Nigeria

Operational Plan Report

FY 2013

Note: Italicized sections of narrative text indicate that the content was not submitted in the Lite COP year, but was derived from the previous Full COP year. This includes data in Technical Area Narratives, and Mechanism Overview and Budget Code narratives from continued mechanisms.

Operating Unit Overview

OU Executive Summary

I. 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 and 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 various African countries. The country has 3.46 million HIV-positive individuals and constitutes the third greatest burden of HIV/AIDS care and treatment worldwide. Adding to this burden are the estimated 2.19million children orphaned by HIV/AIDS.[1] Nigeria also has one of the highest tuberculosis (TB) burdens in the world (311/100,000 population[2]) and the largest TB burden in Africa. Many TB cases go undetected, despite increasing TB detection rates and TB program coverage. This situation results in significant challenges for the HIV/AIDS response due to the high rates of TB/HIV co-infection.

Since reporting 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[3], but significantly higher rates exist among key populations, 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)[4]. Heterosexual transmission accounts for up to 95 percent of HIV infections. Women account for close to 60 percent of all adults living with HIV.[5]

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 a maximum of 12.7 percent in Benue state[6]. 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[7]. Four of the states located in the South-South geo-political zone had seven percent or higher prevalence, while no

[1] United Nations General Assembly (UNGASS) Global AIDS Response Country Progress Report, Nigeria, 2012. Available at: http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/Nigeria%202012%20GARPR%20Report%20Revised.pdf
[2] World Health Organization (WHO) Global Tuberculosis Report, 2009.
[3] National HIV/AIDS and Reproductive Health Survey (NARHS), 2007.
[4] Integrated Biological and Behavioral Surveillance Survey, 2007
[5] UNGASS, 2010.
[6] Federal Ministry of Health (FMOH) ANC Report, 2010.
[7] FMOH, 2008.

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 remain targets for key prevention interventions.

II. PEPFAR Focus in 2013

The United States Government (USG) programmatic approach for COP13 will focus on expanding service delivery and 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 PFIP envisioned a “straight lining” of the USG contribution to the National Response, while GON contributions expanded from now through 2015. While, the GON has fallen short in meeting funding commitments under the PEPFAR Implementation Framework signed in August 2010, there have important advancements made in GON contributions both at the Federal and State levels. The USG will provide technical assistance to the Government of Nigeria (GON) to continue to shift its focus to state and local levels of government to improve capacity in planning, management, and leadership of HIV/AIDS and TB programs. Given the federal structure, it is imperative to work at State level and mobilize State resources in the fight against AIDS. In 2013, the USG will roll out the rationalization of comprehensive treatment activities. The overall vision for rationalization is to improve programmatic outcomes through accountability and create a more manageable package of clinical services to transition to the GON. It is envisioned that this effort will: (1) increase efficiencies through reduction of programmatic overlap and duplication; (2) enhance the USG’s ability to coordinate—both for USG and GON—service provision among implementing partners (IPs) and other stakeholders; (3) increase the potential for local ownership via improved emphasis on site graduation and enhanced participation and coordination with local- and state-level structures. The rationalization process is a more business-like approach to implementation with greater emphasis on “real costs”, a better understanding of cost-per-patient and cost-per site, and an opportunity to identify ways in which to reduce costs to expand services with existing funds.

Along with the rationalization process, we will shift our programmatic direction to focus on the expansion

and scale-up of HIV treatment, prevention of mother-to-child transmission of HIV (PMTCT), services to key populations and care and support for orphans and vulnerable children (OVC). This shift represents an alignment of PEPFAR-funded activities with the key areas of emphasis in the recently awarded Global Fund Phase Two Grant. Activities for key populations will be regionalized to focus on a select number of states. A critical component of the redesign and scale up of the key populations' portfolio includes a comprehensive, multi-stakeholder implemented mapping exercise. This exercise will inform the programmatic and geographic direction of the program within the selected states. Further, the OVC portfolio will continue its transition towards a regionalized platform strategically focused on eighteen states where the mix of HIV prevalence and rates of OVC are highest. $114m of pipeline funds will be programmed in 2013 to bolster these primary intervention areas and to offset reductions in other program areas.

