of the FMOH and SMOH in the 16 states where IHVN is lead implementing partner to hold coordination meetings and other strategic activities. In support of the “Three Ones”, CIA will extend the National Health Management Information System to the PHC level. A uniform unique patient identification s for all PHC clients that links mother infant pairs is used to track clients who access service and National registers used for data collection at sites. A Site Case Manager Data Base that incorporates elements from the client specific data collection tool (DCT) will be maintained at the PHC and regional office for client tracking within the community and between facilities in the PHC cluster.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**

2. Is this partner also a Global Fund principal or sub-recipient? **Principal Recipient**

3. What activities does this partner undertake to support global fund implementation or governance?

Budget Code	Recipient(s) of Support	Approximate Budget	Brief Description of Activities
HTXS		0	
HVTB		0	
MTCT		0	
OHSS		0	

Cross-Cutting Budget Attribution(s)

Construction/Renovation	486,785
Economic Strengthening	65,452
Food and Nutrition: Commodities	31,841
Food and Nutrition: Policy, Tools, and Service Delivery	41,852
Gender: Reducing Violence and Coercion	7,845
Human Resources for Health	50,700

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

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
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**13190**
Mechanism Name:	**Institute of Human Virology Nigeria (IHVN)**
Prime Partner Name:	**Institute of Human Virology, Nigeria**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	0	0

Narrative:

CIA will support the “Three Ones Framework of the Government of Nigeria (GON) by extending the National Health Management Information System (NHMIS) to the PHC level to support service delivery and data sharing. To achieve this, all clients would be given uniform unique patient ID system that links mother infant pairs and ensures the tracking of clients who access different points of service, revised data collection tools (DCTs) will be deployed to sites and site staff trained in standardized completion of these forms. CIA will support GON’s collaboration with Measure Evaluation to review and harmonize PMTCT DCTs to capture required data and plan for roll out in project states.
A Site Case Manager Data Base that incorporates elements from the client specific DCT is maintained at the PHC and regional office for client tracking within the community and between facilities in the PHC cluster. Indicator reports are generated and employed to monitor site specific performance, address deficiencies, guides program strategy and improve training. Support would be provided to GON’s National Reporting Systems in the collection, review, and submission of quality client and program data, while ensuring linkages between Federal, State and Primary health Centres/Community Based Organizations quality improvement processes through the lead implementation partner concept.

For sustainability, the lead IP concept for PMTCT Strategic Information (SI) will be employed to build the capacity of State AIDS and STIs Control Program and State ACTION Committee on AIDS in the establishment of and M&E oversight systems, site monitoring use of data for decision making and to

jointly develop and disseminate training tools and to develop a protocols for reporting, forecasting for DCTs and logistics planning and delivery of DCTs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	0	0

Narrative:

Community in action (CIA) will support the capacity of Government of Nigeria (GON) at the national and state level by its role as lead IP for PMTCT in 16 states by strengthening the networking of PHCs and the coordination roles of SMOH and FMOH and support State and Federal Ministries of Health to hold meetings and other strategic activities to ensure oversight and foster ownership.
CIA will support the finalization of the new PMTCT guidelines and subsequent printing of the guidelines and undertake capacity building on it. The FMOH will be supported to print training manuals as well TOTs and step training that will follow.
At the state level IHVN as a lead IP in PMTCT will support 16 states and develop the capacity of State AIDS and STI Control Program (SASCP) and State Action Committees on AIDS (SACA) in the areas of coordination, planning, implementation and monitoring of PMTCT programs as well commodity logistics.
CIA will develop a memorandum of understanding with each state leadership to secure political buy in, foster accountability and sustainability and gear the state into effectively taking ownership of the PMTCT program.
Community in action will support SASCP and SACA to identify and convene a meeting of other implementing partners and other stakeholders implementing PMTCT program in the seven states to establish a framework for actualizing PMTCT. Community in action will support the establishment of a state PMTCT task team. This task team will be supported to hold monthly meetings. As part of its sustainability plans community in action will support the SACAs/SASCPs to develop a costed scale up plans that will serve as an advocacy tool to policy makers in the state to increase funding for PMTCT program and foster ownership of health programs by the respective state government.
Community in action will support the state technical working group to convene a monthly meeting to review program implementation, analyze gaps and suggest way forward.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	3,036,000	0

Narrative:

In COP 12, Community in ACTION (CIA) will utilize the “Hub, Spoke Cluster” model with PHC linked to secondary and tertiary centers. CIA will work with Ward Development Committees for demand creation to provide HCT to 173,312 pregnant women in Nasarawa, Benue, Niger, and FCT. Focus will be on

integration, comprehensive PMTCT services and community-based intervention.
Health system will be strengthened through National Health Monitoring Information System, human and infrastructural capacity building. Coordination will be by a Site-based Case Manager (SCM) team to increase access, facility delivery and retention in care.

All HIV positive mothers will receive HAART using the 'test and treat' approach. PMTCT State Coordinators will be appointed to provide support to the sites. Geographic information system map of services, Mother-mentors, MHW and peer educators will be employed. Exposed babies will receive co-trimozaxole prophylaxis; EID, Action meal and Pediatric follow-up. The SCM team data base will be used for follow up of clients and exposed babies to increase retention..
Partners of HIV infected women, other children and wives will be provided T&C. Positive Health and Dignity Program (PHDP) messages will be integrated within PMTCT care. Encounters with clients accessing immunization or medical services will be tracked using a unique identifier including linkages for social and OVC services. NPHCDA capacity in the areas of program and financial management will be developed and annual monitoring to ensure compliant with US federal and Nigerian government requirements..
This activity is linked to adult and pediatric care and treatment, OVC, laboratory infrastructure, and will create a sustainable structure through the state lead IP program.
Target population - Pregnant women accessing Antenatal care services; HIV exposed infants and family members.
Areas of emphasis - Integration, comprehensive services, training, referrals and community-based intervention This will focus on male involvement.
Sustainability - Strengthening coordination roles of FMOH, and SMOH in states where IHVN is lead IP.
Production and dissemination of PMTCT guideline and other related activities at all levels.
As part of our strategy to increase the uptake of HTC at antenatal clinics in supported PMTCT facilities, we shall defray/absorb antenatal booking/registration fees for all pregnant women. In addition, we shall ensure that communities served by the health facilities are adequately informed of this benefit/privilege through local media outlets and strategically placed IEC materials.

Implementing Mechanism Details

Mechanism ID: 13564	**Mechanism Name: Federal Ministry of Health, Nigeria**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Federal Ministry of Health, Nigeria	

Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 13,476,399	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	13,476,399

Sub Partner Name(s)

Solina Health Ltd		

Overview Narrative

FMOH will support the Human Resource for Health (HRH) branch to improve on the national Human Resource Informatics Systems (HRIS) started in COP 11. FMOH will also collaborate with 5 states of the federation to establish and strengthen state HRH branches. FMOH will support strengthening of the existing government of Nigeria collaborating centers for leadership and management training and support of 2 FMOH staff to attend the training. FMOH will support the planning and hosting of the 2012 national HRH conference and continual strengthening of the national Health Systems Technical Working group. FMOH will also support the following activities of the government of Nigeria, advocacy visits for the formation of a national patient management monitoring system (PMMS), HIV incidence study, 2012 ante natal care sentinel survey and HIV drug resistance threshold survey. The National Human Research Ethics Committee (NHREC) will be supported to develop a national research policy regulating HIV/AIDS researches involving human subjects in the country. FMOH will also be strengthened to develop a laboratory networks and establish a repository center for specimens and data for surveillance activities and capacity of 6 TB zonal reference laboratories will also be strengthened., A national sample repository center will be developed and institutionalized A National Reference Laboratory to oversee laboratory services in Nigeria will also be established.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Sub Recipient**

3. What activities does this partner undertake to support global fund implementation or governance?
(No data provided.)

Cross-Cutting Budget Attribution(s)

Human Resources for Health	29,684

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing gender equity in HIV/AIDS activities and services
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**13564**		
Mechanism Name:	**Federal Ministry of Health, Nigeria**		
Prime Partner Name:	**Federal Ministry of Health, Nigeria**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	682,279	0
Narrative:			

In line with WHO recommendations, FMoH will work with appropriate Implementing Partners to develop and standardize an EQA reagent repository that will support evaluation of HIV labs ability to collect, process, store and transport samples for HIV serology, viral load assays, TB and malaria testing. FMoH will support CPHL to house the EQA panel in 6 regional reference laboratories and provide technical assistance to HIV, TB and malaria laboratories in Nigeria. FMoH and its partners will pursue accreditation of the EQA labs by the Medical and Laboratory Science Council of Nigeria (MLSCN). FMoH will support CPHL to expand the National Reference Laboratory network from a single site in Zaria to 6 zonal HIV reference laboratories. FMoH will build on its partnership with appropriate PEPFAR Implementing Partners and local Universities to establish one reference laboratory in each geo-political zone. SICDHAN will support the reference laboratories to achieve ISO certification and other accreditations as appropriate. FMOH will develop HIV/AIDS related laboratory protocols and training packages for the implementation of reference laboratories that build upon existing methodologies in Nigeria. A technical review and dissemination of laboratory guidelines and Standard Operating Procedures (SOPs) at National and State levels will be conducted in the first two years of implementation of this project. FMoH and its partners will train 40 laboratory staff on molecular assay to support viral load estimation and Early Infant Diagnosis (EID), as well as in TB/HIV-related laboratory diagnosis to enable effective supervision of HIV/TB centers such as the National Reference Laboratory in Zaria. Also, FMoH will support a national harmonization meeting of laboratory protocols, plans, and an implementation framework based on scientifically proven methodologies. FMoH will collaborate with appropriate partners to mentor the Central Public Health Laboratory (CPHL) and other Nigerian HIV/AIDS laboratories towards MLSCN and international accreditation, in line with National and International best practices. In addition, CHPL will be strengthened to develop and implement an accreditation program for HIV/AIDS laboratories in Nigeria.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	4,150,000	0

Narrative:

FMOH will be supported to carry out the following activities of the government of Nigeria, advocacy visits for the formation of a national patient management monitoring system (PMMS), HIV incidence study, 2012 ante natal care sentinel survey and HIV drug resistance threshold survey

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	8,644,120	0

Narrative:

FMOH will support the Human Resource for Health (HRH) branch to improve on the national Human

Resource Informatics Systems (HRIS) started in COP 11. FMOH will also collaborate with 5 states of the federation to establish and strengthen state HRH branches. FMOH will support strengthening of the existing government of Nigeria collaborating centers for leadership and management training and support 2 FMOH staff to attend the training. FMOH will support the planning and hosting of the 2012 national HRH conference and continual strengthening of the national Health Systems Technical Working group. . The National Human Research Ethics Committee (NHREC) will be supported to develop a national research policy regulating HIV/AIDS researches involving human subjects in the country.

Implementing Mechanism Details

Mechanism ID: 13667	**Mechanism Name: Center for Intergrated Health Program (CIHP)**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Center for Integrated Health Programs	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 26,591,088	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	26,591,088

Sub Partner Name(s)

(No data provided.)

Overview Narrative

CIHP is a newly established, indigenous NGO created as part of the Track 1.0 transition from ICAP's PEPFAR-supported Columbia MCAP.

CIHP's strength lies in the richness of its technical approach, program strategies and management systems from highly experienced technical staff largely inherited from ICAP NG.

CIHP will continue 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 and integrated HIV/AIDS prevention, care and treatment services using a family-centered approach.

CIHP partners with the USG, other donors (GFATM) and implementing partners, GoN (Federal, State and Local), FBOs, non-governmental and CBOs and other for profit partners across six states including high HIV prevalence states of Akwa-Ibom, Benue, Cross River ,Gombe, Kaduna and Kogi.
CIHP targets a combined population using a multi-disciplinary approach to provide continuous support 55 hospital networks across six states of Nigeria.
Key CIHP approaches include: local experience and expertise; strategic partnerships; comprehensive, family-centered care in line with GHI principles; quality and evidence-driven programming; skills transfer and capacity building; advocacy for sustainability and local ownership; gender-sensitive approaches; and greater involvement of people living with HIV.
CIHP will work with GON and NGO partners, private facilities (faith based and community based organizations) to increase programmatic and financial responsibility for managing comprehensive HIV/AIDS services within an integrated health care system with the aim of demonstrating a progressive increase in local stewardship of high quality comprehensive HIV/AIDS and other health services in the six states.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Sub Recipient**
3. What activities does this partner undertake to support global fund implementation or governance?

Budget Code	Recipient(s) of Support	Approximate Budget	Brief Description of Activities
MTCT	CIHP	1708210	In 2011, CIHP became a sub-recipient of the Global Fund (GF) round 9 consolidated grants for PMTCT. This followed an assessment of CIHP program components by NACA. CIHP was selected based on its success and experiences in the scaling up of PMTCT services to with a focus on primary health facilities. CIHP will be supporting the GoN through the GF R9 grant to scale up PMTCT services in three selected states

			as part of its contribution to increasing the national coverage of HTC for pregnant women from the abysmal 13% to 50% by the end of 2012. CIHP is also the lead implementing partner for PMTCT in the five states of Akwa Ibom, Benue, Gombe, Kaduna and Kogi States. According to the Universal access Report of 2011 for Nigeria, only 14% of pregnant women have access to ANC., 11% of HIV positive women have access to ARVs while only 6% of HEIs have access to ARVs. There is urgent need to bridge the PMTCT coverage gap in order to address the unmet need of PMTCT and to achieve the elimination of Mother to child transmission (EMTCT) of HIV target. CIHP will collaborate with NACA to scale –up gender sensitive HIV/AIDS prevention, care, and treatment and support interventions for adults and children in Nigeria. This will be carried out through the implementation of comprehensive PMTCT services across a total of 79 existing Government of Nigeria (GoN) primary health facilities (Non-PEPFAR supported sites) in the three states of Cross River, Benue, and a 3rd state to be determined. This is part of its mandate to address the unmet need of PMTCT and ultimately achieve the elimination target of Mother to child transmission (EMTCT) of HIV. This partnership will contribute to the 50% national PMTCT target by end of year 2012. CIHP will provide the minimum

			package of PMTCT services in these sites including: provision of HIV counseling and testing to 143,640 pregnant women that will receive their test results and linked into appropriate care and treatment programs over a 2 year period, out of which at least 8,889 will receive ARV prophylaxis. CIHP's strategies to scaling up PMTCT Services CIHP as sub recipient of GF consolidated round 9 under NACA (Principal recipient) will continue to rapidly scale up PMTCT services to the hard to reach areas with high ANC attendance in high HIV prevalence states of Benue, Cross- River states as well as in the TDB state. Baseline site assessments will be conducted for the 79 PHCs with the relevant stakeholders ((SMOH, SASCAP, LGAs, SACA, and UNAIDS). As part of its Lead IP role of supporting GoN towards increasing coverage and effectiveness of PMTCT services, CIHP will establish and or strengthen state PMTCT Technical working group /Task team in Benue and support the lead IP partner in Cross River state to ensure effective PMTCT program implementation. This is to enhance the capacity of sub-national levels of government towards improving the coordination, implementation, coverage and quality of PMTCT services. CIHP will support the relevant state authorities in Benue state and the 3rd state to develop

			costed work plan for PMTCT scale up. CIHP will support high quality of PMTCT services across ALL its supported sites in line with the National Guidelines and WHO recommended guidelines.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

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
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**13667**
Mechanism Name:	**Center for Intergrated Health Program (CIHP)**
Prime Partner Name:	**Center for Integrated Health Programs**

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Care	HBHC	3,951,909	0

Narrative:

Adult Care and Support

Early HIV Detection and Enrolment
CIHP will continue to support early detection by strengthening facility based HCT through point of service testing, and targeted community-based testing, prioritizing MARPS.
Provision of care and support services
PLWHIV will continue to receive the minimum care package of BCKs, psychosocial support, nursing care, OI and STI management.

Strengthening of HBC programs
HBC programs will be strengthened and expanded for improved quality and access through involvement of support group network and volunteers.

Improved quality care
Periodic quality checks conducted through the application of checklists, SOPs, Standard of Care and Model of Care assessment tools and the provision of relevant job aids to site clinicians.

Human Capacity Development:
842 HCWs will be trained in palliative care, HBC and OVC service provision

Retention in care
CIHP will strengthen patient appointment, adherence counseling and defaulter tracking systems, and fast track the decentralization process to reduce client waiting time at the clinics

Decentralization of care and treatment:
CIHP will build capacities of PHCs and their LGAs to provide devolved care and support services. CIHP will partner with private hospitals to provide HIV care and treatment services in these settings.

Special considerations for the disabled
Health facilities will be sensitized on fast-tracking services for the disabled and vulnerable populations. Home visits will also prioritize the disabled.

Considerations for injection drug users
CIHP will continue sensitization campaigns against substance abuse, and advocate for the inclusion of Naloxone in the essential drug lists of supported facilities. Screening for Hepatitis B virus co-infection, will

be intensified. Negative clients will be referred for vaccination, while positive clients will be commenced on a Tenofovir based regimen

Addressing gender issues
Care and support services will also seek to address gender imbalances through linkages with CSOs and women groups. Services will also be organized to reflect sensitivity to the needs of vulnerable groups of women and children. MTA strategies encouraging male partner involvement will be encouraged.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	1,425,903	0

Narrative:

OVC
CIHP will partner with at least thirty (30) CBO networks and health facilities to provide OVC supportive services via a family-centered approach, taking into account the individual needs of OVC and their households. Supportive services will be provided at the health facility and community levels.

Facility level VC service
HIV-infected and affected children are provided with HTC, basic clinical care, including nutritional assessments, health education, and preventive care packages (i.e., enhanced basic care kits) as part of the clinical care at health facility level. Linkages will be created between facility and community based services to ensure that OVC are identified and cross referred between the two levels for a comprehensive OVC package.

Community level VC service
At the community level,, Community Care Coalitions for OVC (CCC) a community-driven initiatives to ensure the active participation of community gatekeepers such as religious leaders, women's groups, and traditional leaders in the active identification of OVC will be supported. The CCC is a strong community reference point for the reduction of stigma and discrimination against OVC as well as prioritize selection of OVC for services..

Community-based OVC activities will include OVC identification, assessment, and tracking using the Child Status Index, timely referral for relevant clinical services, psychosocial support, nutrition support through food banks as well as educational support. OVC care givers will be linked to organizations like MARKETS for Household economic strengthening activities. Partnerships with "Sesame Street" will be explored for kids clubs.

Household economic strengthening
CIHP will continue to build on ongoing activities to enhance equity and gender approaches including male involvements that lessen the vulnerability of female OVC by increasing their access to needed services. CIHP will collaborate with relevant stakeholders such as FMWACD, and UNICEF, on OVC policies, guidelines, protocols, and harmonized implementation in line with national OVC strategic plan. Household economic strengthening will be enhanced through establishment of linkages with organizations involved in Income Generating Activities (IGAs). This will be done with the aim to continue to build the economic capacity of caregivers to provide for the needs of their children; retaining them in school, and working with local governments and community to establish strong child welfare and protection systems.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	1,556,229	0

Narrative:

TB/HIV
Intensified TB case finding
CIHP will intensify TB case detection amongst PLWHIV by screening for TB at various HIV service points and referral of suspects for TB microscopy and free radiological diagnosis. CIHP will support high volume TB sites with fluorescence microscopy. All PLWHIV diagnosed with TB will be linked to TB treatment, through support for co-location of TB/HIV services in collaboration with the NTBLCP. Support standardized TB case finding in 34,562 new and old PLWHIV using screening tools and the treatment of TB in at least 2,212 HIV positive patients.

TBHIV prevention
TB/HIV co-infected patients will receive Cotrimoxazole prophylaxis and linked to other palliative care services for provision of BCK components. TB patients will be encouraged to bring contacts for early TB case-finding. IPT for eligible PLWHIV will be provided.

Reducing the burden of HIV in TB patients
Support will be provided to at least 82 DOTs sites to enhance PITC for TB patients and suspects. Referral linkages will be strengthened between DOTS and ART sites. High volume DOTS clinic will be upgraded for ART services in line with one “stop approach”. DOTS facilities will be supported to provide HTC to at least 13,246 TB clients and suspects. 345 HCW will be trained on TBHIV management, TB case detection and TBIC.

TB Infection control (TBIC)

Nosocomial transmission of TB will be mitigated through administrative and environmental control measures including developing facility TBIC plans; safe sputum collection; cough etiquettes and hygiene promotion including separation of suspects; infrastructural repairs for improved ventilation and provision of other TBIC commodities including N 95 respirators.

Improving lab diagnosis and management of MDR TB
CIHP will support the establishment of a Drug Sensitivity Testing for MDR-TB case detection. 3 Gene Expert (Xpert MTB-RIF) machines will be installed at 3 high volume TB sites. Sputum samples for MDR TB suspects will be logged to sites with DST and confirmed cases referred for management at reference hospitals. CIHP will upgrade 2 wards in selected sites to commence MDR TB management based on the availability of second line anti-TB drugs and MDR TB case burden.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	422,807	0

Narrative:

Pediatric care and support

Early identification of infected children and linkage to and retention in care
Intensified case finding and enrolment of pediatric HIV cases will continue from Point-of-service testing at multiple points including pediatric wards, GOPD, immunization and labor wards. The “WATCh” strategy to provide HTC, and enrollment for all children of enrolled adult index cases using genealogy forms will be strengthened. CIHP will support EID by ensuring that HIV-exposed Infants have access to DBS/EID. HTC for children will be integrated into home visits; adolescent testing will be encouraged through youth friendly clinics. Child retention in care will be sustained through enhanced adherence counseling for care givers, same day mother-baby clinics, peer educator support and prioritized defaulter tracking.

Minimum care package
Following enrolment, children will receive a comprehensive package of clinical care and support services including prevention and treatment of OIs, growth and developmental monitoring, TB screening, referrals for immunization as well as VC support services. ART eligible children will be placed on treatment with routine monitoring. CIHP will strengthen the linkage between indigent children and community food banks, and link their care givers to IGAs.

Decentralization of pediatric care services
CIHP will adopt a phased approach in the devolvement of C&T services for children, starting with adolescents and progressively scaling down to younger children of 7 – 12 years age, 4-7 years and

subsequently 2 – 4 years age groups, with increasing expertise and maturity at the PHCs.

Trainings/Capacity building
Health care providers at all treatment facilities and PHCs will be trained, re-trained and mentored to provide sustained high quality pediatric C&T services.

Community Linkages
CIHP will work closely with its NGO/CBO/FBO partners to promote community involvement in the care of children infected and affected by HIV. Linkages will be created between health facilities and the communities to provide a minimum package of psycho-social, health, educational, nutritional support (food bank) for VC. Additional support services will be leveraged from Sesame Street and MARKETS.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	2,502,987	0

Narrative:

Lab Services
Maintenance/Expansion of lab services:
CIHP will continue to expand lab services while maintaining existing ones by strengthening lab capacity and monitoring tests and developing 14 new labs to provide HIV lab services. Supported labs will introduce new tests to strengthen toxicity monitoring of patients on treatment. CIHP will continue to support TB diagnosis by providing 10 additional FM microscopes and safety cabinets.

Strengthening Lab Systems
CIHP will participate in the formation of a National lab plan working with National TWGs providing TA to regulatory bodies. CIHP will continue to provide TA to LGA to provide minimal lab capacity at PHC level. CIHP will continue to support the MLSCN to implement CMEs on lab quality essentials at supported states to build capacity of lab Scientists. CIHP will work with the National QA TWG to establish post market validation of HIV RTKs procured at State level and promote the formation of state lab QM teams.
Integration of Lab Services
CIHP will strengthen lab service integration by strengthening linkages between ART and non ART general lab units to strengthen the national lab systems. CIHP will continue to extend training, mentoring, provision of tools to other lab units to promote integration.

Strengthening Equipment Maintenance
CIHP will continue to strengthen the capacity of SMOH and Lab personnel/engineers to maintain lab

equipments. CIHP will support SMOH to develop equipment maintenance agreements for both hospital and PHCs.

Lab Quality Systems Implementation:
CIHP will continue to strengthen lab QMS in preparation for National/International accreditation by implementation of LQS/accreditation plan. CIHP sites will continue to participate in the National EQA programs for TB, CD4 and RT and use results to improve lab services. In 2012, CIHP will expand EQA participation to CBC and Chemistry testing. State Quality officers with skills in implementing QS will be used to provide supportive mentoring to other labs.

Lab Management Information Systems:
CIHP will strengthen LIS to reduce turnaround time of results and improve patient management. Lab capacity will be build to operate and maintain LIS and develop policy and SOPs on operation.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	776,517	0

Narrative:

CIHP will be to continue to promote innovative approaches to health information system (HIS), monitoring and evaluation (M&E) and surveillance and survey (SS) as well as encourage local ownership of health management information system

Strengthen existing Health Information System (HIS): CIHP will collaborate with various stakeholders to support the strengthening of the national health management information system. A key fundamental principle of this strategy will be to support GoN towards attaining the'' three one'' principles; One HIV action framework; one coordinating authority and one agreed M&E system as enshrined in the national strategic framework (2010-2015). CIHP will strengthen data reporting through the three tiers of government. As lead Implementing Partner for SI in the six supported states, CIHP will encourage and support the government' establishment of HMIS unit with capacity to coordinate HIS, M&E and Surveillance and survey activities, through advocacy, formation of stakeholders pressure group and development of a model LGA and State HMIS system.

Monitoring and Evaluation (M&E):
CIHP will continue to strengthen capacity at all levels for M&E by supporting the building of a critical mass of health workforce at service delivery point, community, LGA and state. CIHP will work with the states to develop and implement cost effective strategies for coordinating strategic information activities

at states and local government level to ensure a harmonized data collection and information flow structure in line with National strategy.

Surveillance and Survey (SS):
CIHP will continue to participate actively in surveillance and survey related activities in Nigeria. In particular, CIHP will avail the GoN at all levels of its expertise in protocol and tool development for both behavioral and biological surveillance systems for tracking the National response. CIHP will provide additional support to GoN in the area of dissemination of findings from such surveys and work with GoN of Nigeria at all level in the analysis of surveys.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	0	0

Narrative:

CIHP will implement activities to improve health sector leadership and governance to support transition over time to state and LGA, site MDTs, and CBOs. CIHP will build on technical support, for regional M&E, logistics, and accounting to support sites, state governments, and local CBOs/FBOs to strengthen capacity, ensure sustainability, and facilitate program activities' transition.

Promoting leadership and governance
Capacity of CBOs/SMOH will be built on SI, proposal writing, project/financial management to increase their skills, enhance responsiveness with emphasis on accountability and transparency.

Enhancing the Service Delivery package
high quality service provision will be promoted through an integrated service package based on population health needs to reduce barriers to equitable access.

Strengthening of the Health care Workforce
CIHP will engage state/local governments to adopt measures for equitable distribution of health workforce especially in the semi-urban/rural areas. It will work with new partners -NMCN, CHPBN and NMDC to implement activities addressing HR and quality challenges across the supported states. It will support the first GON HRH summit to address issues related to an efficient and motivated workforce. CIHP will adopt a sustainable and cost effective in-service training strategy according to national guidelines.

Strengthen existing HMIS

CIHP will evolve a program tracking system including GIS mapping for all sites providing HIV care in the country to enable them provide up to date information on service coverage, HR capacity and linkages.

Strengthening procurement and logistics will improve service delivery at HF. HF will be supported to forecast and request for sufficient commodities using the MAX-MIN inventory control system.
Lab QMS will be instituted in all sites in preparation for National/International accreditation.

Advocating for a good health financing system
CIHP will advocate to states and LGAs to source funds for health services to reduce the financial burden on citizens and improve access. CIHP will strengthen capacities of finance and admin staff while working closely with other IPs and donors like PATHS2, on HSS in Nigeria to leverage resources.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMBL	23,489	0

Narrative:

Blood Safety Strategies
CIHP will promote blood safety with emphasis on strengthening facility blood transfusion committees, community awareness and blood drives, provision of blood safety items, linkage of blood banks to NBTS and building capacity of HCW. CIHP will work to implement the WHO guidelines recommending 10-20 blood donors per 1000 population in supported facilities and communities. In COP12/13, CIHP will reactivate blood transfusion committees in facilities and create new ones in newly supported sites. Blood transfusion committees will be integrated with existing safe injection and waste disposal committees to ensure efficiency and harmonization of activities.

CIHP will develop pool of low risk Voluntary National Blood Donors (VNBD) by strengthening the development of a nationwide voluntary donor recruitment system and providing technical support for blood donation drives in facilities/surrounding communities. CIHP will advocate to supported hospital managements to buy into the NBTS blood services program to create demand, provide support for blood donor organizers, and strengthen health facility and community focused blood drive activities. CIHP will continue to strengthen the use of questionnaire for donor screening and will develop with NBTS standard messages for donor counseling. Linkages between donor points and HTC will be strengthened to ensure positive donors identified receive appropriate counseling, information and linkage to C & T. CIHP will intensify community mobilization and awareness working with the Red Cross, NYSC/Road Safety club, CBOs, FBOs and support groups to sensitize on the need for VNNBD.

CIHP will support the distribution of IEC/BCC materials to promote VNBD in facilities and communities.

CIHP will strengthen and partner with Club 25, a group of youths who voluntarily seek to donate a number of pints of blood before they reach 25 years. CIHP will work with club 25 in Kaduna and other states to provide awareness and promote voluntary non-remunerated blood donation their communities. Club 25 will be linked to CIHPs youth friendly activities to integrate blood safety with other services and duplicate the concept across supported states where feasible.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMIN	44,042	0

Narrative:

Safe Injection Strategies
In COP 12/13, CIHP will promote safe injections and proper disposal of infectious waste generated in all supported facilities, targeting directly HCWs in these facilities and surrounding communities. CIHP will train all HCW (doctors, nurses, lab personnel, waste handlers) in safe injections and waste disposal. CIHP will work with the lead IP in injection safety and waste disposal to train additional 320 HCW in injection safety and waste disposal. CIHP will also provide IEC materials/job aids to promote behavioral change, implementation of USP in supported facilities; protective and waste disposal commodities and devices will continue to be provided to waste handlers and other HCW. Commodities will include: industrial boots, gloves, face masks, vacutainers, protective goggles, face masks, protective aprons and lamina hoods as and others such as sharp containers, bench absorbent pads, biohazard bags, spill kits and hazard neutralization materials. CIHP will work through SCMS mechanisms to procure equipment and supplies for injection safety and waste management. CIHP will also strengthen activities of waste management committees and establish new ones in new facilities.