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 2013, 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 colleagues 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.

III. Progress and Future

1. 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 review occurred after presentation of the National Implementation Plan 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 Nigerian Secretary to the Government of the Federation (SGF) 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 the 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. While continuing to move in this direction, we will continue to scale-up services in COP 2013 as unmet need for those services remains high and are critical if Nigeria is to reach the tipping point in the epidemic. The primary USG policy objective involves supporting the GON by strengthening the capacity and systems of both the GON and IPs in the design, implementation, and coordination (including monitoring and evaluation) of effective evidence-informed programs at national and sub-national levels. We will continue to support decentralization of direct health service provision. Decentralization remains 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 remains integral to expansion of access to quality HIV services and integration of these services with other priority health interventions.
Results for Development (R4D) has been contracted by Office of the Global AIDS Coordinator (OGAC) to work with the PEPFAR Nigeria team and the GON to develop ways to better monitor financial commitments made to the National Response. While the GON implements a bi-annual National AIDS Spending Assessment (NASA), the results are received too late for decision making. One option under study is routine expenditure data collection that feeds into a lighter version of the NASA that could be done every 6 months.

2. Country Ownership

Nigerian President Goodluck Ebele Jonathan committed to achieving universal access to HIV prevention, treatment, care, and support at the 2011 General Assembly High-Level Meeting on HIV/AIDS in New York. President Jonathan stated that the GON needed to commit to 50-percent of HIV/AIDS funding. Although an impressive commitment, the challenge remains putting that pledge into action. Most GON funding for strategic planning and program interventions comes from development partners. This situation is not sustainable, particularly at a time of global economic crisis. Early in 2013, President Jonathan requested the National Agency for the Control of AIDS (NACA) to develop a two year action plan that would address the shortfall in AIDS funding and make significant strides in beating the epidemic.

This plan, dubbed The President's Emergency Response Plan (PERP) is under development and is likely to be presented in the next few months. While a positive development, there is no guarantee the plan will be fully funded or that the earmarked funding will actually be released.

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. Organizational and technical capacity among government offices and staff remains low at the state and LGA levels. Insufficient staff, significant staff turn-over, poorly defined and over-lapping job descriptions, and insufficient resources to carry out key functions (e.g., coordination, planning, monitoring, and reporting) persists as challenges facing state and LGA level offices. Staff members 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. Most reporting lines remain unclear and confusing, with poor data gathering and analysis on HIV/AIDS. The effectiveness of HIV/AIDS programming has proven insufficient.

COP 13 activities reflect the objectives outlined in the NSF2 and the NSHDP and support greater country ownership and sustainability. COP 13 activities while aligned with the commitments agreed upon by the USG, GON, and other PFIP stakeholders, seek to lay the ground work to rapidly scale up key services. The 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 in preparing for COP 13. The USG engaged in specific dialogue with the GON at the national level, via NACA, the Ministry of Defense, and the Ministry of Health (MOH) (specifically the National TB and Leprosy Control Program, the HIV AIDS Division and the Minister of State for Health's office), the MWASD, National Agency for Food and Drug Administration and Control (NAFDAC), the National Planning Commission (NPC), the SGF, and NPHCDA. USG engagement occurs at a variety of levels. Technical-level engagement with GON occurs formally through National Technical Working Groups (TWG), allowing USG officials to incorporate GON priorities into the COP process.

U.S. officials continue to improve upon coordination with other donors, most notably the Global Fund (GF), ensuring complementary efforts and avoiding duplication. The meeting organized by the Office of the Global AIDS Coordinator (OGAC) in May 2012 helped to concretize the relationship. A follow-on meeting planned for this year will include representatives from UNAIDS and will focus on financial investments for HIV and AIDS, specific programmatic and technical areas and develop a roadmap for continued collaboration. 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 has been accomplished through joint planning and analysis in close collaboration with the NPHCDA as well as the GF under the Phase II Grants. Appropriate sites are identified to limit overlap and duplication in efforts. Fifty-four USG supported treatment sites, serving over 67,000 patients have been turned over to NACA who will provide on-going support using GF resources. This effort represents a measurable success in country ownership for the USG. The GF has earmarked an additional $121m in interim funding and the USG is working closely with NACA and the GF to determine the best usage of those funds. 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.

Numerous challenges and opportunities exist regarding 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 monitor, coordinate, and oversee programmatic efforts more effectively. As outlined in the PFIP, the USG remains 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 (CSOs) 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), and 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 organizations remain 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.

In addressing these numerous challenges, the USG continues to identify opportunities to transfer its service delivery and capacity building efforts to local entities. Substantial progress has occurred with several projects designed exclusively for local entities commencing under COP12 and continuing in COP 13. 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 13, the USG will hire an individual whose portfolio will focus on 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 rationalized comprehensive treatment efforts geographically with a “Lead IP” identified for each state. Under rationalization, the USG seeks to prevent overlap of activities, improve standards of care, and 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.

3. Trajectory in FY 2014

PFIP projections show donor resources for Nigeria for 2014 as remaining flat while those of the GON should grow. The USG will seek more accurate data on GON resources expended on HIV and AIDS in Nigeria in 2014through implementation of Expenditure Analysis of PEPAR resources, disaggregated by State, and through the work of Results for Development in quantifying public expenditure on HIV and AIDS. These mechanisms will serve as tools for use with GON stakeholders at all levels and will improve GON resource allocation for HIV and AIDS programming.

The USG will continue to increase the number of women receiving PMTCT and the number of people on treatment by improving the efficiency and effectiveness of its programs and by transferring resources from other programs to these priority areas. Rapid and massive scale up of these programs will be undertaken in the high prevalence and high burden states to ensure we are reaching the maximum number of people requiring services.

The USG team will continue to work closely with the GF and UNAIDS to ensure proper coordination of programs that working synergistically together. Designating and handing over treatment sites to NACA for follow up with GF support is one method employed to created a strengthen and unified treatment program. The USG will work with UNAIDS on the development of the investment case for Nigeria as this will highlight the importance of funding the National Response at an appropriate level, an important outcome of the PFIP.

IV. Program Overview

1. PMTCT

The USG PMTCT portfolio has increased engagement with state and local government through the Lead IP approach 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 (MNCH) service outlets and increasing private sector engagement for PMTCT service expansion are the primary strategies. PEPFAR funds for PMTCT will complement USAID's Child Survival and MNCH funding to support the establishment of a MNCH/FP/RH platform in more than one thousand additional facilities. During FY 13 all lead IPs will carry out detailed assessments of all health care facilities in their high prevalence states and create rapid scale up plans that will be implemented in the second half of the fiscal year and FY 14.

The USG has leveraged resources for PMTCT commodities, including laboratory test kits for HIV testing, reagents for Early Infant Diagnosis (EID) and antiretroviral (ARV) drugs for prophylaxis. In 2011, about 17.1% percent of HIV-positive pregnant women received anti-retroviral therapy (ART) to reduce the risk of mother-to-child transmission (MCT).[8] The USG will work to provide PMTCT services in line with the national guidelines at all centers offering ANC services in the high-prevalence, high- burden states. We will emphasize training and technical assistance to the GON, especially in the fields of quality assurance, quality control, and logistics management. Use of a single, fixed dose regiment will serve to streamline PMTCT services and improve adherence rates.

The USG will continue efforts to expand coverage of PMTCT services to pregnant women in FY 2013. The USG will continue to dialogue with other stakeholders, particularly the United Nations Children's Fund (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 the presence of 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 UNICEF and other donors, and the GON plans for the elimination of MCT through the Global Fund. We will emphasize saturation of services in the highest-prevalence, highest-burden states.

2. Treatment Scale-up

Treatment activities will include 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

[8] United Nations General Assembly (UNGASS) Global AIDS Response Country Progress Report, Nigeria, 2012. Available at: http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/Nigeria%202012%20GARPR%20Report%20Revised.pdf.