Behavioral change will be promoted amongst HCWs to enable adoption of safer workplace behaviors to reduce re-use of syringes and needles, promote segregation of waste, and promote sterilization and appropriate disposal of used needles. CIHP will also promote appropriate waste disposal ensuring that bio-medical and other infectious waste generated are properly disposed of by repairing existing incinerators and providing new ones where required.

CIHP will key into the Integrated USG approach to expiry management by participating in all waste drive process to ensure proper management of expiries of laboratory reagents and drugs. CIHP will participate in the implementation of NPHCDA Health Care Waste Management (NHCWM) framework in collaboration with stakeholders.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	368,285	0

Narrative:

CIHP will provide the minimum prevention package to individuals with messages on Abstinence and be faithful (AB), through participatory activities such as community outreaches, interpersonal communication activities, counseling and youth focused programs. Messages promoting abstinence (primary and secondary) and mutual fidelity will be provided to the appropriate target groups. Prevention messages targeting MARPs, including condom promotion will be supported.
CIHP 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. AB activities for youth/young adults aged 15-24 years, the highest prevalence age group, will be supported. 12,212 individuals will be reached with intensive AB messaging. In addition, 11,233 children and adolescents will be reached with age-appropriate abstinence only and secondary abstinence messaging with particular focus on VC.
A total of 455 HCWs, counselors, and peer educators will be trained to conduct effective prevention interventions inclusive of AB messaging.

Community-based approach
CIHP will partner with CBOs, (FBOs , and PLWHIV groups at its facility and community levels in the dissemination of AB messaging using the peer education model, and to wider audiences through the non curricula based school approach and community awareness campaigns. Activities will include role plays, youth and kids clubs, debate and quiz competition and rallies. To address stigma issues and in compliance with the GIPA principle, at least 10 PLWHIV from the pool of those receiving treatment at facilities who are living openly and positively will be trained as role models to disseminate AB messages.

Facility-based approach
AB messages will be disseminated through HCWs who will continually serve as conduits for age appropriate prevention messaging not only for their work peers but also for their social peers and for all clients with whom they come in contact using the prevention with positives intervention tool. Prevention activities will be integrated into other points of service in each health facility (GOPD, TB, STI clinics, RH and youth friendly clinics).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	1,165,916	0

Narrative:

HIV Testing and Counseling

In COP 12/13, CIHP will support HTC in at least 181 entities including 55 secondary hospitals, PHCs,

and CBOs with strong linkages to 13 non-hospital facilities in six states. Activities will focus on MARPs; scale up of PITC , expanded access to couple HTC services and mobile HTC services including Home based testing.. At least 149,523 individuals including MARPs will receive counseling & testing (in a non-TB/non-PMTCT setting) and receive their results annually.

Reaching MARPs: Innovative approaches will be instituted to reach MARPs in supported states. CIHP will expand access to HTC outreach services in high risk communities; 10 additional stand alone sites will be established in high burden communities.

Community linkages and communication: referral linkages will be strengthened at the facility and community levels; youth-friendly centers will continue to be strengthened. Condom distribution supported by CIHP will be implemented by CBO partners.
HTC Quality Assurance and linkages: CIHP HTC team will work with the Federal and State governments to ensure quality of HIV testing by participating in all QA initiatives. Testing will be conducted with current National testing algorithm. CIHP will strengthen its QA supervision and mentoring to implement GON QA/QC procedures.

Task shifting strategies: As part of CIHP's strategy of promoting task shifting CIHP will promote the use of lay counselors to conduct HIV testing at the facilities and communities. 421 lay counselors will be trained to conduct testing and increase uptake of services annually.
HTC integration with MNCH and TB services: CIHP will integrate HTC into existing MNCH, family planning and TB DOTs services in supported facilities to expand access to prevention services. TB DOT providers and other service providers at these points will be trained to provide HTC services and referrals.

Strengthen linkages and M&E systems: CIHP will strengthen HTC linkages with C & T and other community services. M&E systems will be strengthened through provision of National data capturing tools to ensure documentation and record keeping. 421 HTC providers will be trained in documentation and reporting.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	789,790	0

Narrative:

CIHP will partner with supported health facilities and CBOs to promote safer sex, risk reduction activities, correct and consistent condom use skills and STI management through strategic activities such as community outreaches, IPC activities, capacity strengthening, counseling and youth focused programs as

part of the prevention package.
62,191 individuals will be reached with risk reduction and safer sex promotion activities, correct and consistent condom use messages, communications skills & condom negotiation, partner notification and good health seeking behavior. The target groups will include MARPS, PLWHIV, PABA, and out of school youths; they will receive COP messaging on a regular basis in a non-curricular based approach.
Positive Health Dignity and Prevention Interventions (PHDP)
CIHP will support the PHDP interventions with the provision of job aids, IEC materials, and prevention commodities including the provision of STI screening tools and treatment commodities. A total of at least 432 facility and CBO care providers will have their capacities built on PHDP activities.

Facility-based Approach
The integration of prevention counseling and other services\\ for PLWHIV into FP, STI and MNCH clinics will be supported as part of the PHDP interventions. CIHP will support the provision of job aids, IEC and prevention commodities to promote facility based combination prevention activities. Facilities will be assisted to implement pre and post exposure prophylaxis (PEP) where exposures occur. Job aids and BCC materials on universal safety precautions and PEP will be provided to support prevention at health facilities.

Community based approaches
CIHP will build on partnerships with CBOs to provide appropriate interventions through peer health educators, mother's groups, community role models, and pressure and support group networks.

Supporting Male Involvement
Male involvement will be encouraged through male friendly initiatives for men who accompany their families to clinics. Other expanded male-focused activities will be promoted through FGDs, safer sex practice sensitization. CBOs will be supported to mobilize men to support HIV/AIDS and RH initiatives through community specific initiatives.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	3,099,930	0

Narrative:

Scaling up PMTCT and HIV Exposed Infant Services
CIHP rapidly scale up and expand access to PMTCT services in public and private facilities across all sites especially the high HIV prevalence states of Akwa Ibom, Benue and Kogi CIHP through its lead IP role and build capacity of state partners to coordinate, implement and monitor PMTCT programs across five states. Minimum package of care services to HIV-exposed infants will be provided at PMTCT sites.

Capacity building and Implementation of the current PMTCT Guidelines
ART for PMTCT will follow the National Pediatric/PMTCT guidelines. 5,463 mother-baby pairs will receive ARV prophylaxis and counseling for safer breast feeding practices. HAART will be provided for 1,092 eligible (20%) pregnant women at the nearest comprehensive sites and high volume PHCs. 912 HCWs will be trained using GON curricula, to provide enhanced package of quality MNCH services.

Support GoN on safe Voluntary Medical Male Circumcision (VMMM)
CIHP will encourage safe VMMM where applicable as a preventive measure especially in Kaduna and Gombe states.

Support GoN to integrate and expand PMTCT service package
In line with GHI focus of service integration, CIHP will pilot a comprehensive “Well-Mother” package in high volume HF, to improve health of women. This package targets the leading causes of maternal and newborn mortalities and focuses on safe motherhood services, FP, STIs screening and management, malaria prevention, breast and cervical cancer screening. Cervical cancer screening using visual inspection with acetic acid VIA and referral for Pap smear (positive VIA) will be instituted for all pregnant women attending ANC in the selected PMTCT sites. CIHP will institute continuous health education and messaging to women on the need for regular breast examination.

Strengthening Community PMTCT services and Male Involvement
At least 150 TBAs linked to PMTCT sites will be trained annually to support PMTCT services. CIHP will strengthen the MTA Initiative to promote male support for PMTCT services.

Strengthening PMTCT management information system
CIHP as the Lead IP for M&E, will coordinate and contribute to the national PMTCT program’s M&E efforts through the five states.
As part of our strategy to increase the uptake of HTC at antenatal clinics in supported PMTCT facilities, we shall defray/absorb antenatal booking/registration fees for all pregnant women. In addition, we shall ensure that communities served by the health facilities are adequately informed of this benefit/privilege through local media outlets and strategically placed IEC materials.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	1,548,003	0

Narrative:

ARVs

Supply Chain Management Systems
In COP 12/ 13, CIHP will work with the SCMS and other in-country coordinating mechanisms to provide first and second line ARVs for adult and pediatric clients. CIHP will continue to strengthen local logistics systems, by strengthening the state logistics management systems and renovating SMOH-owned medical stores. Procurements will include site level logistics data, forecasting, quantification and procurement plans for all HIV program areas. Product selection will be based on existing national treatment guidelines using drugs with FDA approval or tentative approval which are NAFDAC registered or approved. CIHP will strengthen logistics support to sites to facilitate prompt, efficient and effective distribution of ARV and OI drugs and other commodities. CIHP will continue to integrate quality assurance, M&E systems into its existing logistics system and continue to increase capacity of site staff in logistics management of ARVs and related commodities, documentation and reporting and inventory management best practices.

Pharmaceutical care services
CIHP will strengthen delivery of pharmaceutical care services to clients by the use of pharmaceutical care tools at service delivery points and will promote adherence by increasing access to ARV fixed dose combinations (FDCs) for pediatric and adult clients. To strengthen ARV ADR reporting and monitoring at supported sites, CIHP will conduct a training of trainers (TOT) on pharmacovigilance and will support the set up of state and facility pharmaco-vigilance teams. SOPs will be provided to guide quality pharmaceutical care implementation for PLWHIV. CIHP will provide technical assistance and build the capacity of health care workers in the delivery of quality pharmaceutical care to PLWHA, pharmacy documentation etc. through trainings, on site mentoring and supportive supervision. CIHP will also provide technical support on management of expired drugs at supported sites. CIHP will support non-monetary incentives for health care workers, through sponsoring the participation of site pharmacy staff and CIHP staff in the Pharmacists' Council of Nigeria endorsed trainings and conferences.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	7,961,415	0

Narrative:

Access and Integration
At least 12 new comprehensive sites (private and public facilities) will be activated to expand access to underserved area with high HIV prevalence. Gender equity will be promoted for increased access to services for women and children.

Support GoN for National Guidelines review

National ART guidelines will be reviewed with FGoN to reflect the new WHO ART guidelines.

Integration of care
Service integration will be encouraged through co-location of services such as TB/HIV, MCH and RH services.

Linkages to wraparound health
VL testing for treatment failure suspects will be ensured through partnerships. Also partner with 30 CBOs to provide community based HTC, OVC, HBC, and PPHD services

Decentralization C&T
Services will be decentralized to additional PHCs for ART pick up for stable patients.

Quality: Management of Treatment Failure, ARV Resistance and Pharmacovigilance
Treatment failure suspects will be identified through the use of structured checklist and algorithms; repeat CD4 testing will be instituted for patients. State and facility pharmaco-vigilance teams will be established.

Provision of quality focused facility based care
Periodic quality checks conducted through the application of checklists, SOPs, Standard of Care assessment tools. Facility level quality Improvement teams will be strengthened to promote ownership of quality process.

Retention in care
Patient appointment and tracking systems will be strengthened through electronic patient database and PE programs for adherence and defaulter tracking respectively.

ARV drugs-Supply Chain Management:
First and second line ARVs will be provided through SCMS. Capacity of site staff will be built in logistics management of ARVs, inventory management and pharmacy best practices.

Laboratory services
At least 14 new labs (for 12 new sites and 2 existing) will be developed to provide HIV lab monitoring services. Services will focus on QMS, equipment maintenance and laboratory information systems.

Human Capacity Building:
ART/Palliative Care and Adherence support start up and refresher trainings will be conducted for at least 1,775 clinicians and HCWs (933 for ART and 842 for Palliative care /adherence trainings).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	953,866	0

Narrative:

Pediatric treatment
CIHP will strengthen the implementation of the gains of “watCh” (Where are the children) strategies through periodic charts review and defaulter tracking of both HIV-exposed infants and infected infants to ensure increase pediatric enrolment and improve the quality of pediatric ART. CIHP will enhance early identification of HIV infection status to reach HIV positive children through various approaches including, pediatric HIV diagnosis; focused pediatric case finding and referral to C&T; comprehensive C&Tx services and ART for HIV-exposed infants (HEI) and HIV-infected infants following the revised national pediatric ART guidelines. CIHP will provide basic package of care, including: BCK, counseling for parents/care givers and psychosocial support, clinical care, growth monitoring, linkages to under-5 immunization services and other services, pain management, OI management, nutritional assessment, early youth development and youth friendly initiatives, lab- baseline, provision of Cotrimoxazole, IPT, HBC. CIHP will use adult care and treatment venues as additional entry points for pediatric services, through thr genealogy form to ensure that HIV-positive adults are encouraged to bring their children for HIV testing at facility. In COP 12/13, targeted testing will be strengthened using skilled CBOs to ensure that children of adult index cases in C&T are tested and linked to care.

Early Infant diagnosis: CIHP will support early identification of HIV exposure and pediatric diagnosis through scale up of EID via dried blood spot sample collection to newly activated PHCs.

Decentralization of services: CIHP will support devolvement of pediatric ART services to PHCs. Services provided will include: ART refill, adherence support, supportive counseling, HIV Education, support group meetings as well as the full basic care package.

Retention in care and treatment: CIHP will strengthen patient appointment and defaulter tracking systems and routine reporting systems for monitoring basic care and support activities. Strategies will include: joint mother-child appointments; improved counseling and peer educator support and treatment preparation before initiation of ART.

Implementing Mechanism Details

Mechanism ID: 13713	Mechanism Name: Medical Laboratories Science Council of Nigeria
Funding Agency: U.S. Department of Health and	Procurement Type: Cooperative Agreement

Human Services/Centers for Disease Control and Prevention	
Prime Partner Name: Medical Laboratories Science Council of Nigeria	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 487,342	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	487,342

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Laboratory services constitute an essential component in the diagnosis and treatment of persons infected with the Human Immunodeficiency Virus (HIV), Malaria, Mycobacterium tuberculosis, sexually transmitted infections, and other diseases. Although universal access to testing remains an essential focus for laboratory services, existing testing services should be of consistently high quality to ensure that clinicians continually trust laboratory results for patient care decisions. Accreditation is that important milestone in the path of continuous quality improvement and serves as to be a useful tool in strengthening laboratory quality systems. Accreditation of laboratories at all levels either privately or publicly owned is the only way to ensure that quality is maintained. Presently, the laboratory infrastructure and test quality for all types of clinical laboratories remain weak in Nigeria. There is an urgent need to strengthen laboratory services and systems across the six geo-political zones of the country. The establishment of WHO-AFRO Laboratory Accreditation Program provides an affordable and potentially ground-breaking opportunity to improve quality of laboratory practices in Nigeria. The Medical Laboratory Council of Nigeria (MLSCN) has recently adopted, and has commenced implementation of the WHO-AFRO laboratory accreditation standards and checklist for the baseline assessment of medical laboratories in Nigeria as part of the Nigerian National Medical Laboratory Accreditation Program. Nigeria needs to further strengthen laboratory capacity for the purposes of effective health systems and sustainability, hence the need to adopt this program.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**13713**
Mechanism Name:	**Medical Laboratories Science Council of Nigeria**
Prime Partner Name:	**Medical Laboratories Science Council of Nigeria**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	487,342	0

Narrative:

Increased challenges resulting from persistent lack of reliable and accurate test results from existing laboratories needed in the management of patients with severe illness and in the improvement of health care delivery, calls for the urgent need to advance all tiers of laboratory system in Nigeria towards national accreditation. Presently, PEPFAR supported laboratories and few other laboratories in Nigeria seem to have quality management system that offers diagnostic services that are of reasonable standards. Therefore they are at the fore front in the delivery of quality laboratory services to support diagnosis, treatment monitoring and prevention of HIV/AIDS and related opportunistic infections. These laboratories are few in the country and serve less than 10% of the affected populace that need their services. Even these few laboratories are yet to achieve national accreditation therefore the quality of laboratory services delivered cannot be guaranteed. Although some of these laboratories have

subscribed to Medical Laboratory Science Council of Nigeria and have initiated the process towards National accreditation, achieving accreditation require guidance and support. This grant will provide the Medical Laboratory Science Council of Nigeria with resources that will enable it mentor, monitor, and regulate the implementation of laboratory quality management systems across Nigeria's public and private laboratories.

Implementing Mechanism Details

Mechanism ID: 13753	**Mechanism Name: Program for HIV/AIDS Integration and Decentralisation**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: National Primary Health Care Development Agency	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 7,099,140	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	7,099,140

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Programme for HIV/AIDS Integration and Decentralisation in Nigeria (PHAID) is an Initiative of the National Primary Health Care Development Agency, with the overall goal of strengthening the Nigerian Primary Health Care (PHC) System to deliver HIV/AIDS services at the primary health level. PHAID aims at developing a locally relevant package of HIV/AIDS services and other interventions which would be implemented and managed by a trained and motivated PHC workforce. In addition, PHC system would be strengthened through some minor renovations on physical infrastructure and the development of relevant policies and strategies for effective staffing and HIV/AIDS service delivery at the PHC level.
PHAID is fully aligned with the Nigerian National Strategic Health Development Plan and PEPFAR goals, which identifies strategies for the integration and decentralisation and scale up of priority HIV/AIDS,TB

and Malaria services. PHAID would impact on 6 high HIV/AIDS burden States, provide facility based and out-reach services from 240 PHC facilities; and train 960 health workers at the PHC level. The expected catchment population for PHAID is projected at 3.6million persons, based on the Nigerian Ward Health System which utilises the political Ward as the basic catchment area for a PHC facility.
In order to assure sustainability, M.O.Us would be signed with the participating States to gradually take over the funding of key activities.
PHAID would have an effective monitoring and evaluation (M&E). The project will be implemented in collaboration with some sub-partners, Solina Health ltd and IHVN.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Sub Recipient**
3. What activities does this partner undertake to support global fund implementation or governance?

Budget Code	Recipient(s) of Support	Approximate Budget	Brief Description of Activities
OHSS	National Primary Health Care Development Agency	0	Global Fund Health Systems Strengthening (HSS) focused on building capacity for integrated service delivery, using a developed integrated training curriculum for health workers, providing supportive supervision for effective service delivery and strengtheing basic physical infrastructure including planned preventive maintenance. Activities also include strengthening of community structures to increase demand for services

Cross-Cutting Budget Attribution(s)

Construction/Renovation	6,219,140
Human Resources for Health	880,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

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:	**13753**
Mechanism Name:	**Program for HIV/AIDS Integration and Decentralisation**
Prime Partner Name:	**National Primary Health Care Development Agency**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	7,099,140	0

Narrative:

The scale up of HIV/AIDS and other priority basic health services in Nigeria has largely been hindered by weak capacity at the local government/primary health care level. These weaknesses are mainly in terms of critical shortage and inequitable distribution of PHC human resources, poor skills for HIV/AIDS service provision and poor commitment of States and LGA to effectively provide the needed health services. This is particularly critical in Nigeria where the HIV epidemic is large and growing with over 336,000 new infections in 2009; and emphasis of care is shifting to life-long community based care.

The Programme for HIV/AIDS Integration and Decentralisation (PHAID) would address most of these systemic challenges in the target States and local government areas (LGA); the recruitment, training and deployment of health workers, development of policies and strategies to ensure incentives and motivate acceptance of rural posting and effective service delivery. Services would be enhanced through the development locally relevant HIV/AIDS package, which would be delivered in an integrated manner; in line with Nigeria's national strategy for the integration and decentralisation of ATM services. In addition, the PHC system of the target States would be further strengthened would be strengthened through some improvement works on physical infrastructure systemic increment in the financing of PHC in the participating States and LGAs. This would be achieved through sustained high level advocacy and the implementation of a signed M.O.U, which would require the States to gradually take over funding of key PHAID activities.

Through PHAID the NPHCDA would be further strengthening its over-sight and stewardship role for PHC in Nigeria and learn valuable lessons for expansion of its Public Private Partnership initiatives. The NPHCDA will also strengthen it's collaborate with existing partners particularly for the development of the continuous education curricula and the training of the deployed health workers.

Implementing Mechanism Details

Mechanism ID: 13785	**Mechanism Name: HHS/CDC ICAP PMTCT**
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	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 2,600,860	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	2,600,860

Sub Partner Name(s)

(No data provided.)

Overview Narrative

ICAP in Nigeria is an international NGO affiliated to the Mailman School of Public Health under the Columbia University New York. Since 20105, ICAP has been supporting HIV/AIDS prevention, care and treatment services in the six states of Kaduna, Cross River, Akwa Ibom, Benue, Gombe, and Kogi States. In partnership with the Government of Nigeria, ICAP provides technical and financial assistance at the national, state, and site levels, for the scale-up of comprehensive HIV/AIDS services. ICAP in Nigeria, as at October 1st 2011 transitioned its Track 1.0 PEPFAR funding to Center for Integrated Health Programs (CIHP) a local indigenous NGO. However, ICAP in Nigeria continues to provide technical assistance to CIHP, under the BRIDGES Project. ICAP was awarded the plus up mechanism in 2008 to support PMTCT scale up efforts in Nigeria. ICAP NG has activated PMTCT services in General Hospital Sabon Tasha and 8 surrounding feeder Primary Health Clinics for PMTCT services. All 8 feeder PHCs refer positive women to GH Sabon Tasha for HAART.

As part of the cooperative agreement between ICAP in Nigeria and the CDC Funding Opportunity CDC-RFA-PS10-1072 for improving uptake of PMTCT services through establishment of Community-based PMTCT Programs in Nigeria under the PEPFAR, funding is being provided to ICAP for the implementation of PMTCT programs in health facilities in the 5 states of Kaduna, Akwa Ibom, Gombe, Benue and Kogi states.

ICAP has initiated PMTCT-HCT activities in 54 public health facilities in all 5 states by July 2011 and 9 private medical facilities in the 3 supported states by October.ICAP has put in place appropriate systems to enable HIV positive pregnant women-exposed infant pairs (and their family members) access such services at the supported facilities.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

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)
Safe Motherhood
Family Planning

Budget Code Information

Mechanism ID:	**13785**
Mechanism Name:	**HHS/CDC ICAP PMTCT**
Prime Partner Name:	**International Center for AIDS Care and Treatment Programs, Columbia University**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	2,600,860	0

Narrative:

In COP 11, ICAP provided PMTCT services to 51 public 3 private HF in 5 states. ICAP will continue to partner with CIHP to rapidly scale up PMTCT services to 1 additional public and 13 private health facilities in hard to reach areas, with high ANC attendance in across the states. The private facilities will be activated as part of the PPPI to achieve state saturation. 123,676 pregnant women will be counseled and tested and 5070 mother-infant pairs provided ARV prophylaxis in COP12.Strengthening capacity building and use of current PMTCT Guidelines
ICAP will train at least 821 HCWs to provide quality MNCH services to HIV positive women. Infrastructural upgrade will be completed in all the PMTCT sites. PHCs will implement AZT from 14 weeks GA, SdNVP at labor and post partum Combivir tail to all positive pregnant women. HEIs will receive daily NVP throughout the breast feeding period. HAART eligible HIV positive pregnant women will be referred to the nearest comprehensive site. ICAP will supply PRIMER CD4 machines to the high volume PHCs and others will continue CD4 sample logging mechanisms supported with motorbikes. Haemoglobinometers will be supplied to all the PHCs to monitor women on AZT as well as urinalysis test strips to support early detection of pre-eclampsia. .
Strengthening HEIs Services
HEI services will be provided at the PHCs including growth monitoring using the under-5 cards, CPT as

well as DBS for EID and linkages to hubs for treatment. Strengthening service integration HCT services will be integrated in RH/FP services while all PMTCT clients will be referred to access RH/FP services post-delivery. HIV+ women will be actively screened for TB and cervical cancers. Strengthening Community PMTCT services CBOs will implement Community-based PMTCT services to create demand, and provide “doorstep” HTC services. Deliveries at HF will be encouraged by the provision of “mama kits”. 40 TBAs will be trained on basic HIV prevention, infection control, and safe motherhood; Mentor mothers will be trained to conduct peer counseling to women on ARVs and support defaulter tracking for positive mother-baby pairs. PMTCT management information system will be strengthen through lead IP concept. As part of our strategy to increase the uptake of HTC at antenatal clinics in supported PMTCT facilities, we shall defray/absorb antenatal booking/registration fees for all pregnant women. In addition, we shall ensure that communities served by the health facilities are adequately informed of this benefit/privilege through local media outlets and strategically placed IEC materials.

Implementing Mechanism Details

Mechanism ID: 14040	**Mechanism Name: Promoting Quality Medicines Program**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: U.S. Pharmacopeia	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,207,600	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	1,207,600

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Promoting Quality of Medicine’s mandate is to help assure the quality and safety of priority medicines by

strengthening medicines quality assurance mechanisms in developing countries. PQM is USAID's response to the growing challenge posed by substandard and counterfeit medicines. These medicines can cause treatment failure and costly adverse events, increase morbidity and mortality, and potentially contribute to the more rapid emergence and spread of antimicrobial resistance. In addition to representing a significant public health threat, these medicines also risk undermining past and current health investments.

The availability of safe, quality and efficacious medicines in Nigeria continues to be challenge due the varying level of quality assurance standards among the local pharmaceutical industries and the quality of certification standards at Nigeria's drug regulatory authority-National Agency for Food, Drug Administration and Control (NAFDAC) for both locally produced and imported medicines. Presently none of the Pharmaceutical Companies in Nigeria has attained World Health Organization (WHO) pre-qualification.

The USG will through this initiative improve compliance of selected manufacturers with Good Manufacturing Practices (GMP) and support the manufacturers in dossier preparation for WHO prequalification or other recognized prequalification systems, furthermore, the USG will through this partner be strengthening national medicines quality control laboratories at NAFDAC, this will address quality-assurance related aspects of drug registration and licensing.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**14040**
Mechanism Name:	**Promoting Quality Medicines Program**
Prime Partner Name:	**U.S. Pharmacopeia**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	1,207,600	0

Narrative:

The proposed budget will be utilized for the following health system strengthening activities:

a) Conduct initial Quality Assurance/GMP Pre- assessment of Select opportunistic infection (OI)Medicines Manufacturers. Develop an Expression of Interest (EoI) document with select criteria for selecting companies to benefit from PQM technical assistance .Conduct Review of Responses from manufacturers and verify through site audits. Assess selected companies(three)capabilities and potential and identify gaps regarding compliance with WHO GMP

b) Provide targeted technical assistance to obtain WHO GMP compliance of facility and manufacturing processes. Assist selected companies to obtain WHO GMP compliance for manufacturing site. This includes 1. Conduct 2-3 visits at various stages of GMP compliance 2.Work with manufacturers to develop process validation procedures, equipment calibrations and develop SOPs. 3. Produce reports and recommendations 4. Follow up on recommendations

c) Assist Selected Manufacturers in dossier preparation and submission to WHO and other Procurement Agencies. This includes evaluation of Active Pharmaceutical Ingredient(API) sources, and evaluation of NAFDAC's requirements for registration dossiers

d) Conduct quality control testing of manufactured OI medicines from the three manufacturers

e) Strengthen the Nigerian National Agency on Food and Drug Administration and Control and facilitate the registration of OI medicines. Conduct targeted assessment of Nigeria NAFDAC registration capabilities and dossiers reviews for OI product and provide assistance. Establish improved registration system and establish post market surveillance of the quality of OI medicine.

Implementing Mechanism Details

Mechanism ID: 14050	Mechanism Name: K4Health/Nigeria
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Johns Hopkins University Bloomberg School of Public Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 400,000	Total Mechanism Pipeline: N/A
Funding Source	**Funding Amount**
GHP-State	400,000

Sub Partner Name(s)

Medical Laboratories Science Council of Nigeria		

Overview Narrative

The K4Health/Nigeria Web-based Continuing Medical Laboratory Education (CMLE) Program is a two-year project that will provide opportunities for Laboratory Scientists to continuously improve their knowledge, update and sharpen old skills, acquire new ones, and broaden their horizons. CMLE is one of the strategies for continuous quality improvement of Clinical and Public Health Laboratory services. The objectives of this project are to (1) increase Medical Laboratory Scientists' access to quality CMLE programs, and in turn, improve the skills and proficiencies of laboratory professionals; (2) develop and build local capacity to design, implement, and manage a quality and sustainable CMLE program; and (3) institutionalize the consistent use of standard-CMLE credits as a requisite for licensure. Johns Hopkins Bloomberg School of Public Health Center for Communication will work closely with and support the Medical Laboratory Science Council of Nigeria (MLSCN) and the Association of Medical Laboratory Scientists of Nigeria (AMLSN) to achieve these objectives. By working side-by-side with leaders and staff at MLSCN and AMLSN, the K4Health team will build their capacity and leadership to manage and implement this project from the onset. By the end of this project (September 18, 2013), at least 50% of Medical Laboratory Scientists (from a baseline that will be determined at the commencement of the project) will earn a CMLE credit from the MLSCN through the K4Health/Nigeria Web-based CMLE

program. In COP12, JHU/K4Health will support the development and implementation of sustainability/Exit strategies and ensure smooth graduation of the CMLE program to the local entities (AMLSN AND MLSCN), in addition to conducting program outcome/impact assessment.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	400,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Malaria (PMI)
TB

Budget Code Information

Mechanism ID:	**14050**
Mechanism Name:	**K4Health/Nigeria**
Prime Partner Name:	**Johns Hopkins University Bloomberg School of Public Health**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	400,000	0

Narrative:

FY2012 funding will support the development of Continuous Medical Laboratory Education (CMLE) courses, by the Association of Medical Laboratory Scientists of Nigeria (AMLSN), the accreditation and

assigning of credits to the CMLE courses by the Medical Laboratory Science Council of Nigeria (MLSCN), and more importantly, support the development of sustainability strategies. JHU/K4Health will provide the needed technical support and capacity building for all of these. In COP2012, JHU/K4Health will support the AMLSN and the MLSCN to expand available courses in the CMLE program, support the procurement of a local portal (through sub-grants) that will host the CMLE courses as a key sustainability strategy in addition to supporting continued capacity building of MLSCN and the AMLSN around all dimensions of eLearning, including eLearning instructional design methodology, the course development process, and use of the course authoring software. The two local organizations will further be supported by JHU/K4Health to develop CMLE Program sustainability plan and its implementation and ensure a smooth transition of the entire program management and administration to the local entities. The outcome and impact assessment of the funded program will also be undertaken in conjunction with USAID and the Local Partners. It is envisaged that by the end of FY2013, the MLSCN would have developed a policy that would require the use of CMLE credits as a pre-requisite for professional licensure; and that AMLSN would have developed capacity for the management and admistration of online CMLE program and ensured its continuous use by its members for professional development and proficiency improvement.

Implementing Mechanism Details

Mechanism ID: 14054	**Mechanism Name: MEASURE Evaluation III**
Funding Agency: U.S. Agency for International Development	Procurement Type: Umbrella Agreement
Prime Partner Name: University of North Carolina	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 2,845,814	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	2,845,814

Sub Partner Name(s)

Futures Group	John Snow, Inc.	