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. In COP13, we will support fewer treatment regimens based on the recommendations of the November 2012 OGAC ART Assessment Team. Rationalization of implementing partners, harmonization of package of care and treatment services for uniform quality of services rendered, 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. Scale up of Pediatric treatment services through increase identification of HIV infected children and early initiation of eligible children as well as improve retention of mother-infant pairs remains a priority in FY 2013. 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. We will also encourage partners to use the provider-initiated approach (PITC) for all patients accessing health facilities. HIV-exposed children under 18 months of age will be identified, placed on co-trimoxazole preventive therapy and linked to early infant diagnosis services. HIV exposed infants confirmed to be infected will be commenced on ART in accordance with the National guidelines.. 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 needs; 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. We will simplify drug procurement and logistics by reducing the number of treatment regimens supported by the USG.

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; 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. In order to ensure that children have increased access to HIV testing which is the entry point for HIV care and treatment, the USG will increase the capacity of health care workers to carry out PITC at the multiple points where children access other services. Access to EID services will be improved by supporting the GON effort in scaling up the National EID network through

capacity building of health care workers and integration of EID services to existing and new health facilities offering maternal and child/PMTCT and HIV treatment services not already in the network, support for laboratory reagents and dried blood spot (DBS) bundle kits for DNA PCR.

Phased transition of first-line ARV procurement to the Ministry of Health (MOH) remains an important goal in the PFIP and COP 2013. 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. The 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.

The USG will continue to pool ARV procurements through the Partnership for Supply Chain Management System (SCMS) in FY 2013. 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 FY2013 is the expansion and enhancement of TB-HIV sites at the state and local levels. The USG will contribute medical equipment including GeneXpert machines, testing commodities, and training to support treatment and testing sites. The USG will continue provider-initiated routine HIV testing in the TB Directly Observed Treatment Short-Course (TB DOTS) settings to increase access greatly 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. We will incorporate data from the USG-supported national MDR-TB and HIV survey into evidence-based service provision in the TB-HIV program.

3. HIV Testing and Counseling and Other Prevention Programs

The GON has identified prevention of new infections as the focus of the national HIV/AIDS response. Prevention activities include 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 perceives themselves as having no or low risk of HIV infection.[9] The USG Sexual Prevention strategic focus

[9] NARHS, 2007

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) focus behavioral interventions 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 remain a source of transmission for HIV and other pathogens, despite gains by the National Blood Transfusion Service (NBTS) since 2007. In FY 2013, 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. While COP13 funds for this budget code have been reduced from previous years, $1.6m in pipeline funding is available to support these activities and is expected to fill in for the shortfall.

We will integrate prevention activities 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. We will employ multiple HCT strategies (provider initiated testing and counseling, mobile HCT, couples HCT, and door-to-door HCT) to enable target populations to know their HIV status as a launch-pad into prevention, care, and treatment services. The total HTC targets for FY13 and FY14 on P11.1D (5,274,593 and 6,099,683 respectively) are targets for testing in all settings (HTC, PMTCT and TB settings) of which the HTC component is expected to be 2,891,718 in both FY13 & FY14. This later component was set at a cost per target of $2.30 (excluding the cost of test kits) based on recent expenditure analysis findings. FY14 targets will be reviewed after APR13.

The USG will continue to prioritize interventions that address focused prevention, treatment and care programs for key populations including men who have sex with men (MSM), injecting drug users and sex workers and their clients. Nigeria has a mixed HIV epidemic, and these vulnerable communities generally have markedly higher rates of HIV infection. USG programmatic activities for key populations will incorporate protecting rights and reducing the barriers of stigma and discrimination faced by these groups. Comprehensive HIV Treatment partners who are Lead IPs in CDC supported states receive funds for Key Populations activities as prime partners. They provide sub-awards to partners that are specialized and highly experienced in reaching these populations such as Population Council, Excellence Community Education and Welfare Scheme (ECEWS), and the International Center for Advocacy for the Rights to Health (ICARH). These partners provide services to these key populations and ensure that they are linked to clinical services such as PMTCT, ART, STI Management, and Hepatitis through their network of health facilities that have been trained to provide these services to key populations without stigma or discrimination. Other activities for key populations will be regionalized to focus on a select

number of states. A critical component of the redesign and scale up of the key populations' portfolio includes a comprehensive, multi-stakeholder (USG, DFID and World Bank) implemented mapping exercise. This exercise will inform the programmatic and geographic direction of the program within the selected states.