Overview Narrative

MEASURE Evaluation provides the Federal Ministry of Health (FMOH), Federal Ministry of Women's Affairs and Social Development (FMoWASD), Departments and Agencies such as NPHCDA, Defense and Education and National Agency for the Control of AIDS (NACA) with technical assistance to strengthen the collection, management, and dissemination and use of health and population data especially in HIV/AIDS. Activities in FY12 will build on previous work in continuing to support the Department of Health Planning Research and Statistics (DHPRS), NACA, National AIDS and STI Control Program (NASCP), FMoWASD and sub-national levels with the objective of improving the quality of data and the use of information for decision-making.

With COP10 and COP11 funds, the following activities would be completed with TA from MEASURE Evaluation:

• Revise National PMTCT tools and guidelines for data collection and reporting as well develop system strengthening plans for the PMTCT data quality improvement in 3 selected states based on assessment findings including case studies and guidelines

• Support GoN and other key stakeholders in developing M&E supportive supervision and monitoring guidelines and checklists as well as feedback mechanism that incorporate data quality and use of data for decision-making.

• Deploy and use of DHIS for health data capture in government facilities in Nigeria.

• Revise the Vulnerable Children monitoring and evaluation plan that align with current national plan of action (2011 – 2016) and training government officials and implementing partners on the use of National VC Management Information System (NOMIS)

Cross-Cutting Budget Attribution(s)

Human Resources for Health	800,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**14054**
Mechanism Name:	**MEASURE Evaluation III**
Prime Partner Name:	**University of North Carolina**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	540,000	0

Narrative:

MEASURE Evaluation will continue the process of building and strengthening a unified national monitoring and evaluation system for OVC programming. MEASURE Evaluation will further assist the government in developing a scale-up plan for rolling out of appropriate tools to enhance data collection/reporting, use of information and integrated quality assurance, and quality improvement as well as integrating this process into the national HIV/AIDS M&E data collection system. In COP12, MEASURE Evaluation will execute the following activities:

• Strengthen the use of information for decision-making by assisting the FMoWASD in data analysis, interpretation and presentation of results in a more easily accessible manner to users.

• Support FMWASD, their state counterparts and implementing partners in the roll-out and implementation of the National VC M&E Plan including the electronic database - the National VC Management Information System (NOMIS) and regular supportive supervision at the sub-national levels

• Provide TA to FMWASD in organizing the M&E subcommittee of the National Technical Coordinating Group (NTCG) to ensure proper implementation of the National NPA on VC

• Provide on-going technical support to government and implementing partners on research and evaluation to meet data needs on vulnerable children programming

• Provide on-going capacity building to government agencies and IPs on supportive supervision for data audit and information use in vulnerable children programming

• Strengthen information transmission and sharing at all levels of the Ministry's systems

• Strengthen coordination among VC stakeholders by assuring the participation of national level CSO staff in SI coordination meetings and assisting the CSOs M&E team to implement decisions taken during such meetings.

• Develop the CSOs M&E team's capacity in collecting, managing, analyzing, sharing, and disseminating VC-related data.

• Strengthen coordination among non-health sector stakeholders by supporting quarterly coordination

meetings on strategic information (information sharing, harmonization and validation of state-level data).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	2,305,814	0

Narrative:

In COP12, MEASURE Evaluation will execute the following activities:
• Assist with capacity building in the scale-up of HIV/AIDS patient-monitoring data-collection tools (paper-based).
• Strengthen coordination among HIV/AIDS data stakeholders by supporting quarterly coordination meetings on strategic information (information sharing, harmonization and validation of state-level data).
• Support routine data collection, review, reporting, dissemination and use efforts of relevant government agencies and continue to offer technical assistance to improve data quality, in their evaluation, surveillance and research efforts.
• Partnerships, collaboration and networking: Identify and team up with other partners of relevant mandate to provide the necessary synergy for the improvement of information systems management in the Nigerian health sector.
• Support and provide TA in the secondary analysis of existing surveys and surveillance datasets.
• Provide technical expertise to NACA and NASCP in the areas of capacity building for monitoring and evaluation, modeling, operations research and impact evaluation in the country
• Strengthen data generation, analysis and use for action plan and decision making at national and state levels
• Provide supervision and mentorship for National, states and Local Government Area M&E staff.
• Develop standardized supportive supervision to train M&E/HMIS personnel
• Support and provide TA to the Federal Ministry of Health and relevant stakeholders in the review of health institutions curricula and incorporate M&E/HIS concepts and fundamentals sessions.
• Strengthen the use of information for decision-making by updating and producing key national policy documents for the health sector.
• Support the deployment of NHMIS Software (DHIS) in Nigeria.

Implementing Mechanism Details

Mechanism ID: 14055	Mechanism Name: PLAN-Health
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	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 4,240,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	4,240,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

PLAN-Health will strengthen the capacity of GON & CSO institutions for improved and sustainable HIV/AIDS response. It institutionalizes capacity building for management and leadership at individual, organizational, and system levels; focusing on key areas like governance, coordination, financing and M&E. The project is currently in Gombe State and FCT; in COP 12, it will add one additional state. In addition, it will support advocacy plan development for FMOH to ensure sustainability and ownership of NHMIS. The project's operational planning approach is being taken to the national scale. All project strategies – results focus, ownership, partnerships and scale-up - contribute to cost effectiveness. In its first year, PLAN-Health achieved a cost share of close to 10% of the PEPFAR obligation. The project works in partnership with UNICEF, UNAIDS, WHO, WB, and various USG IPs. PLAN-Health addresses monitoring and evaluation of capacity building by ensuring that it's PMP captures outcomes and impact, and uses management dashboard to track monthly performance. Consistent with the project's focus on ownership and sustainability, all activities are designed to empower client organizations to perform more effectively through building capacity, coaching and mentoring. The project is committed to developing expertise in local organizations to do the same capacity building work that is done by PLAN-Health. Strategic partnerships for institutionalizing the PEPFAR fellowship program are being explored with Covenant University and the University of Abuja.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Neither**

3. What activities does this partner undertake to support global fund implementation or governance?

Budget Code	Recipient(s) of Support	Approximate Budget	Brief Description of Activities
OHSS	CCM	138000	Capacity building to CCM and its committees and to some Prime Recipients and Sub-Recipients

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	10,000
Human Resources for Health	20,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing gender equity in HIV/AIDS activities and services
Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	14055

Mechanism Name:	PLAN-Health
Prime Partner Name:	Management Sciences for Health

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	40,000	0

Narrative:

The USG has a plan to support the Federal Ministry of Health (FMoH) through the Department of Planning Research and Statistics (DPRS) to support the capacity building and deployment of the nationally agreed DHIS to all levels of the government. To this end, the FMoH is expected to lead a multi-stakeholder process to fully fund and implement the new NHMIS, which is DHIS based.
This activity will support the FMoH to develop and implement an advocacy plan. The FMOH will use the advocacy Plan to interface with high level management of other ministries in the implementation of the DHIS. This will support eventually lead to sustainability and country-led ownership of the NHMIS

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	4,200,000	0

Narrative:

PLAN-Health (PH) addresses skill, knowledge and attitude barriers at the individual level by changing passivity to proactivity and obstacles into challenges for 30 CSOs and public sector institutions at the national, state and local levels. Leadership capacities are built in both public sector HIV/AIDS institutions as well as CSOs, including 3 of the 5 major HIV/AIDS umbrella organizations. Activities address organizational barriers of poor financial, HR, M&E and governance practices by applying highly participative and well-tested systems assessment instruments. PH helps clients develop remedial action plans and provides a capacity-building program using workshops, internships, technical assistance, the PEPFAR Fellowship program, and coaching and mentoring tailored to the needs and absorptive capacity of each organization. PH addresses weak CSO governance by building Board capacity, helping define and monitor Board performance and assisting in the development of strategic and operational plans and resource mobilization. PH will continue to identify and involve women focused and women led CSOs so that they can benefit from the capacity building intervention. PH will work with the new Resource Mobilization Department of NACA to move towards 50% country financing of the HIV/AIDS response per the PEPFAR Framework. At the health system level, PLAN-Health contributes to addressing barriers posed by weak HIV/AIDS response coordination and inadequate health sector financing. PH builds capacity of State and Local AIDS Coordination Agencies to oversee the response by converting State Strategic Plans into operational plans with participation of all stakeholders. PH will support the NHIS and

CSOs piloting the Community Health Insurance Scheme and will help NASCP implement the Partnership Framework. Support to the GF CCM will continue and focus more on the use of the M&E dashboard and site visits for oversight.

Implementing Mechanism Details

Mechanism ID: 14064	**Mechanism Name: Capacity Plus**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: IntraHealth International, Inc	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 4,555,299	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	4,555,299

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The GHI Strategy and the Partnership Framework address HRH as a critical element for sustainable HIV/AIDS and other public health response. Through the CapacityPlus project, the USG intends to improve the availability, distribution and utilization of adequately skilled HRH and Social Welfare Workforce development. The specific objectives of the activity include: : (1) building the capacity of the GON in Planning and Management of HRH;(2) supporting interventions to improve quality and output of in-service and pre-service training programs; (3) providing technical assistance to GON and professional bodies to improve Human Resources Information System (HRIS) in the country; (4) introducing innovative strategies to improve health workers motivation and retention in the rural and underserved areas; and (5) addressing policy challenges to improve HRH at all levels. The activity will be implemented both at the Federal and state levels and in close consultation with the GON and other health systems strengthening partners to promote country ownership and sustainability. It also takes into consideration ongoing strategies and initiatives in the country such as decentralization of HIV/AIDS services, PMTCT Acceleration Plan, and improving greater local ownership of programs among others. The GON will

assume greater responsibility to coordinate, implement and scale-up initiative and innovations that the project introduces. This will make the activity more cost effective and sustainable. Monitoring and evaluation will be a critical component of the program. The implementing partner is required to report on PEPFAR and non PEPFAR custom indicators to effectively monitor the progress and outcome of all activities.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	2,050,099

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Child Survival Activities
Workplace Programs

Budget Code Information

Mechanism ID:	**14064**
Mechanism Name:	**Capacity Plus**
Prime Partner Name:	**IntraHealth International, Inc**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	90,000	0

Narrative:

The activity will support Social Welfare Workforce (SWW) strengthening activities including the SWW gap analysis methodology, planning & implementation; contribute to ongoing collation & desk review of key documents & data sources for Orphans and Vulnerable children (OVC) programming (OVC National Plan of Action, M&E Plan for OVC, situation assessment & analysis on OVC, National Guidelines and Standards of Practice on OVC, Federal, State & LGA structures to map-out OVC SWW posts, public service & NGO job descriptions, training curricula and programs, etc.; support stakeholder data gathering by surveying USG OVC Implementing Partners training and related support to the informal OVC workforce); and, provide periodic TA to OVC & Child Protection staff at USAID, CDC, and UNICEF to move the OVC SWW strengthening agenda forward.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	4,465,299	0

Narrative:

Capacity Plus provided technical assistance to the FMOH HRH Department in COP 11. In COP 12, it will continue to strengthen GON and other relevant bodies in planning, recruitment, management, and retention of HRH. The activity will support the development and/or implementation of National and State level HRH plans; improve HRH management practices; implement improved HRH management systems and tools to address HRH quality, availability, utilization and performance and gender issues; conduct a study on preferences for health worker incentives for rural, underserved areas and associated costing scenarios; pilot locally relevant rural retention strategies in selected states; customize and rolled-out HRIS for state-level workforce planning and to track health worker deployment and distribution/movement between facilities; support professional bodies for better HRH registration and regulation their training and practice; improve the quality, coordination and efficiency of USG supported in-eservice training through introducing innovative strategies. In line with the GHI Strategy, provide TA to the GON in implementing integrated training curricula for the training of frontline health workers so that they are able to deliver comprehensive health interventions when deployed. Training institutions will be supported to improve the quality and output of Pre-Service Training (PST) through curriculum reviews, faculty development and other relevant interventions. In line with the strategy to decentralize HIV/AIDS services and PMTCT Acceleration Plan, the PST will focus on midwives and PHC level professionals. A total of 600 new health care workers will be trained. Policy challenges around task shifting and variations in hiring arrangements will be addressed through organizing evidence based policy briefs and policy discussion forums. HRH Platform/Observatory will be supported as a forum for promoting HRH leadership, policy dialogue, advocacy, coordination, and partnership. All proposed activities will be implemented in consultation with the GON at all levels and will be coordinated with relevant other

USG-supported initiatives and programs of other donors.

Implementing Mechanism Details

Mechanism ID: 14115	**Mechanism Name: Prevention Organisational Systems AIDS Care and Treatment (ProACT)**
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	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 9,851,825	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	9,851,825

Sub Partner Name(s)

Axios Foundation Inc.		

Overview Narrative

MSH ProACT project is designed to develop the leadership and management capacity of health managers and facility teams to improve organizational management and operational systems and to strengthen the capacity of health workers, state institutions and organizations to manage integrated HIV/AIDS programs and deliver quality HIV/AIDS care and support services in communities. Since 2007 the MSH ProACT project has rapidly and systematically scaled up the availability and accessibility of HIV/AIDS services in 25 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 COP12 MSH will continue to support a minimum of 25 sites in six states to provide the full spectrum of HIV prevention, care and treatment services and will continue to 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. MSH will also continue to support the establishment of TWGs, state supervisory teams for M&E, quality assurance and will assist the state and local governments to use M&E and other strategic

information to develop plans that will guide the buy in by Implementing Partners and other donor agencies. Through fixed small grants, MSH will continue to develop the capacity of partner CSOs to deliver community-based TB/HIV services linked with health facilities. The project will continue to build the economic capacity of caregivers to provide for the needs of their children, and working with local governments and community to establish child welfare and protection systems.

Cross-Cutting Budget Attribution(s)

Education	50,000
Food and Nutrition: Commodities	70,000
Food and Nutrition: Policy, Tools, and Service Delivery	50,000
Human Resources for Health	450,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing gender equity in HIV/AIDS activities and services
Child Survival Activities
TB
Family Planning

Budget Code Information

Mechanism ID:	**14115**

Mechanism Name:	Prevention Organisational Systems AIDS Care and Treatment (ProACT)		
Prime Partner Name:	Management Sciences for Health		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	844,927	0

Narrative:

ProACT implements the following care and support services which may be facility or community based: prevention and treatment of OIs and complications, nutrition assessment, counseling and support; adherence support, provision of commodities such as OI drugs and laboratory reagents, ITNs and water guard. Psychosocial care is provided during individual or group counseling and linking clients to facility or community-based support groups, and income generation activities Services are delivered in 25 Comprehensive Care and Treatment sites and communities in Adamawa, Taraba, Kwara, Kogi, Niger and Kebbi states.

In COP11 MSH ProACT built the capacity of facility multidisciplinary teams, CBOs and volunteers to provide comprehensive adult HIV care and support integrated with other health services through a family centered approach. It leveraged resources from local and state government to provide additional support like medication, laboratory reagents and consumables.

In the next 2 years it intends to scale up services to new sites and communities in high prevalence areas in the presently supported states. People living with AIDS will be empowered in a “cell support group” structure and linked to savings and loan associations for economic empowerment. Community institutions will be strengthened to own and provide sustainable care to PLA

To attain optimal client retention, the project will strengthen adherence to care and treatment for ART and Pre ART clients across supported facilities through capacity building for health workers and community volunteers, strengthened intra-facility linkages and empowerment of CBOS to facilitate community-facility linkages with appropriate feedback, and facilitate default tracking of clients. It will continue to empower clients to be responsible for their health by supporting them to build self-esteem via appropriate deployment of patient education materials and linking them to IGA.

The project will increase its Inter-Implementing partners networking and collaboration with community members to leverage other essential wrap-around services.

Data for monitoring PEPFAR specific indicators will come from ProACT internal monthly reporting system and data collected at the facility level using FMOH standard tools.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	462,758	0

Narrative:

MSH ProACT’s OVC program is aimed at improving the quality of lives of OVC and in COP12, will work

to ensure continued access to basic education, broader health care services, targeted food and nutrition support, child protection and legal aid, economic strengthening and training of caregivers. To enhance household economic status in COP11, ProACT facilitated the formation of 10 Savings and Loan Associations (SLA) through PLHIV support groups in two focus states and also supported the initiation of community driven food bank as a strategy to improve food security for OVC and their caregivers. In COP12 ProACT will scale up SLA and food bank activities to additional sites and will strengthen existing partnerships and linkages with the Federal and State Ministries of Women affairs and Social development, Millennium Development Goal programs, National Program for Food Security, FADAMA II/World Bank Projects, National Population Commission and community based organizations to ensure comprehensive care for the OVC and their care givers. The project will continue to build the economic capacity of caregivers to provide for the needs of their children; retaining them in school, and working with local governments and community to establish strong child welfare and protection systems. ProACT will continue to strengthen existing kids' club activities and for OVC who attain the age of 18years, ProACT will leverage on the HIV prevention peer education program to strengthen their life skills and link them to youth friendly reproductive health services, economic empowerment programs such as National Directorate of Employment-Graduate Assistance Program, Unilever Women Empowerment program.

To contribute to the national and state OVC response efforts, ProACT will work to develop leadership and management skills of the OVC Coordinating unit in the State Ministry of Women's Affairs. This support will include strengthening organizational and program management capacity to efficiently and effectively address OVC issues in a manner that ensures sustainability. ProACT will also work through partner CBOs to strengthen LGA child protection committees and will continue to build the capacity of CBOs/community volunteers to provide OVC services using the Orphans and Vulnerable tool (OVI) to determine level of vulnerability and Child Status Index (CSI) to assess OVC needs and provide or refer to necessary services appropriate to HIV status and age.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	185,105	0

Narrative:

MSH PROACT TB HIV activity is implemented through 3 broad strategies-Strengthening capacity of people to better lead and manage TB/HIV programs (MSH LDP),Strengthening capacity for integrated TB/HIV service-delivery and building a trusted partnership with state governments and other TB partners for an effective and coordinated response.

In COP11 the project supported 25 CCT sites in strengthening TB HIV collaboration; health workers were trained in TB/HIV collaboration, TB DOTS, PITC and TB DOTs operators participated in the MSH

PEPFAR Health Fellowship Program. It task shifted clinical screening of PLWHAs for TB and set up functional PITC points at all DOTS units and these resulted in increased TB HIV case detection and treatment. TB infection control was piloted in 4 out of 25 supported facilities.

In COP12 it will support 4 additional high burden sites to strengthen TBHIV service delivery. There will be, ongoing TA to the state TB programme to strengthen TB commodity SCMS, Training and refresher training for health care workers on TB/HIV, HCT and TB microscopy, capacity building of CTBC teams for increased case detection and adherence in the community. TA will also seek to address gender disparities in access to services. It will roll out site specific TB infection control in the remaining sites, Strengthen collaboration with NTBLCP on the management of MDR TB and ensure implementation and pilot implementation of IPT in 2 supported sites and subsequently roll out to other sites.

In COP11 it supported training of 12 microscopist in TB microscopy and 3 TB EQA focal persons and performed excellently in the TB proficiency testing with 97% in Q1.It will train additional microscopist and Set up 4 model TB labs at high volume sites with deployment of fluorescence microscopy and other equipments in COP12.

TB HIV TWG was reactivated in 5 out of 6 supported states and it participated actively in state led joint supervisory visits. In COP12, the TB/HIV coordination platforms will continue to be strengthened across all supported states; using the MSH LDP, will build the capacity of key stakeholders in the State in leadership, strategic planning and coordination of TB HIV activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	68,298	0

Narrative:

In COP 11, Pro-ACT supported pediatric care and support in 25 facilities linked to the other feeder sites. The program witnessed increasing knowledge and awareness of the need to provide services to children evidenced by the data available. Efforts bordered around developing the EID grid for supported facilities using the hub and spoke model. In partnership with the sites alternative means were instituted to improve turnaround time for DBS samples from the reference labs.The HIV exposed infant services and HIV positive support services have been emphasized during mentoring visits. Pediatric focal persons were identified to strengthen care. The mother baby pair appointment system has also helped to keep adherence and reduce cost of accessing care by the clients.
In COP 12, increase access to pediatric enrollment will be given priority using innovative approaches that are sustainable. ProACT will also strengthen Integration of care into existing points of service such as immunization clinics child welfare clinics and Family Planning Units. The package of care will be

expanded to ensure that all children receive cotrimoxazole preventive therapy, immunization, documented growth monitoring, infant feeding counselling and nutritional support. Pro-ACT will build capacity of health care worker and CBOS to use local resources like Kwash pap to improve nutritional needs of infants. Referral services will also be available to link mothers to food banks in the community. Pro-ACT will partner with the SMOH and HMB to provide growth monitoring charts for paediatric clinics that currently do not have.

System for Retaining clients in care will be strengthened by retraining data clerks and volunteers in the documentation and use of tracer cards and client defaulter tracking registers. Community support groups will also be strengthened to help identify and track defaulters back to care.

To improve case detection turnaround time for EID sample will be reduced by installing SMS in more facilities and improving on systems for repeat EID.

Paediatric Quality assessment tools will be updated and will form part of the facility's continuous quality improvement (CQI) process using trained facility staff.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	1,756,379	0

Narrative:

In COP11, LMS focused on strengthening Quality Management Systems, and instituting contracts for equipment maintenance services. In support of Kogi State government effort to expand access to quality diagnostic services, ProACT embarked on infrastructure improvement in 3 secondary health facilities while the SMoH provided 3 sets of lab diagnostic equipment for ART monitoring. In COP 12, ProACT will maintain all existing service contracts with equipment vendors and embark on evaluation of cost-effective lab technologies to replace those that have attained their salvage values. ProACT will work with the SMoH in 3 States to identify secondary health facilities in underserved populations for Laboratory infrastructure development to shore up her treatment targets.

In COP 11, ProACT supported the SMoH to constitute the State Laboratory Quality Management Task team with overall responsibility to institute Quality management systems and lab accreditation preparedness. In COP 12, ProACT will build on this effort to encourage and support registration and accreditation of public laboratories by SMoH through MLSCN in 3 States. ProACT will scale up quality management systems in other states not included in its pilots scheme in COP11 and expand its current external quality assessment scheme to other laboratory networks.

ProACT will in COP 12 support FMoH to constitute a technical advisory team to drive the strategic development of laboratory. FMoH will be supported to conduct population based reference ranges lab parameters in Nigeria. Integration of HIV Lab services will be piloted with consideration for both physical and management integration. Capacity of Laboratory Scientists will be built using the Leadership

Development Program (LDP). Trained Lab managers will be supported to access grants directly from donors to scale up services and increase ownership and sustainability.
Strategic engagement with the private sector working with the Association of Medical Laboratory Scientists of Nigeria (AMLSN) and the Guild of Private Medical Laboratory Directors to identify private Medical Laboratory outfit for support to expand the delivery of quality laboratory services and increase ownership .

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	439,689	0

Narrative:

In COP12 MSH ProACT will sustain efforts aimed at transitioning the reporting of output and achievements of program level results from 56 existing secondary and primary sites in six focus states to the state government. Continued joint program monitoring visits will allow for tracking of results; analysis of scale up; improved program management; and feedback to service providers which will enhance service delivery. In COP11 MSH ProACT worked to integrate vertical HIV M&E systems with mainstream HMIS systems at 15 health facilities in Kogi and Niger states. In COP 12, MSH will work to ensure that all 25 comprehensive Care and Treatment (CCT) sites have fully integrated medical records units. MSH also worked to strengthen the capacity of facility records unit to generate and analyze service statistics data which guided decisions to improve quality of patient care. In COP12 MSH ProACT will strengthen the capacity of the SMOH, SACA and facilities to have functional data management systems (MIS, NNRIMS and DHIS 2.0 systems) that will generate timely and accurate data to inform decision-making at all levels. Through this activity the state governments will be able to utilize data to mobilize resources and coordinate wider stakeholder involvement in monitoring and evaluating HIV/AIDS and TB control efforts-critical elements in the initial steps towards government ownership and sustainability. Technical assistance provided to facilities and the state partners will be coordinated with national and other SI programs and aligned with the national and USG data quality assessment/improvement (DQA/I) and capacity building plan. Capacity building in this area will be achieved through a combination of approaches, including workshop training (training content will include M&E skills building, surveillance topics, and HMIS concepts), on the job training, and facilitative supervision. MSH will also continue to actively participate at national and state level M&E TWG meetings and will utilize evidence from the program to guide and influence the national M&E agenda.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	551,517	0

Narrative:

The LMS/ProACT Prevention program was initiated in COP 09. It includes Abstinence/Be Faithful (HVAB) and Other Sexual Prevention (HVOP) programs. In COP 12, the LMS/ProACT project will continue to engage community and faith based organizations (CBOs and FBOs) through small grants to build upon COP 11 activities and expand to additional sites within the States. The HVAB program fulcrum strategy is peer education, leveraging on the GON Family Life and Health Education (FLHE) curriculum. Supported CBOs/FBOs will carry out behavior maintenance activities in intervention communities.
In COP 12, 65,454 persons will be reached with Sexual Prevention-Abstinence/Be faithful interventions which promote low risk behaviors, abstinence, delay of sexual debut or secondary abstinence for adolescents boys and girls, fidelity amongst married young people, reduce multiple and concurrent partners especially amongst out-of-school youth and young adults (age 18 -30). The HVAB program will pay special attention to the girl-child by empowering them with strategies which enable girls to develop self-esteem, critical thinking, assertiveness, and gain access to increased opportunities. Boys and young men will also be empowered to challenge negative masculine stereotypes and support norms and values of respect and equality between the sexes.
Trained peer educators in schools will continue to use the minimum prevention package interventions (MPPI) standard to carry out their activities. Strategies for MPPI will include the Peer Education Model using peer educators' sessions and interactions and HIV/Health club meetings etc.; Community Awareness Campaigns such as small group discussions and IPC; the School Based Approach will leverage on the existing Family Life and Health Education (FLHE) curriculum in schools to increase knowledge and skills on adolescent reproductive health, HIV/AIDS and life building. Learning will be reinforced through the integration of FLHE into school curriculum. The Peer Education Plus model strategy would also be adopted.
ProACT will build the capacity of the State Ministries of Education to supervise, monitor and ensure quality of FLHE/MPPI through joint supervisory visits to schools.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	975,953	0

Narrative:

ProACT will provide HCT services to MARPs, couples, pregnant women, children and clients seeking health care services at supported health facilities/communities in Kogi, Niger, Taraba, Adamawa, Kebbi and Kwara States using PITC and community outreach strategies. In COP 11 ProACT provided HCT services to 115,177 persons and will provide HCT services to 161,248 people in COP 12. ProACT will train 75 counselor testers to support service scale-up and also retrain 150 counselors to strengthen and update their skills. ProACT will continue to build upon the counseling and testing interventions initiated in COP11 by providing quality HCT services across supported sites; increasing access to HCT services for pregnant women in high prevalence communities through scaling up HCT services to 16 additional

primary health facilities in the supported States.

ProACT will identify and partner with local CBOs in high prevalence communities surrounding the supported health facilities to mobilize and generate demand by working with existing social structures in targeted communities. Community HCT services will focus on male involvement, women and other vulnerable groups. These CBOs will also play a crucial role in promoting facility/community referrals and linkages. Intra-facility escort services and contact tracing will be intensified and supported by trained volunteers to ensure 100% enrollment and increase retention in care.
HIV testing at all sites will be conducted using the current national serial algorithm and ProACT will provide, through its quality control laboratory staff, routine monitoring and mentoring to site staff. Personnel involved in HIV testing will undergo quarterly proficiency testing, while testing accuracy will be routinely re-checked using limited retesting of patient samples. As part of quality control measures instituted at all HCT sites, the quality control staff will ensure that standard procedures are strictly followed in the safe handling and disposal of medical and other laboratory waste materials. Training for PEP will be provided to all staff involved in HCT services.
ProACT will scale up partner testing and couples counseling across supported sites.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	893,639	0

Narrative:

The Other Sexual Prevention (HVOP) program is linked to activities in Adult Care and Support, TB/HIV, HCT, PMTCT and OVC. Since COP 09, ProACT has supported provision of HVOP in 53 health facilities and 24 communities in Kogi, Niger, Adamawa, Taraba, Kebbi and Kwara States. In COP 12, ProACT will continue to engage CBOs and FBOs through small grants to saturate the communities and expand to additional sites. The program fulcrum strategy is peer education, using the Minimum Prevention Package Intervention (MPPI) that addresses behavior change with a combination of intervention models. Supported CBOs/FBOs will carry out behavior maintenance activities in intervention communities.
In COP 12, ProACT will continue to target most at risk populations (MARPS) such as Men Having Sex with Men (MSM), injection drug users (IDU), female sex workers , married women, un-married young girls, transport workers, and uniformed service men. The MPPI for these groups will be Specific Population Awareness Campaigns (small group discussions or IPC); Community Outreach activities (HCT, condom messaging and distribution, balanced ABC messaging, etc); Peer Education Models using social peers (for DU, MSM and FSW populations); Job-related peers; Workplace Programs; Greater Involvement of People AIDS (GIPA), and condom service outlets. MARPs (MSM/IDU) requiring health services will be offered user-friendly services at ProACT supported facilities. Trained MARPS peer

educators will saturate communities with prevention messages focusing on partner reduction, inter-generational sex, mutual fidelity, stigma reduction, etc. Quarterly behavior maintenance activities will be carried out by peer educators and CBOs through regular community outreach programs which focus on motivating sustained behavior change Low risk behavior will be promoted amongst MARPS through increased access to condoms from established condom service outlets. Peer educators will facilitate changes in attitudes and behaviors which put women at risk of HIV by promoting female access to male condoms through women-only ”safe spaces.”

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	1,441,984	0

Narrative:

In COP 11, ProACT provided the minimum package for PMTCT supported sites in 41 health facilities across 6 states. Drug intervention was provided for all positive clients using the 2010 WHO option A and B depending on the facility’s capacity. All positive pregnant women were linked to CD4 within 1 week of diagnosis. HIV–exposed infants received EID services and were adequately linked to treatment or OVC care depending on their status. In addition to receiving PMTCT services, each mother-baby pair were linked through referral to community HIV/AIDS services such as food bank, peer support groups and IGA activities for ongoing support.

In COP 12 ProACT will continue to use available national data to select high prevalence communities to scale up PMTCT services in the six focus states. ProACT will also continue to support quarterly community outreach targeting pregnant women and providing linkage for prophylaxis/treatment and CD4. Pro-ACT will continue to ensure that the quality of PMTCT services across its supported sites is maintained by conducting training and retraining of facility staff using the current National guidelines. 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. Emphasis will be laid on the quality of post test counseling given while the already instituted PITC at the labour ward will be extended to spouses who come to visit post delivery. Food and nutritional supplements will be leveraged from non-PEPFAR implementing partners for malnourished pregnant and lactating positive women. In addition Pro-ACT will collaborate with other partners to further integrate Family Planning into maternal and child health care to improve FP uptake and maternal and child health outcomes.

Pro-ACT will continue to encourage quarterly joint GON/USG/Pro-ACT supportive supervision. Updated National registers would be used with feedback provided to the facilities. The quality of service will be assured through supervision, QA/QI analysis, M and E, and QA checks using standardized national tools. Pro-ACT will disseminate information through regular reporting to the USG and GoN

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	330,967	0

Narrative:

In COP11 MSH ProACT project participated actively in the quantification of ARVs and OIs nationally and facilitated the initiation of a Logistics Management Task team in Niger State which is providing direction on joint warehousing and distribution of HIV commodities to reduce duplications in procurement between IPs and government. In COP12 ProACT will continue to participate in the national forecasting exercise and procurement planning meetings facilitated by the government of Nigeria, USG partners and SCMS project.

In COP11 all adult patients on Stavudine backbone were successfully migrated to Truvada based regimen. In COP12 the following assumptions were used in the forecasting for ARVs: Pediatric clients would be maintained on their current regimen. Children will be maintained on Stavudine only in cases where suitable alternatives are not available. New adult clients would be enrolled based on the following regimen distribution; AZT/3TC/NVP-35%, AZT/3TC/NVP-15%, TDF/FTC/NVP-35%, TDF/FTC/EFV-15% All purchases of ARVs will be via SCMS pooled procurement mechanism in line with OGAC's recommendation. Generic formulations will be used preferentially. ProACT partner Axios Foundation has developed a functional logistics system to ensure consistent availability of secure and high quality ARVs and related commodities plus accountability for the deliveries/usage. In COP12 Axios will continue to integrate its distribution and warehousing with State government network to deliver health commodities to patients.

In COP 11 none of the ProACT supported facilities reported stock out of ARVs. In COP12 ProACT will continue to ensure uninterrupted availability of ARVs to all facilities through leveraging of resources with Government of Nigeria (GON), USAID and other stakeholders and will build the capacity of state partners in the forecasting, procurement and distribution of ARVs and HIV commodities. This concerted effort will efficiently promote a sustainable supply of ARVs and other HIV related products to all health facilities covered by the project. The project will leverage second line pediatric ARVs from the CHAI. In addition, ProACT would leverage PMTCT commodities from CHAI/UNITAID

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	1,704,589	0

Narrative:

In COP 12, MSH ProACT will build on its achievements in providing support to SMOH to provide comprehensive care and treatment services. Additional 4175 patients will be provided with ART with projected cumulative active client load of 11,675

In COP 11 MSH supported the Kogi State Government in the activation of 3 state owned CCT's in

underserved population. Supervisory teams were constituted and trained to provide technical assistance and participate in mentoring visits. In COP12 ProACT will strengthen this partnership with SMOH and institute a state training faculty. This will also be replicated in 2 other states to further scale up ART services.

ProACT's integrated service delivery model enhanced by Management level integration of project management teams and hospital management committees resulted in improved program ownership and coordination with improvement at service delivery units. In COP12 these processes will be strengthened and scaled up to new health facilities.

To improve access to quality ART care, ProACT is supporting the FMOH in the development of a national strategy to decentralize ART services to PHCs and built capacity of state and LGA's in Taraba state. State supervisory team was constituted, In COP 12, capacity of this team will be built to continue the implementation process. The process will also be replicated in states with high client burden.

Capacity of clinicians to evaluate patients in long term care for treatment failure and initiate second line therapy.35 physicians will be trained in advanced ART management. MSH ProACT will provide access for viral load monitoring in treatment experienced patients by building networks with existing PCR laboratories.

In addition facility driven continuous quality improvement (CQI) systems piloted at 6 selected facilities in COP 11 will be scaled up and mainstreamed into all 28 CCT's in COP 12.Capacity of facility based MDT's to perform monitoring and quality improvement checks .Capacity of state supervisory teams will also be built to conduct periodic site performance evaluations and use relevant data to make strategic decisions.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	196,020	0

Narrative:

Pro-ACT in COP 11 focused on building the capacity of facility health and SMOH staff through organized trainings, extended CMEs and support for National TOT. PITC was institutionalized at the pediatric wards and at support group meetings with linkages to the pediatric treatment clinics. Pro-ACT worked with the state partners at the facility and State ministry levels to increase access to DBS by decentralizing collection, developing a hub and spoke model along with innovative ways of transporting the sample to the reference labs. Pediatric adherence was improved by using pediatric fixed dose ARV formulations and strengthening the mother – baby pair appointment system.

In COP 12, Pro-ACT will scale up pediatric uptake by the institutionalization of genealogy forms into the record unit and further train data clerks and triage nurses on its use linkage to the community volunteers for tracking.

Quality indicators will be introduced into the PITC points at the ward and POPD to ensure maximum uptake. Priority attention will be given to parents at the adult ART clinic for accompanying children so as to create demand for pediatric HCT. PITC points will also placed at MCH clinics with active referral to pediatric ART clinics. All PITC points will include DBS collection for children less than 18 months who test sero positive. In order to increase client retention, Pro-ACT will establishing children psychosocial groups in some facilities leveraging from partners like Sesame Street and UNICEF. Pro-ACT will provide a sustainable reward system by leveraging from organizations already into children education. They will provide full/part scholarship, school materials and admission for school age children who have demonstrated good adherence. Pro-ACT will also look into supporting the state partners and supported facilities to establish adolescent reproductive health clinics and give it youth friendly environment to encourage uptake. Capacity building for task shifting to address Human resource gap will be done. Pro – ACT will incorporate few modules from IMCI, and safe motherhood training curriculum into pediatric ART training curriculum to further sensitize and equip Health workers for integration.

Implementing Mechanism Details

Mechanism ID: 14161	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14162	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14169	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14170	**TBD: Yes**

REDACTED

Implementing Mechanism Details

Mechanism ID: 14231	**Mechanism Name: C-Change**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: FHI 360	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 2,209,681	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	2,209,681

Sub Partner Name(s)

Association of Grassroots Counselors	Dreamboat Foundation	Environmental Development & Family Health
Internews	Ohio University	

Overview Narrative

C-Change KABP findings conducted in 2010 revealed lack of in-depth knowledge of HIV/AIDS issues among youths in Kogi and Cross-River States prompting a need to intensify prevention interventions aimed at increasing awareness of HIV/AIDS issues in the two states. The national HIV/AIDS Behavior Change Communication (BCC) response also identified lack of effective coordination and technical direction in the BCC activities implemented by PEPFAR Implementing Partners (IPs) and other developmental partners.

In COP 12, C-Change will continue to partner with local Non-Governmental Organizations (NGOs) to promote preventive behaviors and condom use to reduce HIV risk behaviors among youths 10 to 24 years, in and out of school in the states. Young people will be trained as Peer Educators to promote HIV/AIDS prevention. Capacity of the partner NGOs would be enhanced to ensure sustainability of the ongoing community–level interventions. Mass media would also be engaged to reinforce community activities.

The project will support the joint National Prevention and SBCC Technical Working Group and work with the National Agency for the Control of AIDS (NACA) and the National Prevention TWG to establish a clearinghouse for communication materials as well as develop strategies for collection and dissemination of best practices. The project will reinforce work on improving the effectiveness and sustainability of SBCC for HIV prevention in Nigeria. C-Change will continue to provide technical support to USG partners, NGOs/CBOs and health workers to design and implement evidence-based, community-informed SBCC. Support to Cross-River University of technology (CRUTEC) and University of Calabar (UNICAL) in institutionalizing SBCC training for students.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation

Budget Code Information

Mechanism ID:	**14231**		
Mechanism Name:	**C-Change**		
Prime Partner Name:	**FHI 360**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVAB	800,001	0

Narrative:

C-Change's work with partner NGOs would continue to promote preventive behaviors including abstinence among secondary school youths 10 – 17 years in two focal states (Cross River and Kogi). 220 Peer Educators will be trained and HIV prevention campaigns will be conducted within Cross River and Kogi States, linking mass communication efforts at state level with community based-responses. To fulfill the requirement of the national Minimum Prevention Package Intervention (MPPI), NGOs will employ the MPPI prongs and strategies to reach 2,437 secondary school youths in the two states. The NGOs will conduct community outreach interventions by carrying out community dialogue with stakeholders and gatekeepers of the schools to increase understanding of HIV/AIDS problem, address issues affecting positive behaviors, engender community ownership and support of project. Small group discussions would be held quarterly in target secondary schools to explore risk behaviors, increase HIV/AIDS knowledge, address myths and misconceptions, provide information on condom use, counseling and testing, safer sex including abstinence and make referrals to services. While peer education would serve as the lead strategy, NGOs will conduct Dance/Drama (talent show) events in the secondary schools to enter-educate youths on HIV/AIDS prevention.

C-Change will also continue to support Cross-River University of technology (CRUTEC) and University of Calabar (UNICAL) in institutionalizing SBCC training.

The Project will continue engagement with trained journalist and media houses in providing meaningful support to social and behavior change for HIV prevention. Further capacity building would be provided to the media practitioners to develop programs and media products aimed at increasing HIV prevention. There will be increase in the number of media materials supportive of prevention and positive behavior change that will enhance health and well-being of individuals.

C-Change will also provide further trainings to NGOs on how to engage the media for effective coverage of HIV prevention interventions.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	1,409,680	0

Narrative:

C-Change will continue to partner with local NGOs to promote preventive behaviors including mutual fidelity and condom use to reduce HIV risk behaviors among youths 17 – 24 years in two focal states (Cross River and Kogi). NGOs will employ the MPPI prongs and strategies to reach 2, 563 out- of - school and tertiary institution youths in project states. The NGOs will conduct community outreach interventions in target communities and institutions to increase understanding of HIV/AIDS problem, address negative norms, engender community ownership and support of project activities. Small group discussions would be held quarterly in target communities and institutions to explore risk behaviors, increase HIV/AIDS knowledge, address myths and misconceptions, promote counseling and testing,

safer sex including condom use and make referrals to STI and HIV services. The NGOs will partner with other USG IPs, organizations and Government agencies within project communities to distribute condoms at these sessions as well as provide mobile counseling and testing services. 220 peer educators (PEs) will be trained and they will continue interpersonal and group outreaches, while the NGOs will conduct other support activities. Vulnerability intervention will also be conducted for out-of-school youths. Mass media will reinforce community activities. Capacity of the partner NGOs in the States would be enhanced to ensure sustainability of community–level interventions. C-Change will continue to support the joint National Prevention and SBCC Technical Working Group (TWG) meetings, train TWG members in SBCC guidelines and mechanisms and standards for coordination. The project would also ensure that SBCC implementing partners are reporting required BCC indicators to NNRIMS on a regular basis. NACA and the TWG will be supported to ensure that Clearinghouse for communication materials is functional and develop strategies for collection and dissemination of best practices in Social and Behavior Change Communication (SBCC). Support will also continue to USG partners, NGOs/CBOs and health schools/workers to design and implement evidence-based, community-informed SBCC interventions in line with national prevention priorities.

Implementing Mechanism Details

Mechanism ID: 14233	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14250	**Mechanism Name: TBCARE I**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: KNCV Tuberculosis Foundation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 2,433,077	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**

GHP-State	2,433,077

Sub Partner Name(s)

Damien Foundation	German Leprosy and TB Relief Association (GLRA)	Netherlands Leprosy and Relief Association
The Leprosy Mission Nigeria		

Overview Narrative

TB is a major cause of death among people living with HIV (PLHIV). The HIV sero-prevalence rate among TB patients in Nigeria increased from 2.2% in 1991 to 25% in 2010 (NTBLCP 2010 Report). To address the challenges created by TB/HIV interactions, the NTBLCP and NASCP developed a Joint National Plan in 2006 for phased implementation of TB/HIV collaborative activities supported by USAID. This USAID support has resulted in the following achievements: (1) Development National Guidelines, Strategic framework, Training/policy documents (2) Establishment of a National TB/HIV Working Group (3) Support for 23 State TB/HIV Working Groups (4) Phased implementation of TB/HIV collaborative activities in 23 states (5) Training of DOTS providers on HCT (6) Increased number of DOTS clinics providing HCT (7) Increased number of TB patients counselled and tested for HIV (80%) (8) Increased number of co-infected patients accessing Cotrimoxazole and ARVs (9) Renovations of DOTS clinics and Laboratories. Despite the achievements the provision of joint TB/HIV services in the country still faces the following challenges: (1) The NASCP structure at State/LGA level is not well structured/absent thereby hampering collaboration and coordination (2) Overreliance of NASCP on partners jeopardizing government ownership (3) Limited number of DOTS centres providing TB/HIV services (<50%) (4) Suboptimal access to Cotrimoxazole and ARVs among co-infected patients (58.7% and 33.3% respectively). The COP12 grant (TBCARE I/KNCV/WHO/ILEP) will be used to address these challenges by focusing on the following principles: (1) National/State ownership and leadership (2) Partnership and collaboration with all stakeholders (3) Equitable access to TB/HIV interventions.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **No**

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

TB

Budget Code Information

Mechanism ID:	14250		
Mechanism Name:	TBCARE I		
Prime Partner Name:	KNCV Tuberculosis Foundation		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HVTB	2,433,077	0

Narrative:

The key intervention area under the budget code for HVTB is the scale up of TB/HIV collaborative activities in selected states. TB/HIV collaborative activities will be expanded to 100 DOTS facilities and 50 laboratories through the existing NTBLCP/ ILEP partners (Damien Foundation Belgium, German Leprosy and TB Relief Association, Netherlands Leprosy Relief and the Leprosy Mission Nigeria. The expansion includes: (1) Renovations of clinic/labs (2) (Re) training of DOTS/Lab staff on TB/HIV Collaboration and HCT (3) Procurement of microscopes (50) and test kits in line with the National Algorithm (HIV test kits for 180.000 suspects and patients) (4) Monitoring and evaluation (5) Supervision at all levels (6) Institutionalization of appropriate infection control measures at the incorporated clinics (. In addition to the scale up of TB/HIV collaborative activities, the COP 12 funding will be used to support the MDR Treatment centre at the University College Hospital (UCH) in Ibadan. The funding covers the following activities: (1) Training of 5 UCH staff (2) Patient support costs(feeding, transport)of 50 patients (3) Ensuring effective linkages between the MDR-TB Treatment Centre and the receiving health facilities

(4) Training of General Health Workers, Local Government TBL supervisor and State TBL Control officers (50) on Programmatic management of Drug Resistant Tuberculosis (5) Support for follow up tests and quarterly monitoring visits of staff from the MDR Treatment Centre in Ibadan (75 patients). The collaborating partners are FMOH/TBCARE I/WHO/KNCV/ILEP.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	0	0

Narrative:

The key intervention areas under the budget code for health systems strengthening are: (1) Strengthening NASCP Structure at State and LGA levels (6 pilot states) (2) Support National and State TB/HIV Working Groups (23 states) (3) Strengthening supervision of TB/HIV collaborative activities at National/Zonal level. Under the additional COP11 funding, the following preparatory activities to start up the process of strengthening NASCP have been planned: (1) Situation analysis (2) Gap analysis (3) Stakeholders meeting to design new NASCP structure (4) Development requires policy documents/SOPs/training materials (5) Selection of six pilot states using predefined criteria (6) Support for the conduct of state level advocacy visits. Implementation and evaluation of the newly developed NASCP structure will be supported by COP12 with the following activities: (1) Institutionalization of the designed structures in 6 states (2) Capacity building for NASCP programme managers at State/LGA level (3) Printing/distribution of policy documents/SOPs/training materials (4) Logistics support i.e. procurement of laptops/internet facilities for programme managers, project vehicles/motorcycles (5) Coordination meetings at National/Zonal/State level including National Annual Review Meeting (6) Monitoring and evaluation (7) Supervision at all levels (8) Support for the position of Technical Advisors at National/Zonal level (9) Technical Assistance for development Global Fund Proposal for expansion/scale up. The collaborating organizations are FMOH/TBCARE I/WHO/KNCV/ILEP.

Implementing Mechanism Details

Mechanism ID: 14298	**Mechanism Name: Enhancing Nigerian Capacity for AIDS Prevention**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Deloitte Consulting Limited	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	

G2G: N/A	Managing Agency: N/A

Total Funding: 2,172,149	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	2,172,149

Sub Partner Name(s)

Catholic Action Committee on AIDS	Christian Reform Church of Nigeria AIDS Action Committee, Wukari, Taraba State	ECUMENICAL CENTER, BENUE
Education As A Vaccine Against AIDS (EVA)	FHI 360	Global Agenda for Total Emancipation, Abuja
JIREH FOUNDATION, BENUE	New Generation	Ohonyeta Care Group, Otukpo
OSA Foundation, Makurdi		

Overview Narrative

In COP 12, ENCAP is requesting $ 2,172,149 to deliver HIV prevention services to 75,424 individuals in FCT, Bayelsa, Rivers, Benue, Taraba, and Ebonyi states; and HIV Counselling and Testing services in FCT and Benue state. ENCAP interventions will target the general population subgroups at elevated risk (e.g. female out-of-school youth, widowed, divorced and migrant populations) and MARPs

ENCAP's approach emphasizes mutually reinforcing combination prevention strategies that address population-specific drivers in adherence to national standards. Interventions aim to increase HIV related knowledge and risk perception; reduce stigma; promote abstinence and fidelity; and encourage partner reduction. ENCAP partners will provide condoms and referrals for related services as appropriate. In COP 12, some partners in the FCT and Benue state will be supported to provide HTC services to 24,050 individuals among those targeted with prevention interventions.

ENCAP will support the national HIV response through a comprehensive and outcome-focused approach to building capacity at 3 levels: 1) increasing individuals' skills in management, leadership, and service delivery; 2) building organizations' internal systems and financial viability; 3) supporting state level coordination, civil society participation, and technical leadership. In COP 13, ENCAP will implement a transition strategy to further increase local partners' leadership of interventions and coordination with local and state governments.

ENCAP will conduct a midterm project evaluation in COP 12 and use project data to inform program direction and support USAID/Nigeria to define, measure and drive evidence-based capacity building for HIV programs. ENCAP will work with partners to document and showcase promising practices.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

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

Budget Code Information

Mechanism ID:	**14298**
Mechanism Name:	**Enhancing Nigerian Capacity for AIDS Prevention**
Prime Partner Name:	**Deloitte Consulting Limited**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	628,532	0

Narrative:

In response to the shift in national priorities and adoption of the combination prevention approach, ENCAP will continue to provide comprehensive needs-based services to our target populations in COP 12 and 13. In COP 12, the project will reach a total of 75,424 individuals in the FCT, Bayelsa, Rivers, Benue, Taraba, and Ebonyi states with evidence-based individual and/or small group level HIV prevention interventions guided by the minimum prevention package approach.

The HVAB budget component in COP 12 is $628,532 based on an approximate cost of $25 per individual reached with prevention interventions.
Recognizing the need to provide a comprehensive prevention package, ENCAP partners will implement a mix of strategies incorporating all necessary elements while emphasizing specific approaches tailored to specific target populations, for instance interventions primarily focused on abstinence and delaying sexual debut will reach 25,141 persons in COP 12, focusing mainly on in-school youth, and will be complemented by the provision information on condom use and referrals as appropriate. Similarly, a combination approach will be used to promote partner reduction and fidelity amongst out of-school youth, married persons, and other sexually active individuals. Overall, strategies will include peer education, community outreach activities, community awareness campaigns, peer education plus and school based approaches (for in-school youth). In addition, ENCAP plans to incorporate the provision of HTC to these target population groups, if requested funding is received for this, through a number of ENCAP partners already proving HTC services on a smaller scale.
In COP 12, ENCAP will continue to build CBO partners' capacity to design, manage, and implement tailored prevention interventions in line with national guidelines by promoting best practices in HIV prevention service delivery.
ENCAP is committed to sustainable organizational development and will continue to work with CBO partners to strengthen their institutional capacity with a focus on leadership and governance, financial management, monitoring and evaluation, and human resource development.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	238,533	0

Narrative:

ENCAP project targets general population sub-groups at elevated risk and most-at-risk populations (MARPs) with combination prevention interventions. Addressing the low knowledge of HIV sero-status among men and women is fundamental for combination prevention and promoting entry into care. In COP 12 and 13; ENCAP proposes to expand its scope of services in the FCT and Benue state to include HIV Testing and Counselling services and will reach 24.050 individuals in COP 12.

Seven ENCAP partners in the FCT and Benue state currently provide HTC services and are uniquely positioned to maximize reach by offering HTC services to population sub-groups at elevated risk particularly MARPS, young women and out-of-school youth risk already being targeted with prevention interventions in their communities. ENCAP will build on existing capacities to efficiently scale up HTC services. As a complementary biomedical intervention, HTC will increase dosage and intensity, and serve as an entry point for referral into care. Existing prevention services will serve as a platform to promote

increased uptake of HTC services among those at higher risk of infection. ENCAP partners will use a three-prong approach to deliver services: 1) through peer education interventions; 2) through targeted outreach at community events; and 3) through existing couple counselling structures of faith based partners in FCT and Benue to increase uptake. Nationally developed and currently used HTC service delivery forms will be used to collect data on beneficiaries. Data will be reported to USAID and will feed into the national M&E HTC database. Existing protocols will be reviewed with partners to ensure HIV testing strategies are in line with national guidelines and standard operating procedures (SOPs). Linkages will be established between partners in the all ENCAP states to increase access to related services.

The budget for the HVCT component is $151,533 based on an approximate cost of $6.30 per individual reached. This is based on actual service delivery costs. In COP 12, ENCAP will also allocate $87,000 towards supporting HTC coordination at national level, including an IP HTC meeting and national HTC survey.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	1,305,084	0

Narrative:

In COP 12 and 13, in addition to education on condom use and negotiation, ENCAP will implement other HIV prevention interventions including condom provision as feasible, and continue with the provision of referrals for STI management and other HIV-related services. We will target population subgroups at higher risk including MARPS to reach a total of 50,283 individuals with other prevention interventions in COP 12. In COP 12 and 13, MARPS will constitute about 10% of the total population targeted with comprehensive interventions incorporating HVOP components.

ENCAP partners will continue to implement a mix of minimum package prevention strategies tailored for higher risk populations. Strategies include community outreach, peer education plus, particularly for out-of-school youth and specific population awareness campaigns to target subgroups at elevated risk and MARPs.

ENCAP will also procure condoms for peer educators to distribute to their cohorts (particularly for MARPS) and for other population groups will provide information on condom use and referrals to condom service outlets for greater access. ENCAP will also support direct condom distribution by partners for their cohort groups and use during community outreaches. In addition, the higher risk groups will be able to access HTC services from some ENCAP partner sites in FCT and Benue state.

The budget for the HVOP component is $1,305,084 based on an approximate cost of $26 per individual reached. This cost is based on actual service delivery costs. In COP 12, ENCAP will continue to support institutional capacity interventions to promote the organizational development of partner CBOs and improve their ability to design, manage and implement tailored prevention programs. Key capacity building activities will include strategic planning and policy development, staff coaching, mentoring, on-the-job training, HIV prevention seminars for improved technical capacity; and support for strengthened coordination and referral mechanisms.

Implementing Mechanism Details

Mechanism ID: 14302	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14303	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14348	**Mechanism Name: Links For 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	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,548,058	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	1,548,058

Sub Partner Name(s)

Association for Reproductive and Family Health	Association of Orphans and Vulnerable NGO's in Nigeria	Christian Association of Nigeria
Federation of Muslim Women Association in Nigeria, Adamawa	Jama'atu Nasril Islam	Network of People Livng With HIV/AIDS in Nigeria (NEPWAN)
Nigerian Red Cross Society		

Overview Narrative

Links for Children is a five-year project to improve services and support to OVC in 3 States: Bauchi, Kaduna and Katsina. The project will expand access to treatment services, and care and support for 11,950 orphans and vulnerable children; and training on care and support for 2,620 caregivers and 384 Child Protection Committee members. In COP 2012, project activities will focus on care and support for 6,250 OVC and training of 600 caregivers and 70 CPC members in three states, Bauchi, Kaduna and Katsina. This project will focus on one technical area of support: Support to OVC.

Key Project Outcome Indicators at end of COP 2012: 1) ARFH and 18 CSO partners (6 in each state) have completed an organizational assessment and development plan; 2) 6,250 children will receive support in areas of education, economic, psychosocial, or protection; and 600 caregivers and 70 CPC members will receive training. 3) One training for state government agencies will be conducted in three states. Particular attention will be paid to building economic stability of households so that parents and caregivers are able to provide for their children's long term needs; retaining children in school, and working with local governments to establish strong child welfare and protection systems. Additionally, during youth club sesions, older/adolescent OVC will receive life planning education on gender-based violence and sexual coercion to shape them to meeting the challenges of growing up into adulthood.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Principal Recipient**
3. What activities does this partner undertake to support global fund implementation or governance?
(No data provided.)

Cross-Cutting Budget Attribution(s)

Economic Strengthening	300,000

Food and Nutrition: Policy, Tools, and Service Delivery	250,000
Gender: Reducing Violence and Coercion	100,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

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
Malaria (PMI)
Child Survival Activities

Budget Code Information

Mechanism ID:	**14348**
Mechanism Name:	**Links For Children**
Prime Partner Name:	**Save the Children UK**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	1,548,058	0

Narrative:

In COP 12 ,LINKS will continue to solidify services and consolidate outcomes in the current target communities in all 3 states Kaduna, Bauchi and Katsina States. The project will enroll and support an additional 6,250 new children (OVC), while continuing to maintain the previous 5,900 children currently enrolled from the previous year. Children involvement will be closely facilitated, documented and reported through the kid's club activities in the 3 states. A team meeting will be held inthe second quarter to

discuss achievements and lessons learned as a team; to further refine the project's technical and strategic approach; to finalize the state work plans for COP 13 .LINKS will see the roll-out of the Economic Strengthening (Savings and Loan) activities. This will be with the aim to build the economic stability of households so that parents and caregivers are able to provide for their children's long term needs; retaining children in school, and working with local governments to establish strong child welfare and protection systems Organizational capacity assessments have been completed for ARFH and for each CSO partner in all the 3 states, and implementation of the agreed organizational development plans will continue. Protection system strengthening will be one of the focus inCOP 13 from community reporting and responding to cases of abuse and exploitation to state level systems strengthening. During youth club sessions, older/adoelscent OVC will receive life planning education on gender-based violence and coercion to shape them to meeting the challenges of growing up into adulthood. Trainings of Government Ministries, LGA Officials and OVC Technical Working Groups will continue in Kaduna, Bauchi and Katsina, while collaborations are maintained with all IPs in year 3. The budgeted amount stated above is to be spent in COP2012 under the following sub-line items: 1. Personnel Salaries - $ 789,605; 2. Fringe benefits and allowances - $ 278, 235; 3. Travels/Perdiems (Project cost) - $38,914; 4. Equipment-$15,571; 5. Consultancies-$40,047; 6.a. Other Direct Costs (Project Cost) -$95,673; 6.b. CSO & CPC Grant -$142,292; 6.c. Printing Documents - $5,715; 6.d. Abuja Trainings & Meetings - $6,086; 7. Office Running Cost-$ 118,885.00.

Implementing Mechanism Details

Mechanism ID: 14383	**Mechanism Name: U.S. Department of Defense Walter Reed Program Nigeria**
Funding Agency: U.S. Department of Defense	Procurement Type: Contract
Prime Partner Name: U.S. Department of Defense (Defense)	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 11,536,529	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	11,536,529

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Walter Reed Program – Nigeria (WRP-N) is a partnership between the United States (US) Department of Defense (DoD) and the Nigerian Ministry of Defence (NMOD) that works through the Emergency Plan Implementation Committee (EPIC) to strengthen HIV research, prevention, care and treatment in military facilities. The program currently spans 20 health sites across 16 states in Nigeria.The WRP-N mission is closely aligned with Nigeria's Partnership Framework (PF) and the Global Health Initiative (GHI) as it takes a systemic approach to the reduction in the incidence of communicable diseases, including HIV, tuberculosis, and malaria. Key program elements include: improvement of human resources for health through training, peer support, and supervision; capacity building extending beyond clinical to encompass leadership, management, governance, and accountability; establishment of disease monitoring, logistics and laboratory systems; upgrade of infrastructure; and promotion of research. WRP-N is a unique US Government agency in Nigeria, having already achieved approximately 20% country ownership through funding provided by NMOD, as well as a commitment to scale up funding on an annual basis.WRP-N will continue to pursue increased Government of Nigeria political will and resources, decentralization of services, engagement at the state and local levels, and improved NMOD coordination and program management. Additionally, it will synergize with other donors to ensure cost efficiency, innovation and sustainable development. Monitoring and evaluation of all activities is considered inherent to effective decision making, successful program transition, quality data, and research. The WRP-N will promote the use of electronic information systems and quality data collection tools.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

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:	**14383**
Mechanism Name:	**U.S. Department of Defense Walter Reed Program Nigeria**
Prime Partner Name:	**U.S. Department of Defense (Defense)**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	1,454,893	0

Narrative:

The US Department of Defense Walter Reed Program – Nigeria (DoD WRP-N) Adult Care and Support program provides facility-based services with referrals for community/home-based care for HIV-infected military personnel and civilians in 20 military hospitals, spanning 16 states. The program aims to reach out to 40,748 and 56,232 adults in FY12 and FY13 respectively. Additionally, WRP-N plans to improve access to care and support services, with the addition of 3 sites in Lagos, Benue and Niger states. In addition DOD WRP-N will work with a partner to provide care and support services to most at risk populations (MARPs) including MSM groups in Kaduna.
In accordance with the National Palliative Care Guidelines, the minimum care package includes provision of clinical care, a basic care kit, and two supportive services. Clinical care includes cotrimoxazole prophylaxis, nutritional assessment, nursing care, management of opportunistic infections, and STIs tuberculosis, cervical cancer screening, and malaria prevention. The basic care kit includes a long lasting insecticide treated net, a water guard and vessel, soap, hand gloves and/or condoms, and IEC materials on water sanitation and hygiene. Supportive services incorporate psychological, spiritual, social, and preventative approaches. HIV prevention services include the provision of positive health dignity and prevention services, HIV counseling and testing services for family members and sex partners, prevention messages focused on disclosure, partner testing, correct and consistent condom use, mutual

fidelity, counseling on high risk sexual behaviors, and integration of reproductive health services. Strategies to achieve targets include the decentralization of services using the 'Hub and Spoke' model; improvement in the quality of services through the use of continuous quality improvement (CQI) models; enhanced networking and referral mechanisms; task shifting; further strengthening of linkages between adult and pediatric care and treatment, PMTCT, OVC programs, nutritional services, PLHIV support groups, income generating activities, RH/family planning (FP), and other support services; increased retention of pre-antiretroviral (ART) clients through 3-monthly clinical review and follow up of missed appointments; and overall health systems strengthening.
Monitoring and evaluation will be achieved through regular site visits, data quality assurance (DQA) reviews, mentoring, and supportive supervision. The WRP-N will also carry out an evaluation of the impact of malaria on HIV infection amongst program patients and apply the results to improving the management of malaria and HIV co-infection.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	344,631	0

Narrative:

The US Department of Defense Walter Reed Program – Nigeria (DoD WRP-N) currently supports TB/HIV program integration in 20 military hospitals, across 16 states, serving military personnel, their families, and surrounding communities. In collaboration with the National and State TB Control Programs, the WRP-N will continue to strengthen Directly Observed Treatment Short-course (DOTS) services across all sites. To capitalize on the existing PEPFAR-local government area (LGA) coverage strategy, collaborative activities will be expanded over the next 2 years with the addition of 4 new sites in Benue and the Federal Capital Territory (FCT).