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 implementing the 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 25 percent to 50 percent in 2015.

A critical shortage of health care workers exists, with significant disparities across zones.[10] 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 among government, civil society, and communities to consolidate, manage, and focus CCW services. PEPFAR Nigeria has been supporting various levels of salary support for health care workers and will develop a transition and sustainability plan to phase out these investments. The rationalization process will help to highlight the differences in support currently provided by the IPs and will enable us to develop a more uniform plan for phasing this out.

5. Other Programs

The USG and GON will establish a basic package of services for HIV-positive people and their families.

[10] WHO Global Atlas of the Health Workforce, 2008.

We will promote care services for all HIV-positive patients identified in USG programs in FY 2013, including provision of 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 and use of training materials and increase focus on adherence counseling and pooled commodity procurements.

We will seek to link children of HIV-infected adults currently in care 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. Realizing this programmatic approach will be done through a regionalized platform strategically focused on eighteen states where the mix of HIV prevalence and rates of OVC are highest.

In FY 13 the USG created a Gender Technical Working Group (TWG) to focus increased attention on gender as a cross cutting issue. While many of our programs take gender into consideration we have not articulated this well. In April 2013, PEPFAR staff were trained in gender issues by the OGAC Gender TWG. Our newly trained staff will step down this training to our IPs over the coming months. In addition, the USG is exploring options for hiring a locally engaged staff member who will focus on gender integration. The position description of an existing FTE is likely to be reconfigured to meet this need as it is not possible to add additional positions at this time due to NSD 38 considerations and space at the Embassy.

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. COP13 activities in laboratory support will see a radical shift in approach by the adoption of a standard laboratory package in line with a public health approach and as recommended by the November 2012 Assessment Team. This approach is also being adopted by the GON through the implementation of the Phase 2 Global Fund Grant.

In COP 13, CD4 procurement will be pooled which will significantly reduce costs. Distribution will be through the unified supply chain where available which will further reduce costs. This along with the standardized laboratory package and the utilization of $6.5m of pipeline funds will ensure adequate resources for the planned expansion.

The continued development of a five-year National Laboratory Strategic Plan will remain important in identifying nationwide needs and service gaps in FY 2013. 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 has contributed to establishment of an African Center of Laboratory Equipment Maintenance (ACLEM) to support maintenance and certification of laboratory equipment.

Collection and analysis of strategic information remain key over-arching goals. 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 2013 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. The USG will consider funding an AIDS Indicator Survey in the focus States rather than the National DHS to provide key data for the program.

V. GHI and Program Integration

USG programmatic directions are inter-related and support GHI principles. For example, the focus on improving PHCs will ensure 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 PMTCT services as women seek ante-natal, family planning, 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. Further, COP13 activities will support the GON's Saving One Million Lives Initiative (SOML). Much of the strategic planning to support SOML was done in collaboration with McKinsey & Company, the GON and OGAC. Our activities will be directly aligned with SOML efforts through the scale up of PMTCT.

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 has transferred activities to indigenous organizations with an increased focus on government partners at federal and PHC levels. USAID has also increased its focus on government partners by transitioning fifty-four comprehensive treatment sites.