As part of the WRP-N's health system strengthening strategies, support will be provided for basic renovations, procurement of equipment, and supply of consumables (eg, sputum containers, waste bins, standing fans, and face masks) in order to support TB infection control. Peer health educators (PHE) will be trained and re-trained on the delivery of positive prevention messages, including cough etiquette. In conjunction with the prevention unit, barracks health committees, and faith based leaders, a sensitization program will be rolled out in an effort to encourage communities to refer suspect TB/HIV cases to health facilities. Diagnostic services will be strengthened across all sites, with the provision of fluorescent microscopes. Four Gene Xpert machines will also be procured to improve the early detection of multi-drug resistant (MDR) TB. All detected cases will be referred to the nearest reference laboratory for confirmation.

The capacity of health care workers (HCWs) will be strengthened, through formal TB/HIV training that will

include x-ray diagnostic skills, good sputum specimen collection, laboratory acid-fast bacillus (AFB) sputum smear diagnosis, and TB management. HCW's will also have the opportunity to expand knowledge, share best practices, and discuss challenges through, attendance at continuing medical education (CME) and technical review meetings.

The WRP-N will support the National TB Control Program in the development of clinical support tools, job aids, information, education, and communication (IEC) materials, national registers, and referral forms in order to ensure standardization of quality care.

A Continuous Quality Improvement (CQI) program will also be instituted at sites. Bi-annual review of findings will ensure that appropriate interventions can be instituted in response to any identified gaps or challenges.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	67,279	0

Narrative:

The US Department of Defense Walter Reed Program – Nigeria (DoD WRP-N) Pediatric Care and Support program provides services to HIV exposed and HIV positive children and adolescents. It plans to reach 1,862 and 2,234 children and adolescents in FYs 12 and13 respectively with pediatric care and support services at 20 military hospitals, located in 16 states. There are also plans to expand services, with the addition of 3 hospitals in Niger, Benue and Lagos. The scale up of early infant diagnosis (EID) will be in line with the GoN's plans.

As per the National Palliative Care Guidelines, the minimum care package for each HIV infected child includes clinical care, a basic care kit, and two supportive services. Clinical care includes cotrimoxazole prophylaxis, nutritional assessment, ready-to-use therapeutic food, nursing care, management of opportunistic and sexually transmitted infections, tuberculosis screening, and malaria prevention. The basic care kits are provided to all PLHIV and include a long lasting insecticide treated net, a water guard and vessel, soap, hand gloves and/or condoms, and IEC materials on water sanitation and hygiene. Strategies to achieve targets include the decentralization of services; improvement in the quality of services through the use of continuous quality improvement models; enhanced networking and referral mechanisms including patient tracking; task shifting; further strengthening of linkages between MNCH, adult and pediatric care and treatment, PMTCT, OVC programs, nutritional services, youth friendly clubs, income generating activities, RH/family planning, and other support services; integration of HIV/AIDS services into routine and pre-existing health systems; increased retention of pre-antiretroviral (ART) clients through 3-monthly clinical review and follow up of missed appointments; and health system strengthening. Youth friendly and adolescent centers will also be established to support HIV positive

adolescents.
Monitoring and evaluation will be achieved through regular site visits, data quality assurance reviews, mentoring and supportive supervision. Operational research and program evaluation will be conducted to improve the quality of pediatric care and support provided.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	2,469,483	0

Narrative:

The DoD WRP-N will continue to work with the Nigerian Ministry of Defence (NMOD), through its Emergency Plan Implementation Committee (EPIC) liaison office, in the development and provision of appropriate laboratory support to ensure reliable, quality, and timely laboratory test results for people infected with HIV. Appropriate infrastructure support will also be provided.

President's Emergency Plan for AIDS Relief (PEPFAR) lab activities will be enhanced through training and mentorship. Quality management systems will be embedded into all laboratory processes and procedures. WRP-N will support 10 laboratories for national accreditation over the next 2 years.

Laboratory network linkages and referral systems, using the hub and spoke model, will be adopted. Treatment sites will expand from 20 to 22, as well as the addition of 7 satellite sites. The 68 Nigerian Army Reference Hospital will also be transferred to WRP-N from Harvard.

In collaboration with the National TB and Leprosy Control Program (NTBLCP), tuberculosis case detection will be enhanced. Gene Xpert platform for the molecular diagnosis of tuberculosis will be evaluated and validated in 2 of the sites (45 NAFH, Markurdi and 44 NARH, Kaduna).

The Defence Reference Laboratory will be expanded to include a malaria diagnostic and quality assurance (QA)/quality control (QC) center.

Molecular diagnostics to support prevention of mother-to-child transmission (PMTCT) and treatment scale up will be expanded and automated, with the addition of 2 new sites (44 NARH, Kaduna and 68 NARH, Yaba Lagos). Evaluation and validation of point of care technologies for CD4, blood safety monitoring, and viral load estimation will also be carried out.

The Defence Reference Laboratory will provide and support QA/QC activities across all of the HIV counseling and testing centers. Additionally, a retesting protocol will be developed and implemented for

random samples of patients tested prior to the development of the National HIV Testing Algorithm.

Rapid and molecular diagnosis of sexually transmitted infections (STIs) and clinically indicated opportunistic infections (OIs) will be supported in all the sites and through a specimen referral system to the Defence Reference Laboratory. Supply Chain Management System (SCMS) will continue to provide equipment procurement, laboratory consumables, and preventive maintenance services.

To ensure ownership and sustainability, a phased transition plan for laboratory activities to NMOD-EPIC will be jointly developed and implemented. WRP-N will also support the development of a laboratory strategic plan for the NMOD.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	1,300,000	0

Narrative:

The US Department of Defense Walter Reed Program – Nigeria (DoD WRP-N) will continue to support strategic information (SI) activities at 25 comprehensive and satellite Nigerian Ministry of Defence (NMOD) sites, and an additional 8 prevention of mother-to-child transmission (PMTCT) sites.

Key focus areas will include: strengthening capacity for program monitoring and evaluation (M&E); use of electronic information systems for patient management and program reporting; and supporting research and surveillance activities.

The NMOD-WRP-N SI team will support the Government of Nigeria (GoN) to roll out newly revised data collection tools to all NMOD sites, as well as facilitate site-based trainings with other WRP-N staff on the use of the tools. Emphasis will be on activities that enhance the quality of data being generated across program areas and sites. Quarterly joint site visits and data quality assessments (DQAs) will be carried out in order to ensure high quality program data, while joint program data reviews will also be carried out with the WRP-N and NMOD staff. The team will also participate in the national M&E technical working group (TWG) meetings.

Trainings focused on program M&E, medical records, data quality, data demand and use, and data analysis will be carried out for 100 site staff. 2 site M&E staff will be supported to participate in the MEASURE Evaluation M&E training at participating universities. Program and data review meetings will be held every quarter with the site M&E teams. Furthermore, program initiatives that are aimed at improving quality of care, patient tracking and retention, patient and data flow within the facility, and

review of clinical outcomes will be supported.

In support of the GoN's efforts to utilize the District Health Information System (DHIS) as the national reporting platform, the program will deploy DHIS 2.0 to 20 NMOD sites. SI staff will provide technical assistance to ensure appropriate utilization of the system. Additionally, the Emergency Plan Implementation Committee (EPIC) Electronic Medical Record (EMR) system will be deployed to 6 additional sites. Focus will be on continuous system improvements to strengthen patient management and monitoring (PMM). The program will facilitate the participation of NMOD in the National Health Data Consultative Committee (HDCC).

Technical assistance will be provided for all surveys, surveillance, basic program evaluations (BPEs), and research activities to be carried out by the WRP-N.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	1,110,000	0

Narrative:

The US Department of Defense Walter Reed Program – Nigeria (DoD WRP-N) will continue to support HIV care and treatment services in 20 existing and 3 new sites, through its partnership with the Nigerian Ministry of Defence (NMOD) Emergency Plan Implementation Committee (EPIC).
EPIC will be supported to develop a 5-year strategic plan, in line with the National HIV/AIDS Strategic Response Framework and the Partnership Framework Implementation Plan (PFIP). The capacity of EPIC and the NMOD sites to develop, implement and monitor programs will be strengthened, through specific trainings and mentorship schemes.
The Clinical Training Centre at the 44 Nigerian Army Reference Hospital, Kaduna will be completed and enable capacity development for a cadre of military trainers, who will then be able to provide step-down training to the sites. It will also provide pre-service training for 200 health care workers enlisted in the National Youth Service Corps (NYSC) and in-service training to NMOD personnel in various areas of HIV prevention, care, and treatment.
As part of its support for national systems, the NMOD/WRP-N will adopt the District Health Information System (DHIS) 2.0 as the platform for program reporting. The capacity of EPIC's monitoring and evaluation (M&E) team will be expanded in system management in order to enhance the availability of data for program planning, management, and decision making.
The WRP-N will continue to support the NMOD-owned, Supply Chain Management System (SCMS)-operated warehouse, which manages distribution of drugs and laboratory supplies to all NMOD points of service.

Support and upgrades of laboratory infrastructure will ensure the generation of reliable, quality, and timely laboratory results across all sites. The capacity of NMOD's laboratory personnel will be strengthened in laboratory processes, procedures, and investigative activities, through centralized and onsite training, international exposure, and a mentorship program. Qualified qualitative assurance (QA) monitors will be equipped with appropriate tools and empowered to implement a quality management system in all NMOD sites. The malaria diagnostic and QA/quality control (QC) center will be developed to improve malaria case detection across the program. Finally, teams at two laboratories will be up-skilled to perform PCR assays, as well as support the evaluation and validation of point of care technologies for CD4, tuberculosis, and viral load estimation.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMBL	28,200	0

Narrative:

The US Department of Defense Walter Reed Program – Nigeria (DoD WRP-N) will continue to support injection safety activities across all military sites and blood safety activities will be carried out at 4 sites. In collaboration with the Nigerian Ministry of Defence (NMOD), WRP-N blood safety activities will continue to strengthen linkages with the National Blood Transfusion Service (NBTS).The program will support the NBTS blood drive activities to increase national blood supplies through recruitment of voluntary, non-remunerated blood donors from the 4 military barracks communities. It will also strive to increase the number of first-time donors and the proportion of military and civilian personnel who are regular donors. These objectives will be facilitated through blood drives within professional and social activities, using the national blood donor screening questionnaires, with the data being remitted to the NBTS.

Additionally, sites will be supported in establishing systematic transportation of blood collections to the nearest NBTS site for processing and screening for the 4 transfusion transmissible infections (TTIs) using ELISA. This will include the provision of hazmat mobile storage containers. Blood that has passed the NBTS screening will be collected and stored at the 4 collaborating centers, minimizing the use of rapid test kits for emergency blood transfusions. The NBTS will provide monthly feedback on TTIs rates found by ELISA screening.

Finally, the program aims to strengthen the capacity of military and civilian personnel in blood safety practices through training that will include collection, storage, and transportation safety practices. Step-down training incorporating donor recruitment and management, testing for TTIs, and waste management will be conducted at each site, reaching X health personnel. Quality assurance (QA)/quality control (QC) will be instituted for all processes, and sites will be provided with copies of the National Blood Policy standard operating procedures and job aids. WRP-N will also encourage close collaboration between the NBTS and NMOD with the aim of establishing a fixed blood collection center at one of the

NMOD sites, potentially enhancing collection, safety, and availability of voluntary, non-remunerated blood donations.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMIN	18,800	0

Narrative:

Injection safety activities will promote the Universal Safety Precautions, including reductions in unnecessary transfusions, exposure to blood, and accidental injury/contamination, as well as the provision of essential consumables and services that protect health care workers and other exposed individuals (e.g., rape victims) from contracting transmitted infections. Consumables, including personal protective equipment such as hand gloves, laboratory coats, and masks, will be provided to all US Department of Defense Walter Reed Program – Nigeria (DoD WRP-N) sites. Additionally, each site will make provisions through their antiretroviral therapy (ART) activities for staff to access post exposure prophylaxis (PEP). Safe waste management practices will be promoted through the use of biohazard bags, sharps containers, and incinerators.

The WRP-N will expand injection safety practices to an additional X sites. Activities will ensure availability of safe injection equipment and provide capacity building in areas such as safe waste management system and injection techniques.

The WRP-N will continue collaborations with AIDS Support and Technical Assistance Resources-One (AIDSTAR1) for training, commodities procurement and review of safety protocols. AIDSTAR1 will train select site personnel on supportive supervision and transfer of technology (TOT), enabling them to provide step down trainings and supervision to their colleagues, using the national curriculum. At least XX military health care personnel and waste handlers will be trained or re-trained. The cadre of trainers will conduct biannual refresher trainings across XX sites.

The WRP-N will also procure, via Supply Chain Management System, commodities required for safe injection/needle handling and disposal. These may include disposable syringes, respiratory masks, surgical gloves, waste/sharps collection units, PEP kits, and reprinted or adapted information, education, and communication (IEC) materials for all sites.

Finally, WRP-N will continue to assess site waste management systems, with renovations of waste-disposal pits and incinerators being conducted as required.

Joint supportive supervision and mentoring visits will be conducted on a monthly basis by WRP-N staff.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	370,661	0

Narrative:

The US Department of Defense Walter Reed Program – Nigeria (DoD WRP-N) will continue to provide

comprehensive AB and C prevention services to 22 military facilities and their surrounding communities. In line with the National Prevention Strategy, WRP-N will support the provision of combination approaches with a minimum of three interventions under COP12, including community engagement, peer education/plus (PEP) and condom services.

WRP-N will support EPIC- AFPAC to assess, revise and disseminate the armed forces HIV/AIDS policy to improve the implementation and provision of quality HIV/AIDS services. The program will continue to enhance its peer education interventions, by supporting the training and re-training of military and civilian peer educators.
IEC materials will be developed and provided as tools to encourage and reinforce AB and C information. The knowledge and life- skills of barracks school youths on AB and C prevention will be improved, using the Family Life Health Education (FLHE) school based curriculum. Additionally, evidenced based discussion manuals and guidelines will be provided for abstinence-only initiatives, parent-child communication and school based clubs activities.
The out-of-school youths will be reached via religious and recreational centers, and mammy markets using trained peer educators who will create out of school clubs that will provide peer education and income-generating activities (IGAs)..

In partnership with the Armed Forces Programme on AIDS Control, male and female condom distribution will be strengthened and information, training and skills will be provided on appropriate condom use.
The capacity of barrack groups (religious, community and institutional) will be developed to incorporate and implement AB and C, leadership, and gender activities into their yearly work plans and outreaches. These activities will extend to military and civilian personnel.
Sexually transmitted infection (STI) management will be strengthened by offering high quality STI services to military personnel, dependents and civilians. AB and C prevention messaging and condom provision will also be integrated into other HIV/AIDS services.
Capacity building for PLWHA support groups will include community level Positive Health Dignity and Prevention (PHDP) services and IGAs.

The National Prevention Intervention Tracking Tool (PITT) will be used to track and report on the implementation of activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	215,809	0

Narrative:

US Department of Defense Walter Reed Program – Nigeria (DoD WRP-N) will continue to extend free

access to HIV testing and counseling (HTC) services across 34 military sites. In an effort to improve identification and treatment of HIV positive patients, provider-initiated testing and counseling services will also be available at every site and include patients diagnosed with sexually transmitted infections (STIs), as well as patients from outpatient clinics, inpatient wards, and tuberculosis (TB) clinics.
Linkages will be fostered between health facilities and communities, and/or barrack health community trained volunteers who can escort patients to the HTC center for access and uptake of services. The WRP-N will integrate HTC services into STI, family planning, antenatal, and blood donation services. Additionally, all individuals who test HIV positive will be screened for TB.

Sites will provide high quality, cost-effective HTC using the national algorithm and same day results.

There will be a focus on couple testing and counseling. Partner referrals for HTC, as well as referrals for positive, health, dignity, and prevention (PHDP) and other related services, will be facilitated by PLHIV lay-peer counselors across sites. The integration of HTC, treatment, and prevention programs will take a family-centered, community perspective, including the introduction of a decentralized model in partnership with the Government of Nigeria.

Mobile HTC will encourage the uptake of services by most-at-risk populations (MARPs). HTC will also be integrated into community activities, such as health bazaars, military day celebrations, and social activities.

The WRP-N will support the Armed Forces Program for AIDS Control (AFPAC) to provide quality HTC services and prevention activities to new military recruits and peacekeepers during service medical assessments. This will be achieved through training and re-training of XX facility staff, volunteers, PLWHAs, and implementing partners, using the national curriculum. The WRP-N will also continue to include the training of non-laboratory staff to assist with task shifting. Oversight and supervision of non-laboratory counselor-testers will be provided by facility laboratory personnel.

Clinic renovations, privacy screens, and other relevant equipment will be provided.

Sites will be provided with national guidelines and SOPs, receive quarterly supportive supervision/mentoring visits, and participate in registers and studies.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	106,265	0

Narrative:

The US Department of Defense Walter Reed Program – Nigeria (DoD WRP-N) will continue to provide comprehensive AB and C prevention services to 22 military facilities and their surrounding communities. In line with the National Prevention Strategy, WRP-N will support the provision of combination approaches with a minimum of three interventions under COP12, including community engagement, peer education/plus (PEP) and condom services.

WRP-N will support EPIC- AFPAC to assess, revise and disseminate the armed forces HIV/AIDS policy to improve the implementation and provision of quality HIV/AIDS services. The program will continue to enhance its peer education interventions, by supporting the training and re-training of military and civilian peer educators.
IEC materials will be developed and provided as tools to encourage and reinforce AB and C information. The knowledge and life- skills of barracks school youths on AB and C prevention will be improved, using the Family Life Health Education (FLHE) school based curriculum. Additionally, evidenced based discussion manuals and guidelines will be provided for abstinence-only initiatives, parent-child communication and school based clubs activities.
The out-of-school youths will be reached via religious and recreational centers, and mammy markets using trained peer educators who will create out of school clubs that will provide peer education and income-generating activities (IGAs)..

In partnership with the Armed Forces Programme on AIDS Control, male and female condom distribution will be strengthened and information, training and skills will be provided on appropriate condom use.
The capacity of barrack groups (religious, community and institutional) will be developed to incorporate and implement AB and C, leadership, and gender activities into their yearly work plans and outreaches. These activities will extend to military and civilian personnel.
Sexually transmitted infection (STI) management will be strengthened by offering high quality STI services to military personnel, dependents and civilians. AB and C prevention messaging and condom provision will also be integrated into other HIV/AIDS services.
Capacity building for PLWHA support groups will include community level Positive Health Dignity and Prevention (PHDP) services and IGAs.

The National Prevention Intervention Tracking Tool (PITT) will be used to track and report on the implementation of activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	307,494	0

Narrative:

The US Department of Defense Walter Reed Program – Nigeria (DoD WRP-N) provides prevention of mother-to-child transmission (PMTCT) services in 25 military facilities nationwide. About 80% of the clients receiving PMTCT services are civilians from surrounding communities.
As at July 2011, 8636 women had received counseling, testing and results. 484 HIV positives received antiretrovirals (ARV) for PMTCT. In FYs 12 & 13, 15224 and 21384 pregnant women respectively will receive counseling and testing for PMTCT, generating 500 and 700 respectively receiving ARVs for PMTCT. The program will continue to use highly active antiretroviral therapy (HAART) in the ART sites and Zidovudine (AZT) from 14 weeks in the satellite sites. Clients will receive relevant baseline and follow up laboratory investigations through point of care tests, sample batching and transfer. There will be an emphasis on capacity building and collaboration with the Nigerian Ministry of Defense (NMOD) for the management of PMTCT services in order to ensure sustainability and ownership.
WRP-N will expand across high HIV burden states, with the addition of 8 satellite sites. To achieve cost efficiency, WRP-N will leverage equipment supplies, mentorship, and supportive supervision from the existing military health insurance program and the Emergency Plan Implementation Committee (EPIC) partnership. Emphasis will be placed on increasing male involvement through strengthening of partner testing, capacity building for couple counseling services and linkages for gender based violence screening.
In line with the Global Health Initiative (GHI), WRP-N will integrate PMTCT services into reproductive health services. It will also continue to strengthen the linkage of post partum PMTCT clients and their families for care and treatment. Integration efforts will be achieved through collaboration and leveraging, and referral linkages. In addition, all sites will provide positive health, dignity and prevention (PDHP) services. Quality will be assured through trainings, mentoring, supportive supervision, and continuous quality improvement (CQI) activities. WRP-N will monitor monthly target achievements and activities.
Over the next two years, 120 providers will be trained on PMTCT and integration activities. The laboratory program area will provide quality assurance (QA) and oversight in HIV testing and counseling (HTC), and laboratory related activities for PMTCT. Health care providers will continue to be up-skilled in the provision of infant feeding counseling and support to both mothers and their babies.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	569,897	0

Narrative:

The US Department of Defense Walter Reed Program – Nigeria (DoD WRP-N) will procure anti-retroviral (ARV) drugs to treat 26,533 patients, comprised of 24,939 adults and 1,594 children, in FY12 at 21 military treatment facilities, spanning 16 states (Lagos, Oyo, Edo, Benue, Anambra, Imo, Enugu, FCT, Kaduna, Kano, Plateau, Borno, Delta, Rivers, Cross River and Sokoto). In FY13 these numbers will rise to 24,185 patients, comprised of 22,272 adults and 1,913 children. In setting COP12 & 13 targets,

consideration was given to consolidating WRP-N's COP11 accomplishments, with a focus on continuous quality improvement

WRP-N will continue to provide all sites with the necessary system and infrastructure upgrades, commodity security, and capacity building for efficient forecasting, procurement, storage, and distribution of ARVs. Technical support for drug management will also continue. Pharmacists and other health workers (eg, pharmacy technicians and assistants) will be trained and re-trained in general drug management, adverse drug reaction (ADR) reporting, and the use of standard operating procedures (SOPs). Mentoring will also be provided. Logistics management procedures will be assessed as part of site development planning.

WRP-N's annual forecasting exercise will be done in conjunction with the United States Government (USG) Logistics Technical Working Group and Supply Chain Management System (SCMS). An estimated 60% of people living with HIV/AIDS (PLWHA) and already enrolled in care will qualify for and receive antiretroviral treatment (ART) during FY12, while 4% of the patients are expected to be on second line ARV regimens. In line with the national guidelines to simplify therapy for children, the use of pediatric fixed dose combinations (FDC) will be stepped up over the next 2 years.

CONTRIBUTION TO OVERALL PROGRAM AREA:

The ART drug activity will ensure that quality ARVs are supplied to all patients in a timely manner, as well as contribute to the President's Emergency Plan For AIDS Relief (PEPFAR) target of providing ARV drugs to an increased number of PLWHAs in Nigeria and the Government of Nigeria's (GON's) plan for universal access.

FOCUS AREAS:

Focus areas will include local organization capacity building, logistics, training (including in-service supportive supervision), renovations of pharmacy/stock rooms, quality assurance/quality improvement, and linkages with other sectors and initiatives. WRP-N will also work with relevant stakeholders in FY12 to implement the GOCO warehouse plan.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	2,933,244	0

Narrative:

The US Department of Defense Walter Reed Program – Nigeria (DoD WRP-N) Adult Care and Treatment program currently provides HIV care and treatment to over 12,000 PLHIV, including military personnel and civilians, in 20 military hospitals, spanning 16 states. The program will expand with the addition of 3 sites in FY12 and FY13, in Lagos, Benue and Niger where there is high unmet need. The program plans to reach 18,560 and 22,272 adults receiving antiretroviral therapy (ART) during FY12 and FY13 respectively, and 6,379 adults newly enrolled on ART by the end of FY12.

Strategies to achieve targets include the expansion of ART services to high burden areas,

decentralization of services, and improvement in the quality of services through the use of continuous quality improvement (CQI) models, including the evaluation of clinical outcomes. In accordance with the Global Health Initiative (GHI), HIV/AIDS services will be further integrated with malaria, tuberculosis and other services, resulting in a spill over benefit to non-HIV hospital patients. Adherence support for PLHIV receiving ART, follow up of missed appointments and contact tracking will continue to be strengthened.
A Clinical Training and Research center (CTRC) has been established at 44 Nigerian Army Reference Hospital, Kaduna to conduct pre-service and in-service training including basic ART training for doctors, nurses and pharmacists; antiretroviral (ARV) refill for nurses; and advanced ART training for doctors. The CTRC facilities will be used by the military, Federal Ministry of Health and other implementing partners (IPs). WRP-N has developed a mentorship program to enhance the knowledge and skills of service providers. A regular supportive supervisory schedule will ensure quality service provision, adherence to standards, on-the job training, and provision of job aids.
Performance is tracked on a monthly basis against targets and the CQI program will identify gaps, allowing for the development of improvement plans. The procurement of 3 viral load monitoring machines will also improve service quality. Patient outcomes will be reviewed annually.
In collaboration with the NAFDAC, WRP-N will continue to monitor ARV pharmacovigilance (PV) at all sites. Other activities will include training and re-training of care providersand improved reporting of adverse drug events.
In collaboration with the Nigerian Ministry of Defense (NMOD), WRP-N will review the NMOD Strategic Framework developed in 2007 to ensure it is aligned with the National Strategic Framework II and the Partnership Framework.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	239,873	0

Narrative:

The US Department of Defense Walter Reed Program – Nigeria (DoD WRP-N) Pediatric Care and Treatment program will contribute to the national pediatric scale up of antiretroviral therapy (ART) services by expanding HIV treatment into 3 new hospitals in Benue, Lagos, and Niger. The WRP-N plans to reach 1,594 HIV positive children with ART in FY12 and 1,913 in FY13.
Strategies to achieve targets include the expansion of ART services to high burden areas and improvement in the quality of care and treatment. Services, which will take a family-centered approach, will be integrated into existing maternal, neonatal and child health (MNCH) services. Linkages with other relevant services will also be strengthened. This approach aims to reduce stigma, promote adherence, and provide quality family HIV/AIDS care and treatment. To address retention in care, the WRP-N will continue to strengthen adherence support to people living with HIV (PLHIV) receiving ART, through follow up of missed appointments and contact tracking. Pediatric corners will be established, ensuring

that sites are children friendly. A pediatric mentorship program will be developed to support on-site Pediatric HIV Care and Treatment. Through this program, experienced pediatric ART physicians will be engaged periodically to provide hands on supervision; observation and random case file review, to identify site-specific challenges, strengths, weaknesses and opportunities for quality improvement. They will establish site-specific plans to accomplish improved pediatric ART uptake and retention in care, conduct on-site training and continuous medical education (CME) among health providers and practical demonstration and tutoring on issues and tools to update knowledge and skills of care providers. Intra- and inter-facility referrals (as well as to community) for HIV services will be strengthened through a strong follow up program for HIV exposed infants and HIV infected children. Performance is tracked on a monthly basis and the Continuous Quality Improvement (CQI) program will identify gaps, allowing for the development of improvement plans. The procurement of 3 viral load monitoring machines will improve patient monitoring and help detect treatment failure early. Patient outcomes will be reviewed annually. In collaboration with the National Agency for Food and Drug Administration and Control (NAFDAC), the WRP-N will continue to monitor ARV pharmacovigilance (PV) at all sites.

Implementing Mechanism Details

Mechanism ID: 14384	**Mechanism Name: Sesame Square**
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	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 360,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	360,000

Sub Partner Name(s)

Nigerian Television Authority Abuja		

Overview Narrative

The objective of Sesame Street Nigeria (Sesame Square) is to mobilize television and print media outlets to provide educational programming designed to enhance school readiness among low-income young children. The activity builds sustainable local capacity through its work to:(1) support mass media's role in addressing key issues including basic education, health/hygiene practices, general wellness and HIV/AIDS, life skills, and diversity; (2) support the national primary education policy as well as the Millennium Development goals, the Education for All promise, USAID's Education Strategy, and the Universal Basic Education Commission (UBEC) objectives; (3) provide access to high-quality educational content on television and develop a complementary community outreach initiative; (4) use a multi-media approach to link informal and formal education by targeting preschool-aged children and preparing them for transition into school; and (5) engage parents, families, caregivers, and communities in children's educational, social, and emotional development. Key activities include production of the Sesame Square children's program on the Nigerian Television Authority, development of literacy-focused outreach materials to reach an estimated 81,000 children, and training Master Trainers from 9 states where the project is implementing outreach activities. The project is building the capacity of NGOs to provide caregivers and teachers with HIV-related technical assistance, distribution of workbooks and guides, and teaching OVCs basic knowledge about science, numeracy, HIV/AIDS, reading and writing. The project will solicit in-kind donations and plan for sustainability with the government and NGOs

Cross-Cutting Budget Attribution(s)

Education	360,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors

Increasing gender equity in HIV/AIDS activities and services
Malaria (PMI)
Child Survival Activities

Budget Code Information

Mechanism ID:	**14384**		
Mechanism Name:	**Sesame Square**		
Prime Partner Name:	**Sesame Street Workshop**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	360,000	0
Narrative:			
Development and duplication of math, science and health outreach materials Duplication and Distribution of pilot and literacy outreach materials Step-down training activities associated with pilot and literacy outreach materials Monitoring and evaluation activities associated with pilot and literacy outreach materials			

Implementing Mechanism Details

Mechanism ID: 14444	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14445	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14446	**Mechanism Name: Nigeria Monitoring and Evaluation Management Services (NMEMS II)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract

Prime Partner Name: The Mitchell Group	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 2,079,095	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	2,079,095

Sub Partner Name(s)

(No data provided.)

Overview Narrative

NMEMS II project supports performance M&E for USAID-Nigeria & its IPs. The support focuses on: developing Performance Management Plans (PMP) for Teams & IPs; providing evaluation support, conducting evaluations; conducting DQAs; collating data; including quarterly, semi annual & annual through the Performance Plan & Report; facilitating the use of performance data to inform decision making & resource allocation; and Training of Mission & IPs staff.

During COP 11, the project was able to support the HIV/AIDS & TB team in the following areas: Customized DHIS2 for USG & trained USAID, CDC, DOD & IP staff on the use of DHIS2; Conducted DQA; Facilitated development of HIV/AIDS & TB team PMP; Trained IPs staff on Managing for Results ; Reviewed evaluation scope of works & protocols; Participated in meetings with USG & Microsoft team on the development & hosting of Microsoft data Warehouse and Participated in the review of national HIV/AIDS data collection tools.

In COP 12, NMEMS will focus on consolidating programs started in COP 11, especially in the deployment of USG DHIS 2.0 and DQA

Cross-Cutting Budget Attribution(s)

Human Resources for Health	300,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	14446		
Mechanism Name:	Nigeria Monitoring and Evaluation Management Services (NMEMS II)		
Prime Partner Name:	The Mitchell Group		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	2,079,095	0

Narrative:

In COP 12, NMEMS is planning to implement the following activities to support USAID Nigeria HIV/AIDS & TB teams M&E activities:

? Finalize USG DHIS instance and deploy for use.

? Support Data Management & Analysis for Quarterly, SAPR & APR

? Organize meetings to facilitate common understanding of PEPFAR NGIs & Nigeria Specific HIV/AIDS indicators

? Capacity Building:

o Training and Re-training on DHIS

o NMEMS II and Local Partners Participation in conferences, meetings and Workshops

? Conduct Nigeria IPs DHIS user conference

? PMP Finalization and Review

o Final HIV/AIDS & TB team PMP

o Review IPs PMP

? Conduct DQA and Systems assessments as directed by HIV/AIDS & TB Team

? Support the deployment of the Microsoft Data Warehouse

? Evaluations o Mid Term and End of Project Evaluations: o Special Studies ? Facilitate USG SI strategic meeting

Implementing Mechanism Details

Mechanism ID: 14503	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14505	**Mechanism Name: STRENGHTENING INTERGRATED DELIVERY OF HIV/AIDS SERVICES(SIDHAS)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: FHI 360	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 46,350,198	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	46,350,198

Sub Partner Name(s)

Abia State University Teaching Hospital	Achieving Health Nigeria Initiative	Association for Reproductive and Family Health
Axios Foundation Inc.	Deloitte Consulting Limited	ECWA Clinic and Maternity
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, Yola	German Leprosy and TB Relief Association (GLRA)	Holy Family Catholic Hospital Ikom
Immaculate Heart Hospital and Maternity Nkpor	Iyi Enu Hospital	Mambilla Baptist Hospital, Gembu
Oko Community Hospital	Population Council	Redeemed Action Committee on AIDS, Lagos
Regina Caeli Maternity Hospital Awka	Regina Mundi Catholic Hospital, Mushin	Santa maria Catholic Hospital Uzairrue
St Mary's Hospital	University of Nigeria, Nsukka	

Overview Narrative

SIDHAS will build on GHAIN's successes and lessons learnt to achieve three objectives:1. Increased access and improved coverage of high quality comprehensive HIV/AIDS treatment, care and related services through improved efficiences in service delivery;2. Improved quality and intergration of HIV/AIDS services; and 3. Improve stewardship by Nigerian institutions for the provision of high quality comprehensive HIV/AIDS services in over 130 public sector tertiary, secondary and primary level health facilities. SIDHAS activities will be fully aligned with GON strategies and plans in order to to streghnten government systems and optimize ownership at federal ,state and local government levels. SIDHAS is designed with focus on health systems strenghtening(HSS); service intergration;local ownership;and quality- with all interventions delivered within GON's strategic health framework and structure. Program and technical staff will work hand in hand with public sector providers and mangers at all levels of the health system to build their capacity"on the job" through program planning, implementation and M&e. The project has built in continuous quality improvement(CQI) and the graduation mechanisms to ensure a gradual systematic transition to greater GON responsibility and accountability for HIV/AIDS services. As such, SIDHAS represents a shift from an emergency response to a chronic care model that harnesses the strenghts of the health system, communities, families and individuals in manging HIV and its effects in a more sustainable manner.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Sub Recipient**
3. What activities does this partner undertake to support global fund implementation or governance?

(No data provided.)

Cross-Cutting Budget Attribution(s)

Education	50,000
Food and Nutrition: Commodities	50,000
Food and Nutrition: Policy, Tools, and Service Delivery	10,000
Gender: Reducing Violence and Coercion	60,000
Human Resources for Health	220,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
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:	**14505**

Mechanism Name:	STRENGHTENING INTERGRATED DELIVERY OF HIV/AIDS SERVICES(SIDHAS)
Prime Partner Name:	FHI 360

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	12,197,232	0

Narrative:

In COP 12 and 13, SIDHAS will provide care and support services to 283,950 adults . SIDHAS will adopt the chronic care model to harness the strengths of the health system, communities, families and individuals in managing HIV/AIDS and mitigate its effects. SIDHAS will also adopt positive health dignity and prevention (PHDP) to empower the PLHIV/PABA to increase their health competency and enhance their capacity to care for themselves. A chronic care checklist will be used to routinely screen for important risk factors and health issues in all patient encounters.

SIDHAS care and support services to will focus on early identification of HIV- infected persons, linkages, and retention in care; reduction in HIV-related morbidity and mortality; optimizing quality of life for HIV-infected clients and their and reduction in transmission of HIV infection. Clients enrolled into care will receive a minimum care package and the basic care kit. Basic care kits will be channeled through facility and community-based support groups for distribution within specific catchment areas.

SIDHAS will maintain appointment diaries for all Pre-ART clients to identify defaulters for both co-trimoxazole and vitamin refill and a list generated daily for contact tracking. services provided will include clinical assessment, laboratory services including OI prophylaxis and treatment, nutritional assessment/support, safe water, psychosocial support (PSS), chronic care for diseases such as hypertension, diabetes, provision of condoms STI treatment, drug adherence, risk reduction, family planning behavior change communication interventions for HIV prevention as well as pain and symptom management.

The capacities of health care providers will be built on PHDP to help change the attitudes of health care workers on stigma and discrimination. SIDHAS will support community-based organizations, support groups and community volunteers to provide home-based care to PLHIV. SIDHAS will strengthen an LGA wide referral system and use referral directories to facilitate access to comprehensive services for PLHIV. SIDHAS will also support effective coordination through quarterly care and support NTWG meetings.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Care	HKID	900,000	0

Narrative:

In COP 12 and 13, SIDHAS will support the GoN through the Ministry of Women Affairs and Social Development in coordinating care for vulnerable children. The project will support the development of OVC service standards, guidelines and SOPs, support the review and production of an advocacy tool kit; and ensure adherence to standards through joint monitoring and supportive supervision.

Services provided will be based on the needs of each child and household in each of the service areas: Health, Food and Nutrition, Education, Protection, Household Economic Strengthening, Psychosocial support, Shelter and care. Services will be provided directly or through linkages within the chronic care continuum. SIDHAS will support strengthening of referral network among service providers. ary services appropriate to age and HIV status; build family/household capacity to care for OVC and address their basic needs. Particular attention will be paid to building economic stability of households so that parents and caregivers are able to provide for their children's long term needs; retaining children in school, and working with local governments to establish strong child welfare and protection systems.

SIDHAS will support IAs to provide:(1) Psychosocial support including at least three of the following: disclosure issues, grief and loss, kids support groups and recreation, group counseling, home visits; (2) Educational support activities including facilitation of the enrolment of female and male OVC in schools, provision of school uniform and books etc. (3) Nutritional support for all OVC involving at least three of the following: assessment, counseling, supplementation, therapeutic nutrition (4) Health services (ART and non-ART care for infected and affected children). SIDHAS will provide preventive kits to HIV positive OVC (water guard, lidded bucket, long lasting insecticide treated nets). OVC will also access other services through referral to the relevant organizations for: (5) Child protection activities including legal support, birth registration, abuse monitoring, and child meaningful participation and collaboration with child protection networks being supported by other IPs (6) shelter, (7) household economic strengthening

SIDHAS will support the GoN in the roll out of the National OVC Management Information System at federal, state and LGA levels.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	1,584,840	0

Narrative:

In COP 12 and 13, SIDHAS will strengthen TB/HIV collaborative activities across all operational sites To increase early TB detection and treatment among PLHIV. TB screening, diagnosis, treatment and prevention will be based on the new WHO recommendations, using the “3 I’s” strategy:1) intensified TB

case finding among PLHIV; 2) infection control and 3) isoniazid preventive therapy, including antiretroviral therapy (ART) for people co-infected with TB. SIDHAS will leverage resources through Global Fund and the National TB and Leprosy Control Program (NTBLCP) to optimize DOTS expansion and expand from 186 sites to 215. TA and training will be provided to HIV/AIDS/TB programs managers to ensure all TB patients know their HIV status and cotrimoxazole prophylaxis for those who test HIV positive. SIDHAS will ensure all HIV positive patients are screened for TB following WHO recommended clinical algorithms during their first and follow up encounters.

Infection control will be strengthened through development of facility implementation plans based on risk assessments. Training on TB infection plan will be based on gaps identified. Committees on TB IC will be set up and supported on a quarterly basis through review meetings and continuing medical education. Performance TB/HIV indicator data will be analyzed on a monthly basis and feedback shall be provided to at all levels for decision making.

SIDHAS will continue to support Nigeria's national plan to expand DR TB diagnosis and management by supporting the operations of the renovated existing specialized TB wards and labs. SIDHAS will collaborate with IHVN and TBCARE1 to leverage resource for MDR TB expansion. GeneXpert for sensitive and rapid diagnosis of both TB and Rifampicin resistant TB in designated centers will be utilized. SIDHAS will partner with TBCARE1 in COP 12 and 13 to maintain the existing community TB care projects using CBOs and community volunteers (CVs) for community sensitization and mobilization, suspect referral and treatment support. A family centered approach will be used for symptom screening of all TB patient contacts as well as household members and referring those indicated as TB suspects for diagnosis and treatment.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	1,302,975	0

Narrative:

In COP 12 and 13, SIDHAS will support 27,223 children with facility and community based care and support services in line with national guidelines. SIDHAS will provide services that are children-focused and friendly across the following core areas: clinical care, prevention care and supportive care tailored to the specific needs of the child and the family. A minimum care package including basic care kits, clinical services and laboratory services will be supported.

Routine multipoint testing through PITC will ensure early identification of HIV- infected children. Linkage with PMTCT services to ensure follow up of mother baby pair, EID and enrolment of HIV infected babies will be strengthened. The linkages for exposed babies to the existing national EID networks shall also be strengthened. CPT, multivitamin supplementation, deworming, nutritional assessment/support, growth

monitoring/developmental milestones, immunization and prevention/management of childhood illnesses will be strengthened within an IMNCH package. Early infant treatment will be instituted based on national guidelines. Strategies to ensure retention in care and treatment; reduction in HIV-related morbidity and mortality; optimizing quality of life for HIV-infected child and their families throughout the continuum of illness will be strengthened. Laboratory services for monitoring of hematological, blood chemistry and immunological status, management of opportunistic infections, age appropriate medication adherence counseling, drug side effects management, stigma reduction, psychosocial support and spiritual counseling will be provided.

HIV positive children and their caregivers will be linked with community services. SIDHAS will collaborate with Association of Community Pharmacists of Nigeria (ACPN) and the NHIS for the provision of limited PMTCT related support services under the GON NHIS on a fee-for service basis. The capacity of CBOs and support groups will be built on nutritional support to children and their families and the preparation of MIMAGROWS (A locally sourced nutritional supplement) Screening and treatment of children with acute malnutrition with RUTF will be supported through partnership with CHAI.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	6,394,118	0

Narrative:

In COP 12 and 13, SIDHAS will maintain 125 GHAIN supported labs across all 36 states and the FCT and upgrade six PMTCT standalone sites to full laboratories to support ART services. HIV disease monitoring tests will be conducted. Laboratory tests will include HIV serology, CD4 count, hematology, clinical chemistry, VDRL, pregnancy test, and HBsAg. SIDHAS will support additional tests for OIs, pilot POC CD4 testing at the PHC level, establish and strengthen the sample referral and transfer networks and pilot the integration of the ART laboratory into general laboratory.

SIDHAS will ensure equipment maintenance through service contracts in collaboration with other IPs. LGA and facility management will be trained in planned preventive and routine maintenance and equipment contracts management. In collaboration with GoN and other partners, SIDHAS will support the deployment and training of staff, supply of commodities, and use of LMIS across all levels of service delivery. The national Proficiency Testing system will be strengthened through assistance to MLSCN, while sustaining the current PT with South Africa. Internal quality control will be enforced in routine practice and introduction of DBS and DTS in HTC sites. SIDHAS will collaborate with the SLAMTA team and MLSCN to extend WHO/AFRO level accreditation support from five laboratories to 10. National accreditation will also be supported for some secondary sites.

SIDHAS will support in-service training and re-training of lab staff according to the national guidelines. SIDHAS will collaborate with relevant stakeholders to strengthen the National strategic plan for laboratories, provide standard lab training tools and support LTWGs in the development of laboratory policies and guidelines.

In collaboration with the NTBLCP, TBCAP, CR SMoH and other partners, upgrade of MDR-TB labs in UPTH Port Harcourt and NIMR Lagos to BSL2 and BSL3 respectively will be supported to enhance MDR-TB diagnosis & increase TB case detection. Case detection capacity will also be enhance through the introduction of GeneXpert technology. SIDHAS will continue support of the FMC Jalingo PCR-EID laboratory which will be expanded to include HIV viral load testing using DBS specimen.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	2,700,874	0

Narrative:

SIDHAS will build a government driven sustainable M&E system by promoting the 'Three-Ones principle' that facilitates timely and complete reporting of service statistics from the communities and health facilities, through the LGA and state to national level. SIDHAS will participate in technical working groups (TWGs) and subcommittees, partner coordination fora as well as data and program review meetings. SIDHAS will support the ongoing indicator harmonization exercise, the use of electronic data management system, the national roll out of NOMIS and DHIS 2.0 and the use of LAMIS as well as the review of national data collection tools (DCTs).

In COPs 12 and 13, SIDHAS team will engage with state authorities to establish SITs, with M&E representation in all 36 states and the Federal Capital Territory (FCT). SITs will be supported to develop costed annual M&E work-plans and to coordinate the implementation of M&E activities in their respective states, with technical assistance and supportive supervision from SIDHAS technical teams. SIDHAS will deploy national DCTs to service delivery points (SDPs) and institute a data collection and reporting cycle in line with the national system. Joint monthly data validation and quarterly data quality assurance (DQA) visits will be carried out to verify data. The DQUAL (an electronic data quality assessment tool) will be deployed to support electronic transmission and aggregation of DQA scores. Data collection and validation activities will be transitioned to LGA M&E officers by COP 13, with the SIDHAS team maintaining mentoring oversight on their activities through the joint quarterly DQA exercises with state officers.

CQI tools will be integrated, addressing technical, institutional and financial sustainability. Implementation of LAMIS will be maintained in 14 comprehensive sites. SIDHAS will roll out a simplified version of LAMIS (mini-LAMIS) to better track patient level outcomes. Baseline mapping of state level master trainers and M&E training using an integrated curriculum will be conducted. SIDHAS will facilitate the conduct of operations research at selected facilities to assess cost, effectiveness and efficiency of different program models to guide implementation.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	0	0

Narrative:

SIDHAS overarching goal is to support GoN to take ownership of the health sector and lead a sustainable response to HIV/AIDS. In line with GHI and the paradigm shift towards decentralized services, the health system strengthening building blocks will be used as guiding strategies. SIDHAS will focus on integration and sustainability and build on the earlier successes to wean program off technical support. Continuous Quality improvement systems platform will be used to track progress of health facilities, civil society organizations, LGAs and SACA/SMOH across the sustainability domains towards graduation. At the national level, SIDHAS will work with AHNi's gender expert to harness on strong relationships with government agencies to support and build their leadership roles in reviewing and implementing the 2006 National Gender Policy.

SIDHAS staff will be co-located in GoN state offices, to ensure ongoing decentralized support and capacity building for state counterparts. Key staff of SMOH, HMB & LGA service commission will be identified for training to strengthen human resource management systems such as workforce planning, recruitment practices, and performance management, as well as HR managers able to perform these functions. Staff capacity will be built to scale up workload analysis (WLA) to 4 LGAs per COP year and to adapt Workload Indicators of Staffing Needs (WISN) to secondary health facilities. This will support the deployment of appropriate skills mix for achieve optimal effect.

.

SIDHAS will support advocacy to increase GoN's financial commitment to HIV/AIDS and other health services. The advocacies will be continuous and will target National Council of Health, Nigerian Governor's Forum, Association of Local Government Areas of Nigeria, CSOs and USG. SIDHAS will support the financial and institutional capacity building for States, LGAs, secondary facilities and CSOs. SIDHAS will collaborate with NACA to conduct cost-related operational research. The capacity of GoN will be strengthened to develop workplans and budgets; prioritize activities for implementation; advocate

for and manage resources; analyze budgets; retire expended funds appropriately; track and report expenditures.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMBL	56,400	0

Narrative:

It is estimated that between 5% and 10% of all HIV infections worldwide is through transfusion of contaminated blood and blood products. To reduce medical transmission of HIV, SIDHAS will facilitate screening for transfusion- transmissible infections, capacity development, universal safety precautions in handling blood and blood products, good laboratory practice and management of medical wastes. SIDHAS will support the 30 blood safety sites and Hospital Linkage Program (HLP) to promote use of rapid test kits for the screening of all donated blood for transfusion transmissible infections (TTIs) including HIV, hepatitis B, hepatitis C, Treponema pallidum (syphilis). SIDHAS will also provide ELISA screening in selected sites in order to improve blood safety funding permitting. SIDHAS will provide support for the 4 HLP sites as a model blood banks linked to the National Blood Transfusion Service (NBTS). These sites will conduct blood donation drives in collaboration with the NBTS, promote the principles of centralized blood transfusion services, voluntary non-remunerated blood donation as opposed to paid donors/family replacement. The National blood donor questionnaire will continue to be used to screen all donors and the data submitted to NBTS center as part of the national database.

SIDHAS will work closely with health facilities and Hospital Management Boards on universal precautions and the provision of essential consumables and services that protect the health worker from contacting blood borne pathogens. The safety materials that will be provided include personal protective equipment (PPE) such as hand gloves and laboratory coats, Aprons, blood containers and other consumables (Methylated-spirit, bleach, biohazard bags, and antibacterial soaps). SIDHAS will collaborate with Safe Blood for Africa Foundation (SBFAF) and NBTS on trainings of health care workers on safe blood transfusion, commodities management, support for blood donor drive for continuous availability of fully screened safe blood to minimize emergency screening. SIDHAS will strengthen capacity of health care workers with appropriate knowledge and skills to deliver effective services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMIN	155,100	0

Narrative:

Unsafe injection practices have been well documented as a major cause of transmission of blood borne pathogens such as HIV, hepatitis B virus (HBV) and hepatitis C virus (HCV). In recognition of the importance of infection prevention and control in injection safety, SIDHAS will support access to safe

injection practices in all supported sites. Activities will include on-site refresher trainings and strategic behavioral change

SIDHAS will train facility supervisors and HCWs on universal safety precautions and post exposure prophylaxis (PEP) at all sites. SIDHAS will support availability of PEP drugs in all comprehensive and ART refill sites. SOPs and forms for reporting PEP will be made available in all facilities.

In order to facilitate behavior change of the health workers and clients at all supported health facilities, SIDHAS will support the federal and state ministries of health in their efforts through dissemination of the injection safety policy at all levels of government. Behavior change communication (BCC) materials on injection safety produced by John Snow Inc. /AIDSTAR One project will continue to be distributed to all supported sites and may be reproduced where unavailable. SIDHAS will strengthen capacity of health care workers through onsite or centralized training as appropriate, mentoring, coaching among others. These will equip health care workers with skills to deliver quality services to clients.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	343,687	0

Narrative:

In line with the National Prevention Plan (NPP), in C0P 12, SIDHAS will support sexual prevention interventions including Abstinence and Be faithful (AB). A combination of intervention strategies will be employed to appropriately address the needs of the different target population groups such as adolescents and youths; occupational migrant workers such as Road Transport Workers (RTW) and People living with HIV (PLHIV).

Abstinence interventions will be tailored to address the needs of youths particularly adolescents (age 10 – 19 years). This activity will largely be integrated in the prevention, care and support package for Orphans and Vulnerable Children (OVC). SIDHAS will support selected CBOs to train behavior change agents (peer educators, volunteers and caregivers (family-centered approach) in life skills and improve adolescents' knowledge and skills on sexual and reproductive health including HIV/AIDS prevention. The supported CBOs will reach both in-school and out-of school young people utilizing forums such as sports events and church clubs. In addition to one-to-one interactions, CBOs will disseminate prevention messages using IEC materials. The messages will emphasize both primary and secondary abstinence.

The 'Be faithful' component will target men and women of reproductive age using the platform of the PMTCT mothers support group, the Safe Space Youth Clubs (SSYC), and the PLHIV support groups. This is with the aim of addressing the prong 1 of the PMTCT gap, and promoting positive health, dignity

and prevention.

Furthermore, SIDHAS AB Prevention program will address issues relating to preventing unintended pregnancy (PMTCT prong 2); sexually transmitted infections including HIV by promoting abstinence, delay of sexual debut, be faithful, condom use and offer opportunities to practice negotiation and refusal skills. It will also seek to address the key drivers of Nigeria's HIV epidemic such as low personal risk perception, multiple concurrent sexual partnerships, transactional and intergenerational sex, gender inequalities, stigma and discrimination, and accessing health services by mobilizing communities to address norms/behaviors that predispose individuals to HIV.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	0	0

Narrative:

HTC is an entry point for HIV prevention, care and treatment. In COP12 and 13, SIDHAS will build on GHAIN and leverage on Global Fund to support established 147, HTC facilities and communities through a combination of provider and client-initiated testing and counseling. HTC will be provided at multiple service delivery points like medical, pediatric wards, outpatient units, ANC, FP, TB and STI clinics, with same-day results. SIDHAS will encourage and support couple HIV testing and counseling. SIDHAS will incorporate effective strategies to transform harmful gender norms and behaviors, empower women and girls, and engage men and boys as partners and agents of change in improving uptake of HTC services. These strategies will identify and address gender norms that affect disclosure, constrain demand for couple counseling and testing for HIV and impede sustainable uptake/utilization of HTC services women and girls.

SIDHAS will update and use the existing national referral directory developed by GHAIN to link positive clients to access treatment and other care and support services. HTC activities will be linked to community-based activities through CSOs to create demand for service uptake. SIDHAS will emphasize keeping individuals HIV negative through building capacity of health care workers as prevention advocates who will assist to translate knowledge about HIV prevention into practice by helping clients to commit to three activities to remain negative and after three months assess results and provide reinforcements. CSOs will be trained to implement the MPPI strategy. Community and outreach activities will be conducted to deliver messages on shared responsibility and interventions about keeping negative within the context of promoting health and self-esteem. SIDHAS will promote sustainability ownership, through training of responsible departments at national, state and local levels (NACA, NASCP, SACA, SASCP, LACA) in planning and managing HTC programs as well as monitoring and evaluation (M&E) and reporting. Resources will be leveraged through the GoN, private sector and other funders, to carry

out mobile T&C services. SIDHAS will ensure quality control of HIV testing using DBS and or dry tube sample (DTS).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	754,293	0

Narrative:

GHAIN's other prevention activities focused on HIV/AIDS behavior change communication targeting audiences such as the National Union of Road Transport Workers, Female Sex Workers, and Men having Sex with Men through CSO partners. In COP12 and 13, SIDHAS will continue to implement MPPI to increase access to HTC services for MARPs and hard-to-reach populations by establishing outreach HTC through CSOs in three-high burden geopolitical zonesof Nigeria (NE, NC and SS). SIDHAS will collaborate with the partner implementing the USAID funded MARPs program to establish linkages to care and treatment. SIDHAS will work to make condoms availability at service delivery points at the health facility and the community. Community based distribution pattern will be established through supporting local CSOs and peer groups. SIDHAS will continue to collaborate with other USG partners in condom programming for supply, management and monitoring. The national monitoring and evaluation tools will continue to be used to capture data on condom forecasting, distribution, and data management.

SIDHAS will provide preventive HIV services to PLHIV through facility and community based activities by implementing the three interrelated components of positive health dignity and prevention (PHDP) as stated in the Nigerian National HIV/AIDS Prevention Plan 2010-2012 and implement prevention activities through Minimum prevention Intervention package (MPPI) strategy. PHDP will focus on safer sex, condom use and fertility desires; illness prevention through cotrimoxazole preventive therapy, adherence to ART and consistence insecticide treated nets (ITN) and support clients and strengthen self-care practices that promote good health and well-being; referral procedures for FP, PMTCT, TB, STI, mental health and other PHDP related services at community level.
It will involve education of PLHIV and their families; and training and mentoring of HCWs and PLHIV support group members to achieve greater confidence, obtain problem solving skills and lead healthy lifestyles.(E.g. reducing alcohol and tobacco use). Strategies to transform harmful gender norms and behaviors, empower females and engage males as agents of change will be incorporated.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	6,995,626	0

Narrative:

In COP 12&13, SIDHAS will continue supporting PMTCT services in existing 182 GHAIN-supported sites and decentralize services to all ART refill PHCs particularly to reach underserved populations with high

HIV prevalence. PMTCT services will be decentralized to 13 PHC clinics in COP 12 and 20 HTC sites in COP 13.

Using the WHO four pronged approach, sites will be supported to offer provider-initiated testing and counseling (PITC) at multiple service delivery points including ANCs, labour ward, PNCs and FP clinics and integrated within the INMCH settings. HIV positive pregnant women will be provided with ARV for therapy or prophylaxis in line with national guidelines. Access to CD4 testing for all HIV positive pregnant women, and point-of-care testing machines at ANCs and PHCs (where feasible) will be provided to reduce attrition along PMTCT cascade. Through Continuous Quality Improvement (CQI) ARV prophylaxis uptake and adherence will be strengthened. SIDHAS will support increased ANC attendance through outreaches and linkages to peripheral facilities and work with 20 CSOs to disseminate primary HIV prevention and PMTCT messages to women of reproductive age, encourage partner testing and provide male and female condoms. Sociocultural barriers to contraception and gender issues will be addressed through community mobilization, health education and the promotion of male involvement in family planning interventions. SIDHAS will support the development of an SSYC community service/PMTCT module that builds on members' capacity to promote ANC utilization.

Trainings of HCWs at the PHCs on drug inventory management process and rational use of ARVs will be conducted and capacity will be built on adherence counseling, ARVs clinical pharmacovigilance and follow up of mother baby pairs. Safe infant feeding practices and adequate nutrition of mothers will be promoted within the ANC and postnatal clinics. In addition, women will be linked to facility and community-based support groups using the chronic care model while exposed infants will be provided EID services. SIDHAS will evaluate the effectiveness of PMTCT interventions and also work with GON to review the National Drug Policy at the PHCs level.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	0	0

Narrative:

Continuous availability of commodities is essential to the provision of good quality services. SIDHAS will focus on training the State Ministry of Health (SMOH), Local Government Area (LGA) and facility staff on supply chain management for health commodities to ensure efficient and quality services delivery at minimum cost possible to the patients. In addition, there will be infrastructural development, integration of health commodity management at all levels and decentralization to foster ownership and sustainability of health programs by Government of Nigeria (GON).
SIDHAS will support the renovation of health commodity stores in 50 health facilities and support the integration of HIV commodities management with that of other health commodities. An additional model

warehouse will be renovated to support the health facilities in the North East geopolitical zone in COP 12 to increase availability and access to commodities.

In COP 12, in line with Global Health Initiative (GHI) principles, SIDHAS will initiate discussion for the integration of the supply system of contraceptives and antituberculosis drugs to enhance logistics system strengthening for all health commodities at both the state warehouses and health facility stores. SIDHAS will also initiate the process of transitioning of supply chain management services to GON staff at the state level.

In COP12 and 13, SIDHAS' will support the decentralisation strategy through the states and LGAs for efficient decentralised storage and, for the dispensing of health commodities for both ART and PMTCT in PHCs. In COP13, SIDHAS will advocate for state-led partner co-ordination and, will establish an integrated health commodity distribution system for increased efficiency.

SIDHAS will work closely with GON and States Ministry of Health in the selection, forecasting and quantification processes to ensure continuous availability, prevent stock out and expiries. Staff of state and LGA will be trained on good warehouse management practices. SIDHAS in conjunction with GON will conduct joint supportive supervision visits to support the transition process

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	10,068,313	0

Narrative:

SIDHAS will scale up ART services from 124 to 130 sites in COP 12 by upgrading six PMTCT standalone sites to deliver ART. Treatment services will be designed using chronic care model, smart integration and continuum of care to improve quality of services and promote country ownership. Technical support to sites will focus on adherence, retention, strengthening facility-based continuum of care and capacity building. Early identification of treatment failure cases as well as prompt switch to next line drugs when required will be ensured. The GoN will be assisted to decentralize ART services from secondary health facilities to 55 additional PHCs by end of COP 12 and 13 making a total of 65 ART refill sites. Capacity building, refurbishment and access to essential CD4 testing will be provided. The community pharmacists program established in GHAIN will be used to support the ART decentralization. Using workload analysis tool, SIDHAS will work closely with GoN on optimizing existing staff at the PHC level for ART decentralization. Integration of HIV treatment services into hospital systems at secondary facilities will be instituted and where feasible, ART services will be integrated in outpatient clinics to optimize resources. The use of bulk sms text messaging as a platform to strengthen adherence and retention of patient in supported ART facilities will be explored.