PEPFAR activities leverage other USG resources as well as those of other donors. For example, integration activities have begun with the President's Malaria Initiative (PMI), initially focusing on two states. Specifically, PEPFAR and PMI will consolidate supply chains to deliver critical commodities to primary health care facilities. After the initial pilot testing, the consolidated supply chain will be used to deliver a full supply of key maternal and child health-related commodities to several states. This joint effort between PEPFAR, PMI and USAID's reproductive health program is targeted at increasing ANC attendance, PMTCT service uptake and other health outcomes. PEPFAR will continue to leverage reproductive health supplies from the Federal Ministry of Health (supported by USAID, DFID and UNFPA) and collaborate with social marketing programs to improve condom availability. Finally, the USG will continue to use USAID-specific TB funding in combination with PEPFAR resources to support the National TB Program in treating 2.6 million new sputum smear positive TB cases and 57,200 MDR cases. New areas of collaboration in 2013 between the national TB program and PEFPAR include improving isoniazid prophylaxis and HIV testing through better joint planning and coordinating supply logistics, which will leverage commodity supplies procured by the FMOH.

Population and HIV Statistics

Population and HIV Statistics				Additional Sources		
	Value	Year	Source	Value	Year	Source
Adults 15+ living with HIV	3,000,000	2011	AIDS Info, UNAIDS, 2013			

Adults 15-49 HIV Prevalence Rate	04	2011	AIDS Info, UNAIDS, 2013			
Children 0-14 living with HIV	440,000	2011	AIDS Info, UNAIDS, 2013			
Deaths due to HIV/AIDS	210,000	2011	AIDS Info, UNAIDS, 2013			
Estimated new HIV infections among adults	270,000	2011	AIDS Info, UNAIDS, 2013			
Estimated new HIV infections among adults and children	340,000	2011	AIDS Info, UNAIDS, 2013			
Estimated number of pregnant women in the last 12 months	6,332,000	2010	UNICEF State of the World's Children 2012. Used "Annual number of births as a proxy for number of pregnant women.			
Estimated number of pregnant women living with HIV needing ART for PMTCT	230,000	2011	WHO			
Number of people living with HIV/AIDS	3,400,000	2011	AIDS Info, UNAIDS, 2013			
Orphans 0-17 due to HIV/AIDS	2,200,000	2011	AIDS Info, UNAIDS, 2013			
The estimated number of adults and children with advanced HIV infection (in need of ART)	1,422,653	2011	WHO			
Women 15+ living with HIV	1,700,000	2011	AIDS Info, UNAIDS, 2013			

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

How is the USG providing support for Global Fund grant proposal development?

Currently there are no grants under development; however, the USG was extensively involved in the development of both the malaria (signed March 2012) and HIV-TB (signed December 2012) Round 2 grants.

Are any existing HIV grants approaching the end of their agreement (Phase 1, Phase 2, NSA, CoS, or RCC) in the coming 12 months?
No

Redacted

To date, have you identified any areas of substantial duplication or disparity between PEPFAR and Global Fund financed programs? Have you been able to achieve other efficiencies by increasing coordination between stakeholders?
No

Public-Private Partnership(s)

Created	Partnership	Related Mechanism	Private-Sector Partner(s)	PEPFAR USD Planned Funds	Private-Sector USD Planned Funds	PPP Description
2012 COP	Central Medical Store Upgrades PPP		TBD			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. USG

						resources are likely to go towards cold storage upgrades or distribution costs.
2012 COP	New Pharmaceutical Warehouse PPP		TBD			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
2012 COP	Workplace HIV Prevention		TBD			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.
2012 COP	Zonal Reference Laboratories		Abbott Laboratories			This PP is to support the establishment of Regional Reference Laboratories in the 6 geopolitical zones of the country, to provide specialized clinical and public health laboratory services to the labs within the zonal networks. The zonal reference labs will be linked to an apex lab – a National Reference lab to

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

						management, and lab process standardization.