SIDHAS will institute a multidisciplinary approach to active clinical pharmacovigilance for ARV drug

therapy that involves active screening for ADRs in all supported facilities in collaboration with National Agency for Food and Drug Control (NAFDAC). CQI systems will be expanded at the facility level by improving service quality using a collaborative approach while strengthening links between the community and facility. PHC facilities will also be strengthened using the integrated service delivery model that appropriately links clinical and pharmaceutical services in the health facility and care services in the community. PHDP will be implemented within facility and community by focusing three key components of preventing onward transmission of HIV, illness prevention and gender based violence and enhancing self-care capacity.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	2,896,740	0

Narrative:

In COP 12 and 13, SIDHAS will focus on providing children and adolescents integrated services using the family centered approach. SIDHAS will enroll HIV positive children below 15 years newly on ART and provide treatment services to 13,937 HIV infected children in ART sites in 36 states and the FCT. SIDHAS will follow up mother-baby pairs by aligning it with infant immunization schedules and strengthen referral linkages between the community, PMTCT and ART sites for continuum of care of mother-infant pair. Early infant diagnosis for HIV exposed babies will be provided by promoting testing from 6 weeks. Capacity of health care workers will be built through a combination of workshops, on-site mentoring, continuing medical education and provision of pediatric job aids, SOPs and guidelines. Health workers will be re-trained to provide fixed dose combinations (FDCs), to improve treatment adherence. The on-site mentoring program will engage experienced pediatric ART physicians to provide hands on supervision; observation and random case file review to identify site-specific challenges, strengths, weaknesses and opportunities for quality improvement

SIDHAS will promote integrated service delivery by incorporating infant and young child feeding counseling; routine child growth and development monitoring; nutritional counseling and counseling on EID into pediatric ART care and treatment services. SIDHAS will also strengthen disclosure and adherence counseling with parents and guardian through sharing of age appropriate, gender and culture sensitive information. SIDHAS will work with the primary health care development agency (NPHCDA) and other related agencies to strengthen the capacity of community health officers (CHOs), community health extension workers (CHEWs) and nurses to provide HIV/AIDS services including ARV refill at the PHCs using the IMAI and IMCI tools.
Pharmacists will be trained/re-trained on pharmaceutical care and pharmacy best practices. Community pharmacists will provide pediatric treatment supervision. Pharmacists will be trained to provide specialized medication adherence counseling, ARV clinical pharmacovigilance and support effective

drugs inventory control in the pediatric ART sites.

Implementing Mechanism Details

Mechanism ID: 14535	**Mechanism Name: Cheikh Anta Diop University (CADU)**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Cheikh Anta Diop University	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 487,342	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	487,342

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The overall funding is to support the development of a National Medical Laboratory Strategic Plan and annual implementation plan that aligns with the national policy in place. The objective is to assess the current status of diagnostics and referral (including health related research) laboratories as it impacts on the health of all Nigerians. Specifically this is to assess the high access/ burden sites (laboratories) using tools that will focus on how to identify potential solution that improves access, quality service delivery, strategy for country sustainability and continued leadership.This is to be achieved through laboratory needs assessment plan/ road map, review and hold discussion on the needs assessment outcomes (workshop) - initiation of national strategic plan development which is in line with the themes for the development of the SWOT tool for infrastructure, organization, governance and HR needs
Develop assessment tools based on the themes identified by the FMOH and the strategic plan development core team
Conduct field assessment representative of Nigeria, including infrastructural and HR mapping.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	1,500

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**14535**
Mechanism Name:	**Cheikh Anta Diop University (CADU)**
Prime Partner Name:	**Cheikh Anta Diop University**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	487,342	0

Narrative:

The overall funding is to support the development of a National Medical Laboratory Strategic Plan and annual implementation plan that aligns with the national policy in place. The objective is to assess the current status of diagnostics and referral (including health related research) laboratories as it impacts on the health of all Nigerians. Specifically this is to assess the high access/ burden sites (laboratories) using tools that will focus on how to identify potential solution that improves access, quality service delivery, strategy for country sustainability and continued leadership.This is to be achieved through laboratory needs assessment plan/ road map, review and hold discussion on the needs assessment outcomes (workshop) - initiation of national strategic plan development which is in line with the themes for the

development of the SWOT tool for infrastructure, organization, governance and HR needs Develop assessment tools based on the themes identified by the FMOH and the strategic plan development core team Conduct field assessment representative of Nigeria, including infrastructural and HR mapping.

Implementing Mechanism Details

Mechanism ID: 14575	**Mechanism Name: Community REACH**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Pact, Inc.	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 4,139,591	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	4,139,591

Sub Partner Name(s)

Amana Association	Catholic Diocese of Abakaliki	Catholic Diocese of Lafia, Nigeria
Centre for Better Health & Community	Centre for Health Education and Developmnet Communcation, Lagos	Community Health Action Initiatives
Community Health Initiatives ORE	Destiny Daughters of Nigeria (DEDAN)	Emmanuel World Children Foundation
Environmental Development & Family Health	Family Health Care Foundation	Family Heritage International (FAHI)
Family Reformation & Community	First Step Action for Children, Mbaakon	Good Samaritan Mission
Humanity Family Foundation for Peace & Development	JIREH FOUNDATION, BENUE	Kids & Teens Resource Centre
Knowledge and Care Providers	League of Imams and Alfas	Methodist Care Ministry

	(NASFAT)	
Physicians for Social Justice	Safe Motherhood Ladies Association	Society for Women & AIDS in Africa (SWAA)
Volunteers for Change in Africa, Ebonyi	Women Children's Health and Community	Youth for Christ Development Ministry (YFC)

Overview Narrative

The REACH program is being implemented in 9 states, Bayelsa, Ekiti, Enugu, Ebonyi, Kwara, Nasarawa, Niger, Ondo, and Rivers. The two thematic areas are HIV Prevention which targets the general population, in and out of school youths and small groups of special populations, the visually and hearing impaired; and the OVC program area targeting orphans and vulnerable children under age 18, their caregivers and care providers.

For COP12, REACH will focus on consolidation of achievements of the last two years. The REACH sub partners have been assessed and institutional strengthening plans are currently being implemented. The focus will be on leadership, governance, resource mobilization and community participation to ensure continuity at all levels. In order to develop a sustainable and cost effective model, REACH will continue to provide support to the relevant government agencies to ensure enhanced coordination and partnership; while enhancing partner capacities in community participation, community health insurance, block granting in education and health, Saving and Loans, leveraging of resources, and private sector partnerships. REACH will ensure that accurate, reliable and timely data is used to inform programmatic decision-making at all levels.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	300,000
Education	200,000
Food and Nutrition: Commodities	120,000
Food and Nutrition: Policy, Tools, and Service Delivery	25,000
Gender: Reducing Violence and Coercion	90,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Child Survival Activities
Mobile Population

Budget Code Information

Mechanism ID:	**14575**		
Mechanism Name:	**Community REACH**		
Prime Partner Name:	**Pact, Inc.**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	0	0
Narrative:			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	3,721,783	0
Narrative:			
In COP 12 REACH Nigeria will strengthen the institutional and technical capacity of 35 sub CBOs to provide comprehensive care and support to Vulnerable Children. The REACH Nigeria sub grantees will be supported to implement the Child Protection standards. Communities would be sensitized to respond to the needs Vulnerable Children and their care givers including child protection issues. Community resource mobilization to meet the needs of vulnerable households will be supported. Community VC Committee will be established in every community. Community leaders and influential members of the community will be members of this committee. They would also ensure that their communities are responsive to child protection issues. REACH Nigeria will continue to support vulnerable families cope			

with challenges of providing basic needs of their children. Efforts will be put in place to continue to build the capacity of Households so that parents and caregivers are able to provide for their children's long term needs; retaining children in school, and working with local governments to establish strong child welfare and protection systems. Caregivers will receive skills acquisition trainings and seed grants. Female caregivers will be empowered to strengthen the financial base of their small businesses. These women will also receive training on entrepreneurial skills and be linked to micro credits agencies and private sector. Caregivers will be encouraged to form saving and loans groups using the WORTH model. Through this model caregivers will learn about literacy, savings and loans, small income generating activities and issues related to care and protection of children who are under their care. Caregivers will be trained and empowered to provide to children less than 5 years with required ECD support. Caregivers will receive training on IMCI, parenting skills and psychosocial support with emphasis on increasing their confidence to make choices that would ensure that the rights of their children are met. Adolescent VC will be provided with HIV and RH education. Older VC will receive vocational trainings or be encouraged to further formal education. Emphasis will be place on building the life skills of older VC to prepare them for exiting the program. Linkages will be increased to other existing program such PMI.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	200,000	0

Narrative:

REACH Nigeria prevention will be focusing on providing HIV prevention services among women groups, youths in school and out of school, youths with hearing impairment, youths with visual impairment and fisher folk. In working with these groups REACH Nigeria will employ appropriate best practices in promoting HIV sexual prevention at individual and small group levels. Interventions will contextualized and based on data regarding HIV prevalence and epidemic drivers. Using combination of prevention interventions with focus on providing a Minimum Package of Intervention to each target population group in line with the National Prevention Plan, REACH Nigeria will provide HIV prevention messages to a total of 25,200 individuals. Activities will be designed to; increase knowledge and improve skill for HIV prevention at individual levels, encourage community participation and address structural barriers to HIV prevention. REACH Nigeria will achieve this working with 21 Civil Society organizations in three states of Nigeria (Ondo, Ekiti and Bayelsa States).

Individual and Group level activities: REACH Nigeria will be utilizing a combination of appropriate strategies to educate its target population. Strategy options will include different peer education models, peer education plus models and other Interpersonal communication methods to increase knowledge, improve skills, and promote appropriate behaviour changes that lessen HIV risk among different target groups.

Community level intervention: community level interventions will aim at promoting community participation, enabling environment for behaviour change, address risky cultural practices relating to childbirth, intergenerational sex, multiple sexual partnerships, early sexual debut, female circumcision, HIV testing among pregnant women, gender inequality and women, and male's role and responsibilities in HIV prevention.

Structural level interventions: Structural issues identified in REACH project communities in terms of service provision and policy environment will be addressed in partnership with Civil society Organisations, and other implementing partners and government agencies such as SFH, LACA and SACA and the Ministry of Health in the focus states.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	217,808	0

Narrative:

Condoms promotion will form an integral part of REACH Nigeria prevention programming among out of school youths, fisher folks and women groups. REACH NIgeria will seek to ensure that high-quality condoms are accessible to its target groups, when they need them, and that they have the knowledge and skills to use them correctly and consistently. In order to increase the knowledge of beneficiaries on condom use and it benefits, REACH Nigeria will employ multiple channels to ensure that all beneficiaries receive accurate, culture- and age-appropriate information about how male and female condoms prevent HIV infection. HIV prevention education and condom promotion will address the challenges of complex gender and cultural factors, ensuring that gender issues are not a barrier to information about and access to condoms. Such channels as peer education, printed materials and condom demonstrations at appropriate for a will be employed.

In order to increase availability of condoms to beneficiaries, REACH Nigeria will link beneficiaries with implementing partners as Society for family Health to either obtain high quality condoms free of charge or at low cost. In addition to linking up beneficiaries with other development partners, REACH Nigeria will also explore supply opportunities with State Agencies for the Control of AIDS to establish condom outlets in the various project communities.

Implementing Mechanism Details

Mechanism ID: 14583	**Mechanism Name: MARKETS (SVHP)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Chemonics International	

Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 2,700,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	2,700,000

Sub Partner Name(s)

Adolescent Girls Initiative	Association of Grassroots Counselors	Christian Association of Nigeria
Community Support and Development Initiative	Conscientising Against Injustice & Violence	Education As A Vaccine Against AIDS (EVA)
Fahitma Women and Youth Development Initiative	Initiative for People's Good Health	INTEGRATED DEVELOPMENT INITIATIVES(IDI), IKOM
Jireh Foundation	Kind Hearts	Ohonyeta Care Group, Otukpo
Otabo Care Givers and Support for Orphans, Mbaakon	Rahama Women Development Programme	Save the Child Initiative
Ummah Support Initiative	Women Gender Developers, Kano	

Overview Narrative

MARKETS' Family Nutritional Support Program (FNSP) was launched in September 2008 to support income-generating activities for OVC caregivers through a homestead farming activity and to provide nutritional supplements to the most vulnerable OVC. This activity leveraged an existing USAID-funded economic growth program to provide support to OVC enrolled in PEPFAR programs. Building on the success of MARKETS' FNSP activities, the program piloted an activity in 2010 that addressed malnutrition and food insecurity at the household level through relevant livelihood training and the local production of ready-to-prepare therapeutic food for care givers from food-insecure households.
Post-project, BtM2 designed an approach to understanding the willingness and ability of consumers currently aware of Grand Vita to purchase the product in the retail market. BtM2 and Grand Cereals have identified two broad markets for the Grand Vita product: direct sales to consumer markets, and bulk sales to donor intermediaries for distribution to targeted beneficiaries.

In 2011, Bridge to MARKETS 2 continued training care givers with the livelihood and household nutrition modules that were used in conjunction with the MicroEnterprise Fundamentals® course. The course focused on the interrelatedness of improved income, household nutrition and homestead farming. The curriculum promoted best practices such as exclusive breastfeeding, proper weaning methods, improved cooking and sanitation practices, and recommendations for preparing balanced meals with locally available resources produced from homestead farms. Working through PEPFAR implementing partners and their implementing agencies BtM2 trained care givers in six states of Sokoto, Kano, Kaduna, Bauchi, Benue and Cross River.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing women's access to income and productive resources

Child Survival Activities

Budget Code Information

Mechanism ID:	**14583**		
Mechanism Name:	**MARKETS (SVHP)**		
Prime Partner Name:	**Chemonics International**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	2,700,000	0

Narrative:
The sum of $2,700,000 is planned to support the activities of the Bridge to Market to households of vulnerable children. This will be utilized to empower caregivers with training / capacity enhancement on agro-based income generating activities. This activity is to encourage economic independence of caregivers to provide for their children's need; retaining them in schools and providing health care services and other needs. Vulnerable households will also be provided with food supplement to enhance nutritional status of vulnerable children.

Implementing Mechanism Details

Mechanism ID: 14589	**Mechanism Name: ABE-LINK**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Creative Associates International Inc	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 2,160,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	2,160,000

Sub Partner Name(s)

Adolescent Girls Initiative	Adolescent Health Education and Development Centre	Children and Family Support Initiative
Community Mobilization and Development Initiative	Fahitma Women and Youth Development Initiative	Federation of Muslim Women Association in Nigeria, Kebbi
Life Helpers Initiative	Rahama Women Development Program	Reproductive Health Initiative and Support Association
Rural Women and Youth Initiative	Society for Women Adolescent Health Initiative	Ummah Support Initiative
Young Men Christian Association		

Overview Narrative

To achieve Objective 2, NEI will provide for and build the capacity of both local communities and government agencies to initiate and support OVC programs and services, including education, health, life skills and psycho-social counseling. NEI will work with communities, local government and state agencies to:

(i) increase support (and provision) of education and health services for OVC by: establishing community coalitions, setting up an OVC referral system for education and health services, enhancing teacher ability for literacy and numeracy instruction to OVC, establishing non-formal learning centers, providing OVC support packages, and providing access to vocational education;
(ii) increase support (and provision) of supplementary OVC support activities by: training teachers and OVC support persons in mentoring, psycho-social counseling and hygiene, implementing an adolescent girls program, establishing “kids’ clubs,” and building capacity of communities and caregivers to support OVC education and well-being;
(iii) strengthen systems for increasing access to education and health services by: adapting the national OVC plan of action in each state, strengthening capacity of OVC-responsible ministries and officers, developing procedures to integrate academic subjects into Quranic schools, and building capacity to integrate OVC into formal schools.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	14589		
Mechanism Name:	ABE-LINK		
Prime Partner Name:	Creative Associates International Inc		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	2,160,000	0

Narrative:

To increase support for education and health services for OVC, NEI will build the capacity of twenty Community Coalitions (CCs) to implement action plans around basic education outcomes and OVC support; support 20 CCs and 200 OST with assorted BCC materials to promote enrolment and retention for school children including 15,200 OVC in 200 demonstration schools. Develop training modules and train 600 OST on PSS, WASH, mentoring, and counseling to enable them provide care and support for OVC, as well as produce OST guidelines and procedure handbooks. A total of 4000 OVC were provided with educational support packages, 400 VC will be attached to local craftsmen to learn vocational skills while 1600 VC in NFLCs will be trained with the vocational equipment provided by NEI .

To Increase support for supplementary OVC support activities, NEI will train 3,718 teachers in mentoring, psycho-social counseling, and hygiene, train 600 OST members on the use of CSI; implement adolescent girls' programs in 20 centres; implement 320 kids' forums (Dandalin Yara); and build capacity of 6,500 communities and caregivers to support OVC education and well-being as well as produce and broadcast radio programs on OVC.

To Strengthen Systems for increasing OVC access to education and health service, NEI will ensure vertical OVC systems; strengthen systems for increasing OVC access to education and health services; assist state-level partners—MOWA, MORA, MOE, and SUBEB - to conduct internal self assessments, identification and prioritization of needs and adaptation of the National Plan of Action (NPA) for OVC and develop annual work plans; train 70 OVC Officers in line MDAs, LGAs on their roles and responsibilitie

Implementing Mechanism Details

Mechanism ID: 14595	**Mechanism Name: Community Support for OVC Project (CUBS)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract

Prime Partner Name: Management Sciences for Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 4,329,012	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	4,329,012

Sub Partner Name(s)

Africare	Center for Community Health and Development	Environmental Development & Family Health
Global Health & Awareness Research Foundation	Koyenum Immalar Foundation	Spring of Life, Los
WOMEN ALIVE FOUNDATION IN NIGERIA - ETINAN		

Overview Narrative

Recognizing the need to ensure that the efforts and achievements made in previous COP years are sustained and that CSOs can continue to provide services to OVC as well as be a voice to advocate for children rights, CUBS have also built the organizational capacities of the CSOs earlier engaged on the project through ensuring that they have systems and processes to guide their operations. These CSOs now have well developed and clearly articulated policy manuals on operations, management, finance and HR. These achievements have enabled CSOs to secure public and private funding, further supporting CUBS's exit strategy as well as enabling them to broaden their scope to becoming sustainable entities. For the newly contracted CSOs, CUBS will in COP12, concentrate efforts towards laying necessary foundation for delivery of quality services, while continuing to build their technical and organizational capacities.

Owing from capacity building efforts of COP11, over 20,000 OVC have been provided with a minimum of 3 services. In order for continuation of services, project has introduced community based and data driven household economic strengthening (HES) support to female heads of households. Post-trainings, material support has been provided to over 200 female caregivers enabling them to improve the wellbeing of OVC

under their care.

Since all of these efforts were geared towards ensuring that institutional and systems change will take place so that there is a better and dynamic structure at state level, CUBS have also been strengthening capacity of state ministry of women affairs to understand and carry out their coordination functions. These activities will continue in COP12.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	150,000
Education	100,000
Food and Nutrition: Policy, Tools, and Service Delivery	15,000
Gender: Reducing Violence and Coercion	50,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

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
Family Planning

Budget Code Information

Mechanism ID:	**14595**

Mechanism Name:	Community Support for OVC Project (CUBS)		
Prime Partner Name:	Management Sciences for Health		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	4,329,012	0

Narrative:

With 38 civil society organizations contracted and provided with grants to provide services to OVC, the major part of our contract budget will go towards the grants. Since the majority of these CSOs have limited organizational and technical capacity, a major part of our activity will be building and strengthening these capacities, in particular the organizational capacity to enable them function even beyond the project life span. The project is also demonstrating a number of models that will in the long run encourage ownership and sustainability through empowerment. Our economic strengthening activities is based on needs and guided by assessments that demonstrate where the greatest impact will be for funds expended. Particular attention will however be paid to building the economic stability of households so that parents and caregivers are able to provide for their children's long term needs; retaining children in school, and working with local governments to establish strong child welfare and proctection systems. We will also be spending significant funds and time in getting state and non state partners including community, traditional and religious leaders to begin to discuss how they will cater to the varying needs of OVC in their community. We are using education as one such need of the OVC that if met can empower and help ensure that the child has a better chance of being successful in life. Our gender focused programming is a component that absorbs about 20% of our funds as we target both female adolescent OVC as well as female heads of households with various interventions to bring their needs to the fore and help reduce the burden of care on them. In the 11 states where we are programming, we will utilize a portion of our resources towards systems strengthening for the ministry of women affairs at state and local government level. Funds will be expended in expanding coordination functions through support to set up child protection networks and OVC forums while building the capacity of the memberships of such fora to better carry out their functions. The project is supporting the federal government with a social welfare systems strengthening efforts towards developing a more needs based and demand driven human resource structure from local government level up to state levels to ensure that the structure and human resources needed are informed based on the needs on the ground.

Implementing Mechanism Details

Mechanism ID: 14596	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14599	**Mechanism Name: Health Care Improvement (HCI) Project**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: University Research Corporation, LLC	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 360,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	360,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

In August 2011, HCI led a QI coaches training for the FMWASD and other stakeholders (including USG, implementing partners, UNICEF, and AONN representatives). In September 2011, a hands-on training was also conducted to provide an opportunity for FMWASD staff and other stakeholders trained during the coaches training to gain practical experience around what they had learned and adapt the information to their own local context and situation. At the state level, the TWG and participating implementing partners have been supported to choose states where each will be lead agencies supporting the pilot process. The IPs and local organizations are supported to facilitate the formation and strengthening of OVC state technical working groups and QI teams by the State Ministries of Women Affairs in the various pilot states. These groups serve to provide oversight for the implementation and coordination of care and support programs for vulnerable children in each state while also providing support and oversight forthe piloting of standards at the state level.

Based on the results of HCI activities thus far, HCI proposes to provide the following SOW for COP 2012: 1) Facilitate national endorsement of the Standards that are integrated within a national strategy response. 2) Scale-up implementation of the OVC Standards of Care. 3) 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. 4) Strengthen capacity of government and partners at national, state and local

levels for provision of quality services to vulnerable children and caregivers. 5) Create a community of shared learning across all OVC stakeholders.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

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
Child Survival Activities

Budget Code Information

Mechanism ID:	**14599**		
Mechanism Name:	**Health Care Improvement (HCI) Project**		
Prime Partner Name:	**University Research Corporation, LLC**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	360,000	0
Narrative:			
Labour , workshop, travels fringe benefit			

Implementing Mechanism Details

Mechanism ID: 14658	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14663	**Mechanism Name: Livelihoods and Food Security Technical Assistance (LIFT) Project**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: FHI 360	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 180,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	180,000

Sub Partner Name(s)

Care International	Save the Children US	

Overview Narrative

LIFT will provide support to USAID/Nigeria and their OVC implementing partners in the following areas: (1) targeted, direct technical assistance (TA) to address immediate capacity gaps in household economic strengthening (HES) programs and improve the quality of existing programs; and (2) developing a technical toolkit for HES activities that will enable program implementers to draw on appropriate resources to implement or link to effective HES interventions.

LIFT has previously provided ongoing technical support to USAID OVC implementers through rapid assessments of OVC implementers and their technical capacity and TA needs, and provided a broad training in economic strengthening for OVC implementers. Through this assessment LIFT identified village savings and loan associations (VLSAs) as a core area for additional support and provided training

in VSLA design and implementation.

Building off the previous technical assistance, LIFT will provide targeted training that meets the previously identified technical capacity needs. LIFT will develop a toolkit that enables USAID/PEPFAR implementing partners to make their own decisions and design programs with their own resources. LIFT will also support information and knowledge sharing among LIFT, USAID/PEPFAR, its partners, other donors and the GON. LIFT will also look into the possibility of developing or supporting an online platform to provide tools and e-learning materials to partners.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	180,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing women's access to income and productive resources
Child Survival Activities

Budget Code Information

Mechanism ID:	**14663**
Mechanism Name:	**Livelihoods and Food Security Technical Assistance (LIFT) Project**
Prime Partner Name:	**FHI 360**

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Care	HKID	180,000	0

Narrative:

LIFT will build on its ongoing technical assistance to USAID/Nigeria OVC implementing partners by developing and delivering targeted training that meets previously identified technical capacity needs. Training will focus on M&E and impact assessment of HES interventions for OVC, and implementation of high-quality provision interventions and other technical areas identified in coordination with the USAID/Nigeria mission. Training will ensure that OVC implementers have the technical capacity to assess and categorize household vulnerability and assets which informs the development of appropriate economic strengthening interventions.

LIFT will develop a toolkit that enables USAID/PEPFAR implementing partners to identify appropriate HES program area to meet OVC needs, and design interventions with their own resources. LIFT will support linkages between OVC programs and economic strengthening interventions, including increasing the capacity of economic strengthening partners to deliver services to OVC and their caregivers. LIFT will also support information and knowledge sharing among LIFT, USAID/PEPFAR, its partners, other donors and the GON and enhance online learning platforms to make resources more accessible.

Implementing Mechanism Details

Mechanism ID: 14664	**Mechanism Name: Integrated MSM Prevention Program**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Heartland Alliance for Human Needs and Human Rights	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,735,819	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	1,735,819

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Heartland Alliance /IMHIPP is targeted at prevention of HIV among MSM in Nigeria focusing on strengthening organizational and technical capacity of grassroots MSM organizations, to design, manage and evaluate HIV programs to promote ownership and sustainability. With a five years grant (2009-2014), from USAID, and with technical assistance from Howard Brown Health Center, IMHIPP is being implemented in FCT, Lagos, Cross River, Rivers, Kano State in COP 2012 and a yet to be determined sixth State. Focus for 2012 will also be on other programming for other MARPS.
HA through the Peer Educators (PEs) and Outreach Coordinators (OCs) of local MSM organizations is implementing IMHPP by using the combination minimum prevention package of three out of six strategic interventions relevant to IMHIPP. The interventions promote correct and appropriate HIV prevention messaging, uptake of condoms and lubricants and referral for HTC and ART.
HIV testing and counselling (HTC) is the gateway to various HIV prevention treatment, care and support services. Currently, IMHIPP does not have the mandate to provide HTC. Integrating HTC in COP 2012 will create an enabling environment that will promote universal access to friendly, safe and quality services for MSM, their female sexual partners thus improving couple counselling.
Programming for MSM is a challenge that is underpinned by stigma and discrimination and low technical capacity of MSM organizations to implement HIV and AIDS prevention, care and support interventions. The local partners through several capacity building programs now have a pool of resource persons to reach other hard to reach MSM. Acquisition of skills will continue to create ownership and make local partners technically viable for other donors.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	50,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors

Increasing gender equity in HIV/AIDS activities and services

Budget Code Information

Mechanism ID:	**14664**
Mechanism Name:	**Integrated MSM Prevention Program**
Prime Partner Name:	**Heartland Alliance for Human Needs and Human Rights**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	107,512	0

Narrative:

Promoting Positive Health, Dignity and Prevention (PHDP) for MSM+ve through access to palliative care and support is one of IMHIPP's essential components.

Strategies such as provision of psychosocial, nutritional and drug adherence counseling, prevention with positives (PWP), Home-Based Care, provision of HBC materials such as insecticide treated nets, water guards to MSM and their female sexual partners and their dependents. Provision of condom and lubricants, be faithful messaging, improved negotiation skills, support group services and referrals to MSM friendly facility-based service for treatment of STI and ART.

IMHIPP is currently supporting four local partners ICARH, TIER, IMHI and PP in Abuja, Lagos, Cross-river and Rivers States to access MSM friendly community and clinical/facility services to improve the quality of care for MSM+ve and will support a 5th State Kano in COP12. Currently HCT is done through referrals but will be integrated into the care and support services to provide access to all other HIV/AIDS support services in COP 2012

As part of the strategies to effectively monitor care and support services and retain clients is the development of referral system to reduce the Lost-To-Follow-Up (LTFU). HA has a four way referral system introduced to engage and track both the client and service providers in the process of care delivery.

To ensure quality of services will be provided training to acquire skills in palliative service. MSM+ will be equally trained to be able to take care of their members thus promoting ownership and sustainability. Client satisfaction checklists are

The community centers serve as a safe space for the MSM+ve to up-take various support group services without discrimination, couple and discordant counseling, and risk reduction assessments including referrals for specific needs to appropriate health facilities.

Integration of a MARPs Clinic is currently piloted at one project site in FCT ICARHad will be scaled up to the other four states to improve both access and uptake of services at a one stop shop at all community centers amongst others.
Linkages will continue for referral to access to food support to other partners who provide these services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	0	0

Narrative:

Strategic information (SI) focuses on capturing of data, review of data tracking tools to reflect effective and high quality data collection. These reviews will be forwarded to the national technical working group on strategic information for inclusion in the national prevention tracking tools to enhance quality of data collected nationally. This is achieved by monthly collation of data from project sites. The authenticity of the information collected from the field is very vital therefore tracking tools incorporate columns for clients 'phone number, Unique ID, old or new clients for validation purposes and to avoid double counting.
Training of Peer Educators (PEs), Outreach Coordinators (OCs) and program staff is continually conducted on the use of the PITT, CMPPI, DHIS and other relevant national tracking tools to reflect IMHIPP prevention care and support interventions for effective and efficient data quality. In order to ensure that program is aligned to it intended objectives, the Program Monitoring Plan is routinely reviewed.
Periodic data collection, field visits and on – the – spot check and supportive supervision of PEs and OCs in addition to random validation are ways of ensuring that activities on prevention interventions and palliative care activities are in line with achieving program and national HIV prevention goals.
Training of PEs, OCs and local partners' staff on SI management is a way of building the capacity and skills of local implementing partners creating a platform for sustainability and ownership at the exit of Heartland Alliance (HA).
During the COP2012, a mid – term evaluation shall be conducted to assess the impact of IMHIPP on the beneficiary target group. SI unit will develop monthly summary report to provide additional insight to the program both for national consumption and for local partners. This will enhance MSM prevention programming in Nigeria. International and national lessons learnt / experience sharing within program States will be organised, promoted and supported to help implementing partners learn from one another, improve programming and compliment each other's effort.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and	OHSS	0	0

Systems			

Narrative:

Programming for MSM is a challenge that is underpinned by stigma and discrimination and low technical capacity of MSM organizations to implement HIV and AIDS prevention, care and support interventions. Capacity building is provided for Outreach coordinators and peer educators of the local partners to effectively acquire the skills for prevention messaging. This will continue in the COP year 2012 as IMHIPP scales up to other new states. The local partners through several capacity building programs now have a pool of resource persons that will continue to reach other hard to reach members of their community with prevention messages at grassroots. Acquisition of skills will continue to create ownership and make local partners technically viable for other donors.
Inability of MSM to have access to necessary services has made them more vulnerable to HIV infection in Nigeria. In order to improve access to services MSM friendly Health Care, facilities, other relevant organizations and state actors will be continually trained on MSM specific health needs and stigma reductions in the project States. This will also be achieved through advocacy and creating of referral linkages.

Through these linkages MSM have been able to leverage services such as HTC, STI management, ART and income generation activities. In line with the objectives of IMHIPP, strengthening the relationship between the MSM local partners and service providers will create ownership and sustainability. Leveraging from NDE programmes has also provided skills acquisition to unemployed MSM to provide other alternative sources of income. HA will to facilitate these state partnerships to ensure better understanding of MSM issues and improved health outcomes at all levels.

Though these opportunities highlighted have been explored some missed opportunities have been identified such as engaging with other CSOs to leverage other services that IMHIPP does not have mandate to provide. The COP year will see greater engagement with CSOs to expand MSM access and network to leverage resources and services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	336,621	0

Narrative:

Target population Approximate Dollar Coverage-number Activity
MSM 28,217 Condom& lube distribution Messaging on the 3Cs programs
Peer educating
MSM are male persons who engage in same sex activities. MSM are one of the high risk groups to HIV transmission and other sexually transmitted infections associated with unprotected anal sex.

Stigmatization, discrimination and low self esteem amongst MSM increase their vulnerability too.
HA through the Peer Educators (PEs) and Outreach Coordinators (OCs) of local partners is implementing IMHPP using the combination minimum of three out of six strategic interventions. These are, Community Outreach, Peer Education Models (PEMs), and PEMs+, STI management, specific population awareness and vulnerability issues. The selection was based on the effectiveness and avenues for engagement with the target group. It combines a mix of strategies that reinforce sustained behavioral change at the individual and community level. The interventions promote correct and appropriate HIV prevention messaging, uptake of condoms and lubricants and correct and consistent usage as well as referral for HTC and ART. MSM community centers in all project sites serve as safe spaces to access prevention services without fear of stigma and discrimination.
IMHIPP is designed to be implemented in five States over a period of five years 2009-2014 Lagos, FCT, Cross River, Rivers and Kano States to start in COP 2012.
Regular field visits are conducted, data collated and validated by PEs, OCs and Program Officers (POs). This process ensures high quality of data flow. The Program Advisors and other HA technical staff supervise programmatic and technical interventions to ensure quality of services. It is a combination of quality service delivery and multi-level capacity development program through mentoring, coaching and transfer of knowledge and skills to ensure ownership and sustainability.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	176,104	0

Narrative:

The current minimum package intervention in Nigeria incorporates the provision of comprehensive HIV prevention services to individuals and groups at the community level. The IMHIPP project is reaching out to MSM in five current operational states through the Outreach coordinator- Peer education model and achieving remarkable success. However, there are still identified gaps in the prevention as stipulated by the National prevention guidelines particularly in the provision of HTC. Acknowledging the importance of HIV testing and counseling (HTC) as the gateway to various HIV prevention, treatment, cares and support services, the IMHIPP established community centers (CC) within all program sites to facilitate the uptake of services in partnership with other service providers. Heartland Alliance through IMHIPP also has been engaged in advocacy with public and private health care facilities to ensure friendly MSM services uptake.
Monitoring referrals to these services, has shown enormous limitations in reaching clients with qualitative HIV care and support services as most positive clients are usually being Lost-to-follow-up (LTFU). This has ultimately affected not only the outcome of service delivery, but has impacted on the number of positive MSM that enroll in the IMHIPP Palliative Care/Home Based Care and support services as well as the as enrollment into support groups.

Integrating the provision of HTC at the community center will create an enabling environment that promotes universal access to friendly, safe and good quality HTC services for MSM. Also, integrating HTC services into the community centers as against a low referral rate (16.2%, IBBSS 2010) will reduce the time lag between HTC and enrolment into care services for HIV positive MSM.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	1,115,582	0

Narrative:

Target population Approximate Dollar Coverage-number Activity
MSM 28,217 Condom& lube distribution
Messaging on the 3Cs programs Peer educating

MSM are male persons who engage in same sex activities. MSM are one of the high risk groups to HIV transmission and other sexually transmitted infections associated with unprotected anal sex. Stigmatization, discrimination and low self esteem amongst MSM increase their vulnerability too.
HA through the Peer Educators (PEs) and Outreach Coordinators (OCs) of local partners is implementing IMHPP using the combination minimum of three out of six strategic interventions. These are, Community Outreach, Peer Education Models (PEMs), and PEMs+, STI management, specific population awareness and vulnerability issues. The selection was based on the effectiveness and avenues for engagement with the target group. It combines a mix of strategies that reinforce sustained behavioral change at the individual and community level. The interventions promote correct and appropriate HIV prevention messaging, uptake of condoms and lubricants and correct and consistent usage as well as referral for HTC and ART. MSM community centers in all project sites serve as safe spaces to access prevention services without fear of stigma and discrimination.
IMHIPP is designed to be implemented in five States over a period of five years 2009-2014 Lagos, FCT, Cross River, Rivers and Kano States to start in COP 2012.
Regular field visits are conducted, data collated and validated by PEs, OCs and Program Officers (POs). This process ensures high quality of data flow. The Program Advisors and other HA technical staff supervise programmatic and technical interventions to ensure quality of services. It is a combination of quality service delivery and multi-level capacity development program through mentoring, coaching and transfer of knowledge and skills to ensure ownership and sustainability.

Implementing Mechanism Details

Mechanism ID: 14666	TBD: Yes
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14668	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14676	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14678	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14683	**Mechanism Name: The New Tomorrow''s Project**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Gembu Center for AIDS Advocacy, Nigeria	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,730,805	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	1,730,805

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The New Tomorrows Project (TNTP) is comprehensive HIV prevention and care/support activity implemented by the Gembu Centre for HIV/AIDS Advocacy Nigeria (GECHAAN). The prevention component of this activity requires the provision of a minimum package of services relying on lessons learned from a pool of established best practices appropriate to the population being targeted. The prevention component will emphasize intensity and appropriate dosage of messages and services. Interventions include peer education, curriculum and non-curriculum based school interventions, community outreach interventions, interventions addressing vulnerability concerns, sexually transmitted infection management, condom services including education on the use of water based lubricants, training in skills relating to condom negotiation and use, and HCT interventions targeting youths, adult males and females in the general population. The OVC component of the proposed activity will support the OVC National Plan of Action, bolster technical and management capacity of community based organization (implementing agencies), and increase meaningful participation of children and youth. to prioritize household-centered approaches that link OVC services with HIV-affected families (linkages with PMTCT, care and support, treatment, etc.) and strengthen the capacity of the family unit (caregiver) to care for OVC.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Sub Recipient**
3. What activities does this partner undertake to support global fund implementation or governance?

Budget Code	Recipient(s) of Support	Approximate Budget	Brief Description of Activities
HVAB	Trainings, seminars, Community dialogues, sensitization, advocacy meetings etc	2465491	Trainings, seminars, Community dialogues, sensitization, advocacy meetings etc
HVCT	Community mobilization,sensitization, counseling	122800	Community mobilization,sensitization, counseling and testing

	and testing		

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation
Increasing women's access to income and productive resources
Malaria (PMI)
Child Survival Activities
Mobile Population
TB

Budget Code Information

Mechanism ID:	**14683**
Mechanism Name:	**The New Tomorrow''s Project**
Prime Partner Name:	**Gembu Center for AIDS Advocacy, Nigeria**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	607,500	0

Narrative:

Situation analysis and needs assessment using CSI conducted in four additional LGAs to determine number and priority needs of OVC. Provide comprehensive foster care and support services. Utilize sustainable community and family-based structures for OVC program. Build capacity of foster parents

and care givers to engage in economic activities to enhance income and provide vocational skills training for OVC who head households. Educate communities on the rights of the child and legal implication of child abuse. Home –Based Care visits to identify abused children with CDCs providing necessary oversight. Protection sub-committees integrated into Community Development Committees while birth registration is provided for OVC without birth registration.
Improve Community Justice System for child abuse, rape and other violence against children. Educate foster parents, care givers and general community on child protection and train them on identification of an abused child to improve ability to initiate protection measures. Establish partnership and linkages with legal aid group for asset claims and adjudication. Leverage and provide supplements to augment OVC nutrition. Caregivers provided skills to prepare basic, cheap and readily available nutritionally rich substances within communities. Plumpy nuts, nutritional formulas, multivitamins provided. In addition, the project will continue to build the economic stability of households so that parents and caregivers are able to provide for their children's long term needs; retaining children in school, and working with local governments to establish strong child welfare and protection systems. Psychosocial support training for foster parents and field officers and monthly foster parents meeting held. Financial support provided for education. Block grants for tuition fee, uniforms, books and other educational needs provided and advocacy visits for levies waivers with regular school progress monitoring. Direct school fees payment, purchase of uniforms and books only for children for re-integration back to school. Identified OVC and foster parents trained on rocket stove technology, bio-sand water filter, soap making and petroleum jelly cream (Vaseline) production as sustainability initiative. Supervised anti-helminthic treatment provided. Collaborate with government agencies and other partners to improve OVC programs. Rigorous monitoring, supportive supervision and program evaluation done with Knowledge management and experience sharing forum established.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	500,000	0

Narrative:

TNTP's overall approach to prevention will be achieved through addressing the population specific epidemic drivers using the Minimum Prevention Package of Interventions.TNTP will seek to prevent HIV transmission in the general population through select sub-populations of youths (in and out-of-school), married coupes, widows, seperated or divorcees, teachers, PLHIV, OVC and foster parents in its OVC programs as well as community and religious leaders. TNTP will continue to encourage the delay of sexual debut among unmarried youths, the conduct of other youth pprevention activities in the communities with community fora utilized for dialouges where identified drivers of the epidemic will be discussed and slolutions proferred at the community level.TNTP's prevention programming is comprehensive involving an appropriate mix of policy and programmatic interventions that have been

proven effective, with emphasis on combination prevention to address vulnerability and risk factors at different levels.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	415,331	0

Narrative:

GECHAAN mobilized resources and introduced "every village visitation campaign" where communities were mobilized, provided enlightenment on issues of HIV/AIDS including addressing issues of prevention, stigma and discrimination, correcting myths and misconceptions surrounding HIV/AIDS and the need to care for those infected while stressing the importance of HCT. The village visitation campaigns at the grassroots involved community members and thus influenced, challenged and motivated the people to support and become involved in HIV/AIDS prevention activities. As at 2010, a total of 26, 734 individuasl were counseled and tested out of which 9.3% (2,486 individuals) tested positive. An additional 3,012 individuals were counseled and referred for testing at other sites as test kits were not available. TNTP community-based GCT program will utilize both client initiated and provider initiated approaches through the implementation of the HCT Mobile/Outreach Model meant to provide services to populations living in remote areas, highly mobile populations including long distance truck drivers, fiishermen, nomads and other people whose work schedule makes it difficult for them to assess services. TNTP will utilize community-based HCT as a general approach in its effort with HCT schedule begining with planning sessions to determine geographical areas of critical need, ensuring availability of test kits to address demand for services and proper documentation of services provided. Services will be provided in accordance with the national HCT standards using the serial algorithm in accorddance with the National Guidelines for HCT.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	207,974	0

Narrative:

GECHANN and GECHANN-supported CBOs will employ the MPPI prongs and strategies to reach targeted groups within the LGAs. The engaged CBOs will conduct community outreach interventions in target communities to increase understanding of HIV/AIDS problem, address negative norms, and engender community ownership and support of project activities. Small group discussions would be held quarterly in target communities and institutions to explore risk behaviors, increase HIV/AIDS knowledge, address myths and misconceptions, promote counseling and testing, safer sex including condom use and make referrals to STI and HIV services. The CBOs will partner with other USG IPs, organizations and Government agencies within project communities to distribute condoms at these sessions as well as provide mobile counseling and testing services.

Implementing Mechanism Details

Mechanism ID: 14757	**Mechanism Name: Central Condom Procurement**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Central Contraceptive Procurement	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 428,489	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	428,489

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Low levels of use of male and female condoms is one of the major factors for responsible for HIV transmission in Nigeria (NACA 2007).. For both females and males, the proportion of respondents who had ever used condoms peaked between the age ranges of 20 to 29 years and declined thereafter (NARHS 2007). Overall, 16% of the sexually active respondents reported using male condoms as at the time of the survey. Eight percent of females and about a quarter (24%) of males were current condom users. There was a significant variation between the proportion of male current users in urban areas (32%) and in the rural areas (19%) (NARHS 2007). Condoms are more affordable and accessible in the urban areas than the rural areas (NARHS 2007) where just 30% of Nigeria's population lives.
While the awareness of condoms may be high, the usage is still abysmally low and poorly sustained. COP funding for USAID Nigeria has either flat lined or reduced over the past 4 years. This reduces the prospects of expanding our Condoms Programming viz a viz our Sexual Transmission Prevention Portfolio to be robust enough to respond to the HIV Prevention issues of a country as large as Nigeria. Based on a diminishing Prevention Portfolio, the burden on the treatment, care and support portfolio of PEPFAR Nigeria is increasing. As such, a boost in the condom programming component of the STP portfolio will reduce the rate of new infections especially with an array of partners with proven experience

in executing such Prevention Programs in Nigeria and consequently reduce the burden on other portfolios.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors

Increasing gender equity in HIV/AIDS activities and services

Budget Code Information

Mechanism ID:	**14757**		
Mechanism Name:	**Central Condom Procurement**		
Prime Partner Name:	**Central Contraceptive Procurement**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVOP	428,489	0
Narrative:			
Condoms are more affordable and accessible in the urban areas than the rural areas (NARHS 2007) where just 30% of Nigeria's population lives. While the awareness of condoms may be high, the usage is still abysmally low and poorly sustained.			

COP funding for USAID Nigeria has either flat lined or reduced over the past 4 years. This reduces the prospects of expanding our Condoms Programming viz a viz our Sexual Transmission Prevention Portfolio to be robust enough to respond to the HIV Prevention issues of a country as large as Nigeria. Based on a diminishing Prevention Portfolio, the burden on the treatment, care and support portfolio of PEPFAR Nigeria is increasing. As such, a boost in the condom programming component of the STP portfolio will reduce the rate of new infections especially with an array of partners with proven experience in executing such Prevention Programs in Nigeria and consequently reduce the burden on other portfolios.

Implementing Mechanism Details

Mechanism ID: 14768	**Mechanism Name: SUPPLY CHAIN MANAGEMENT SYSTEMS**
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	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 99,265,818	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	99,265,818

Sub Partner Name(s)

3I Infotech	Booz Allen Hamilton	Crown Agents
i+solutions	John Snow, Inc.	Management Sciences for Health
Map International	Northrup Grumman	The Manoff Group
UPS Supply Chain Solutions	Voxiva	

Overview Narrative

OVERVIEW

SCMS will continue pooled procurement and SCMS will implement several big changes in the supply and

delivery of commodities with COP 2012 resources. SCMS will unify PEPFAR supply chains in the next two years and plan the transition of PEPFAR procured commodities to the GON supply system in the next five years.

ONGOING ACTIVITIES
SCMS will continue to pool the procurement of ARV drugs, rapid test kits, cotrimoxazole and will begin to pool CD4 reagents under COP 2012. Savings from previous procurements have been reflected in SCMS's budget. SCMS will continue to provide technical assistance to the GON on nearly every aspect of the supply chain, and SCMS will continue to assist other PEPFAR partners in re-supplying commodities.

NEW ACTIVITIES
Under the 2012 COP, the USG will consolidate over a dozen supply chains into one unified HIV/AIDS supply chain. SCMS will pilot the unified supply chain with the primary focus on making the unified supply system more manageable. Increases in efficiency and a reduction in waste are also expected. The unification will increase the likelihood that the work can be handed to the Government of Nigeria (GON) within five years.

The USG is taking an innovative approach to increasing the amount of quality warehousing in Nigeria. Currently, there is a shortage of warehouse space that meets donor standards. In the COP 2012 period, the SCMS project will work with the GON to engage the private sector in improving existing infrastructure for all public health programs. Funds have been designated for improving existing infrastructure and leveraging private sector funding for new warehouse infrastructure.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Neither**
3. What activities does this partner undertake to support global fund implementation or governance?

Budget Code	Recipient(s) of Support	Approximate Budget	Brief Description of Activities
HTXD	NACA	1502741	strengthen PSM and in country supply chain for GF commodities

OHSS	NACA and Federal Ministry of Health	1790168	strengthen HSS - Coordination, harmonising LMIS & distribution, training in Warehousing & Quantification,

Cross-Cutting Budget Attribution(s)

Human Resources for Health	1,300,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**14768**
Mechanism Name:	**SUPPLY CHAIN MANAGEMENT SYSTEMS**
Prime Partner Name:	**Partnership for Supply Chain Management**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	1,637,102	0

Narrative:

SCMS supports PEPFAR in Nigeria by providing increased access to quality HIV/AIDS commodities. SCMS is supporting the USG by improving PEPFAR implementing partner's supply chains, and by improving the GON's procurement and supply management capabilities. For a full description of systems strengthening activities that benefit care and support programs, please see the Health Systems Strengthening program area narrative.

The budget for SCMS in this program area is for the procurement of commodities including:

Cotrimoxazole and CD4 reagents.

Please note, for the first time, SCMS will be pooling CD4 reagent procurement (starting with half of the required CD4 commodities). It is expected that the pooled procurement will harness the economies of scale offered by purchasing and shipping the goods in bulk, and will improve the overall supply of CD4 reagents in Nigeria.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	307,448	0

Narrative:

SCMS supports PEPFAR in Nigeria by providing increased access to quality HIV/AIDS commodities. SCMS is supporting the USG by improving PEPFAR implementing partner's supply chains, and by improving the GON's procurement and supply management capabilities. For a full description of systems strengthening activities that benefit TB programs, please see the Health Systems Strengthening program area narrative.

The budget for SCMS in this program area is for the procurement of commodities including: Cotrimoxazole and HIV rapid test kits.

SCMS will supply one hundred percent of the forecasted HIV test kit need for HVTB programs, due to the challenges of depending on the GON's supply of test kits. Should the PEPFAR program successfully leverage HIV test kits from other sources, the kits supplied by SCMS will be reduced and the leftover funding will be factored into subsequent COP budget requests.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	385,200	0

Narrative:

SCMS supports PEPFAR in Nigeria by providing increased access to quality HIV/AIDS commodities. SCMS is supporting the USG by improving PEPFAR implementing partner's supply chains, and by improving the GON's procurement and supply management capabilities. For a full description of systems strengthening activities that benefit pediatric care and support programs, please see the Health Systems Strengthening program area narrative.

The budget for SCMS in this program area is for the procurement of commodities including: Cotrimoxazole and CD4 reagents.

Please note, for the first time, SCMS will be pooling CD4 reagent procurement (starting with half of the required CD4 commodities). It is expected that the pooled procurement will harness the economies of scale offered by purchasing and shipping the goods in bulk, and will improve the overall supply of CD4 reagents in Nigeria.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	1,000,000	0

Narrative:

SCMS supports PEPFAR in Nigeria by providing increased access to quality HIV/AIDS commodities. This year SCMS will supply laboratory commodities for the DOD-WRP and other Nigeria programs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	13,977,666	0

Narrative:

In FY 2012, supply chain strengthening through SCMS will be one of the most expansive health systems strengthening efforts by PEPFAR in Nigeria. Until now, the PEPFAR program did not use or invest in the GON supply system because it lacks capacity to safely and reliably store and distribute drugs, and the basic infrastructure and governance challenges seemed insurmountable. Recent changes within GON boosted USG's confidence in GON's ability to handle some supply chain operations being currently fully funded by PEPFAR; with USG adopting the goal of merging PEPFAR and GON supply chains within a 3 to 5 year time frame. GON’s supply chain management capability will be built at the federal and state levels to achieve concrete Partnership Framework goals.

In 2011, PEPFAR partners began maintaining stocks within set limits, to reduce overall cost of inventory in the supply chains. Savings from this measure are reflected in this COP. SCMS will continue to build the capacity of PEPFAR IPs, the GoN and other stakeholders to : resupply commodities, forecast drug needs, create supply plans, procure commodities using international standards, etc.

Major COP-PFIP 2012 activities will include:
A) Unify the 12 implementing partner supply chains into a single PEPFAR supported supply chain, beginning with a pilot. This will also improve performance and reduce overall costs.
B) Visit, monitor and supervise sites jointly with the GON and supporting IP, to provide feedback on supply chain activities and improve site performance.
C) Build on the paper-based Logistics Management Information System by developing and piloting an

electronic LMIS.
D) Improve GON ability to manage HIV/AIDS commodities by partnering with the private sector to construct, operate and maintain a new central medical store for the national program. The PFIP funding embedded in this budget code will go towards the new warehouse PPP.
E) Rennovate the existing central medical store in Lagos as the GON meets specific milestones. The PFIP funding embedded in this budget code will also go towards this activitiy.
F) Standardize supply chain training and offer it nationally to include lab, pharmacy and HCT staff.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMBL	352,500	0

Narrative:

SCMS will procure commodities needed for blood safety programs. Procurement support will include limited quantification assistance, ensuring program managers understand lead times for blood safety products that will be ordered by SCMS, ensuring program mangers understand the level of funds remaining in SCMS for new orders, and ensuring products are NAFDAC registered. Products will be stored and distributed as requested by the blood safety program.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	13,547,561	0

Narrative:

SCMS supports PEPFAR in Nigeria by providing increased access to quality HIV/AIDS commodities. SCMS is supporting the USG by improving PEPFAR implementing partner's supply chains, and by improving the GON's procurement and supply management capabilities. For a full description of systems strengthening activities that benefit HIV counseling and testing programs, please see the Health Systems Strengthening program area narrative.

The budget for SCMS in this program area is for the procurement of HIV rapid test kits. SCMS will ensure that that all procured HIV test kits pass the Nigerian post-market validation process; to ensure the quality of test kits used by PEFPAR clients.

Finally, SCMS will supply one hundred percent of the forecasted HIV test kit need for counseling and testing programs, due to the challenges of depending on the GON's supply of test kits. Should the PEPFAR program successfully leverage HIV test kits from other sources, the kits supplied by SCMS will be reduced and the leftover funding will be factored into subsequent COP budget requests.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	MTCT	1,782,220	0

Narrative:

SCMS supports PEPFAR in Nigeria by providing increased access to quality HIV/AIDS commodities. SCMS is supporting the USG by improving supply chains that are fully managed by PEPFAR implementing partners, and by improving the GON's procurement and supply management capabilities. For a full description of systems strengthening activities that benefit PMTCT programs, please see the Health Systems Strengthening program area narrative.

The budget for SCMS in this program area is for the procurement of commodities including: HIV/AIDS rapid test kits, Cotrimoxazole and CD4 reagents. ARV drugs for PMTCT programs will also be procured and distributed by SCMS; however, these drugs are budgeted for under the HTXD program area.

Please note, for the first time, SCMS will be pooling CD4 reagent procurement (starting with half of the required CD4 commodities). It is expected that the pooled procurement will harness the economies of scale offered by purchasing and shipping the goods in bulk, and will improve the overall supply of CD4 reagents in Nigeria. In addition, SCMS will supply one hundred percent of the forecasted HIV test kit need for PMTCT programs, due to the challenges of depending on the GON's supply of test kits. If the PEPFAR program succeeds in leveraging test kits from other sources, the funding will be factored into subsequent COP budget requests.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	59,772,319	0

Narrative:

SCMS supports PEPFAR in Nigeria by providing increased access to quality HIV/AIDS commodities. SCMS is supporting the USG by improving PEPFAR implementing partner's supply chains, and by improving the GON's procurement and supply management capabilities. For a full description of systems strengthening activities that benefit treatment programs, please see the Health Systems Strengthening program area narrative.

This program area contains funding for ARV procurement as well as for the unification of multiple PEPFAR implementing partners' storage and distribution systems.

PROCUREMENT

The COP 2012 will provide funding for 1st and 2nd line ARV drugs for adult and pediatric patients; as well as ARVs for PMTCT prophylaxis and PREP. The USG require SCMS to procure a greater range of

ARVs if the USG must take up the former CHAI and UNITAID donations (pediatric, second line and PMTCT ARVs).

SUPPLY CHAIN UNIFICATION

The unification will be done in one pilot region, and lesson from this pilot will be used to unify all PEPFAR supply chains in the next two years. This endeavor will better prepare the USG to merge its supply of commodities with the GON's supply chain system. For more information, see the OHSS budget code. Of the budgeted amount of 44,472,319 in COP 12, $15,300,000 is additional funding granted by OGAC for treatment.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	6,263,052	0

Narrative:

SCMS supports PEPFAR in Nigeria by providing increased access to quality HIV/AIDS commodities. SCMS is supporting the USG by improving PEPFAR implementing partner's supply chains, and by improving the GON's procurement and supply management capabilities. For a full description of systems strengthening activities that benefit care and support programs, please see the Health Systems Strengthening program area narrative.

The budget for SCMS in this program area is for the procurement of CD4 reagents. This year for the first time, SCMS will be pooling CD4 reagent procurement (starting with half of the required CD4 commodities). It is expected that the pooled procurement will harness the economies of scale offered by purchasing and shipping the goods in bulk, and will improve the overall supply of CD4 reagents in Nigeria. $2,263,052 was budgeted in COP 12, $4,000,000 was recieved from OGAC as additional funding for treatment

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	240,750	0

Narrative:

SCMS supports PEPFAR in Nigeria by providing increased access to quality HIV/AIDS commodities. SCMS is supporting the USG by improving PEPFAR implementing partner's supply chains, and by improving the GON's procurement and supply management capabilities. For a full description of systems strengthening activities that benefit pediatric treatment programs, please see the Health Systems Strengthening program area narrative.

The budget for SCMS in this program area is for the procurement of commodities including: Cotrimoxazole and CD4 reagents. ARV drugs for pediatric treatment programs will also be procured and distributed by SCMS; however, these drugs are budgeted for under the HTXD program area. Please note, for the first time, SCMS will be pooling CD4 reagent procurement (starting with half of the required CD4 commodities). It is expected that the pooled procurement will harness the economies of scale offered by purchasing and shipping the goods in bulk, and will improve the overall supply of CD4 reagents in Nigeria.

Implementing Mechanism Details

Mechanism ID: 14788	**Mechanism Name: UNICEF**
Funding Agency: U.S. Agency for International Development	Procurement Type: Grant
Prime Partner Name: United Nations Children's Fund	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 179,999	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	179,999

Sub Partner Name(s)

(No data provided.)

Overview Narrative

UNICEF's on-going effort in integrating Child Justice into the Justice Sector Reform has three key components namely: coordination; capacity building; and access to justice. The current project aims to achieve the following: 1) increased sector coordination and development of sectoral policies, legislation and plans in the justice sector; 2) strengthened judiciary training and research capabilities; and 3) increased access to justice and respect for human rights for the vulnerable. In specific, under the result 1, UNICEF plans to facilitate involvement of Social Welfare Sector in the Justice Sector Reform and ensure that child justice issues remain visible, and that social welfare actors who are critical to child justice work are included. UNICEF will work with government and local actors to identify appropriate interdisciplinary

child justice specific coordination mechanisms. This may include a focal point model, sub-groups or child justice advisory groups, all of which would be directly linked to broader justice coordination bodies. Under the result 2, in lieu of setting up and managing separate child justice trainings, UNICEF will work closely with national counterparts, UNODC and other partners to integrate child justice into training curriculum and programmes (both pre-service, in-service phase) of justice, prison and police personnel. The priority will be given to Specialized Children's Units of Police and Family Courts who will be trained on key concepts of child development, effective communication with children, and ethical issues specific to children and others. Under result 3, UNICEF will support child friendly legal assistance and establishing specialized child units within the Nigerian Police Force.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **No**

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	80,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**14788**
Mechanism Name:	**UNICEF**

Prime Partner Name:	United Nations Children's Fund		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	179,999	0
Narrative:			
increased sector coordination and development of sectoral policies, legislation and plans in the justice sector; 2) strengthened judiciary training and research capabilities; and 3) increased access to justice and respect for human rights for the vulnerable			

Implementing Mechanism Details

Mechanism ID: 14833	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14836	**TBD: Yes**
REDACTED	

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	GAP	GHP-State	GHP-USAID	Central GHP-State	Cost of Doing Business Category Total
Computers/IT Services		887,933			887,933
ICASS		470,908			470,908
Management Meetings/Professional Developement		677,461			677,461
Non-ICASS Administrative Costs		2,476,859			2,476,859
Staff Program Travel		1,236,758			1,236,758
USG Staff Salaries and Benefits	0	3,453,427	0		3,453,427
Total	**0**	**9,203,346**	**0**	**0**	**9,203,346**

U.S. Agency for International Development Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services		GHP-State		887,933

ICASS		GHP-State		470,908
Management Meetings/Professional Developement		GHP-State		677,461
Non-ICASS Administrative Costs		GHP-State		2,476,859

U.S. Department of Defense

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Central GHP-State	Cost of Doing Business Category Total
Computers/IT Services		50,000			50,000
ICASS		50,000			50,000
Indirect Costs		0			0
Institutional Contractors		2,177,632			2,177,632
Management Meetings/Professional Developement		0			0
Non-ICASS Administrative Costs		22,257			22,257
Staff Program Travel		80,000			80,000
USG Staff Salaries and Benefits		1,026,377			1,026,377
Total	**0**	**3,406,266**	**0**	**0**	**3,406,266**

U.S. Department of Defense Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services		GHP-State		50,000
ICASS		GHP-State		50,000

Indirect Costs		GHP-State		0
Management Meetings/Professional Developement		GHP-State		0
Non-ICASS Administrative Costs		GHP-State		22,257

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Central GHP-State	Cost of Doing Business Category Total
Capital Security Cost Sharing		947,519			947,519
Computers/IT Services		1,250,000			1,250,000
ICASS		2,500,000			2,500,000
Management Meetings/Professional Developement		600,000			600,000
Non-ICASS Administrative Costs		7,166,562			7,166,562
Staff Program Travel		1,785,000			1,785,000
USG Staff Salaries and Benefits	3,056,000	3,694,919			6,750,919
Total	**3,056,000**	**17,944,000**	**0**	**0**	**21,000,000**

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		GHP-State		947,519

Computers/IT Services		GHP-State		1,250,000
ICASS		GHP-State		2,500,000
Management Meetings/Professional Developement		GHP-State		600,000
Non-ICASS Administrative Costs		GHP-State		7,166,562

U.S. Department of State

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Central GHP-State	Cost of Doing Business Category Total
ICASS		18,298			18,298
Non-ICASS Administrative Costs		300			300
Staff Program Travel		11,402			11,402
USG Staff Salaries and Benefits		170,000			170,000
Total	**0**	**200,000**	**0**	**0**	**200,000**

U.S. Department of State Other Costs Details

Category	Item	Funding Source	Description	Amount
ICASS	ICASS	GHP-State	Support Services &equipment	18,298
Non-ICASS Administrative Costs	Printing	GHP-State	Supplies	300