Surveillance and Survey Activities

Surveillance or Survey	Name	Type of Activity	Target Population	Stage	Expected Due Date
Survey	AIDS Indicator Survey	Population-based Behavioral Surveys	General Population	Planning	10/01/2013
Survey	Ante-natal Care Sentinel Survey	Sentinel Surveillance (e.g. ANC Surveys)	Pregnant Women	Planning	10/01/2013
Survey	ART Costing Study	Evaluation	General Population	Planning	12/01/2013
Survey	ART Impact Assessment and Operational Research	Qualitative Research	Other	Planning	06/01/2014
Survey	Evaulation of Intensive Case Finding of TB among PLHIV	Evaluation	Other	Planning	06/01/2014
Survey	HIV Drug Resistance among ART Naive Clients	HIV Drug Resistance	Pregnant Women	Planning	10/01/2013
Survey	HIV Drug Resistance threshold survey	HIV Drug Resistance	General Population, Pregnant Women	Planning	10/01/2013
Survey	HIV False Recent Rate (FRR) Survey	Recent HIV Infections	Other	Planning	10/01/2013
Surveillance	HIV Incidence Study	Recent HIV Infections	Pregnant Women	Implementation	09/01/2013
Survey	Integrated Biobehavioural survey	Behavioral Surveillance among	Female Commercial Sex Workers,	Planning	09/01/2013

		MARPS	Injecting Drug Users, Male Commercial Sex Workers, Men who have Sex with Men		
Surveillance	Integrated, Biological and Behavioural Surveillance (IBBSS)	Behavioral Surveillance among MARPS	Female Commercial Sex Workers	Development	09/01/2013
Survey	Military Applicant Study	Population-based Behavioral Surveys	General Population, Uniformed Service Members	Planning	06/01/2013
Surveillance	Monitoring of HIV drug resistance among patients on first line ART	HIV Drug Resistance	Other	Planning	10/01/2013
Survey	NARHS+	Population-based Behavioral Surveys	General Population	Implementation	06/01/2013
Survey	National Adult HIV Care and Treatment Program Outcome Evaluation	Evaluation	General Population	Implementation	05/01/2013
Survey	National AIDs and Reproductive Health Survey +	Population-based Behavioral Surveys	Female Commercial Sex Workers, General Population, Migrant Workers, Mobile Populations, Street Youth,	Development	06/01/2013

			Youth		
Survey	National Demographic Health Survey	Population-based Behavioral Surveys	General Population	Planning	07/01/2013
Surveillance	National HIV Incidence Survey	Recent HIV Infections	General Population	Development	09/01/2013
Survey	NDHS	Population-based Behavioral Surveys	General Population	Development	12/01/2013
Survey	RV329: The African Cohort Study (AFRICOS)	Evaluation	Other	Planning	12/01/2013
Survey	RV352: An Evaluation of HIV and Malaria Co-Infection in Two Military Hospitals	Evaluation	Other	Planning	12/01/2013
Surveillance	Scale up Monitoring for ART Resistance during Treatment in Nigeria (SMART-N)	HIV Drug Resistance	General Population	Development	06/01/2013
Surveillance	Testing Utility of PMTCT Data as Alternative to HIV Sero-Prevalence Sentinel Survey Data	Evaluation of ANC and PMTCT transition	Pregnant Women	Development	06/01/2013

Budget Summary Reports

Summary of Planned Funding by Agency and Funding Source

Agency	Funding Source			Total
	GAP	GHP-State	GHP-USAID	
DOD		8,720,031		**8,720,031**
HHS/CDC	2,868,591	164,179,432		**167,048,023**
HHS/HRSA		400,000		**400,000**
State		303,000		**303,000**
State/AF		300,000		**300,000**
USAID		281,843,227		**281,843,227**
Total	**2,868,591**	**455,745,690**	**0**	**458,614,281**

Summary of Planned Funding by Budget Code and Agency

Budget Code	Agency							Total
	State	DOD	HHS/CDC	HHS/HRSA	State/AF	USAID	AllOther	
HBHC		400,277	16,450,015			11,108,899		**27,959,191**
HKID			4,431,395	400,000	300,000	30,561,500		**35,692,895**
HLAB		1,135,437	15,658,046			23,901,305		**40,694,788**
HMBL		21,196	3,017,240			47,587		**3,086,023**
HMIN		22,615	286,796			1,587,277		**1,896,688**
HTXD		43,459	0			88,045,796		**88,089,255**
HTXS		1,213,148	48,257,373			32,703,831		**82,174,352**
HVAB		41,250	712,313			829,227		**1,582,790**
HVCT		127,842	4,169,730			19,863,803		**24,161,375**
HVMS	303,000	3,776,268	12,872,322			3,481,072		**20,432,662**
HVOP		305,033	5,707,172			10,845,976		**16,858,181**
HVSI		350,844	5,788,338			5,233,868		**11,373,050**
HVTB		150,409	3,609,411			3,756,384		**7,516,204**
MTCT		563,482	23,646,907			24,865,695		**49,076,084**
OHSS		359,764	12,826,737			18,001,222		**31,187,723**

PDCS		60,702	2,594,661			1,883,015		**4,538,378**
PDTX		148,305	7,019,567			5,126,770		**12,294,642**
	303,000	**8,720,031**	**167,048,023**	**400,000**	**300,000**	**281,843,227**	**0**	**458,614,281**

National Level Indicators

National Level Indicators and Targets

Redacted

Policy Tracking Table

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: 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	Consistent	The	The	JHU.CCP/K	Part of the

	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.	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 professionals in an approved CMLE program, as a result licensure of lab professionals is not based on evidence of completeion of CMLE program.	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 Lab professionals manadatory and the use of CMLE credit as prerequisite for licensure.	MLSCN has reviewed and approved the Policy which is called Continuing Professional Development Policy	4Health 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	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
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: 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	1. Support technical capacity building for organizations and institutions that address the violation of the human rights of vulnerable populations especially of PLHIV.	

				national and state levels 2. Wide disseminati on of the bill to all stakeholder s when the law is passed.	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						

Technical Areas

Technical Area Summary

Technical Area: Care

Budget Code	Budget Code Planned Amount	On Hold Amount
HBHC	27,959,191	0
HKID	35,692,895	0
HVTB	7,516,204	0
PDCS	4,538,378	0
Total Technical Area Planned Funding:	**75,706,668**	**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	40,694,788	0
HVSI	11,373,050	0
OHSS	31,187,723	0
Total Technical Area Planned Funding:	**83,255,561**	**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	20,432,662	0
Total Technical Area Planned Funding:	**20,432,662**	**0**

Summary:
(No data provided.)

Technical Area: Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
HMBL	3,086,023	0
HMIN	1,896,688	0
HVAB	1,582,790	0
HVCT	24,161,375	0
HVOP	16,858,181	0
MTCT	49,076,084	0
Total Technical Area Planned Funding:	**96,661,141**	**0**

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	88,089,255	0
HTXS	82,174,352	0
PDTX	12,294,642	0
Total Technical Area Planned Funding:	**182,558,249**	**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	2013	Justification
P1.1.D	P1.1.D Percent 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 with known HIV status (includes women who were tested for HIV and received their results)	2,012,702	
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	74,736	
	Number of HIV-	93,421	

	positive pregnant women identified in the reporting period (including known HIV-positive at entry)		
	Life-long ART (including Option B+)	37,368	
	Maternal triple ARV prophylaxis (prophylaxis component of WHO Option B during pregnancy and delivery)	29,895	
	Maternal AZT (prophylaxis component of WHO Option A during pregnancy and deliverY)	4,484	
	Single-dose nevirapine (with or without tail)	2,989	
	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)		
	Sum of regimen type disaggregates	74,736	
	Sum of New and		

	Current disaggregates		
P6.1.D	Number of persons provided with post-exposure prophylaxis (PEP) for risk of HIV infection through occupational and/or non-occupational exposure to HIV.	5,000	Redacted
	By Exposure Type: Occupational	235	
	By Exposure Type: Other non-occupational	1,970	
	By Exposure Type: Rape/sexual assault victims	2,795	
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	710,611	
P8.1.D	P8.1.D Number of the targeted population reached with	n/a	Redacted

	individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the 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	180,000	
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	60,000	

	prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence 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	492,857	
	By MARP Type: CSW	98,283	
	By MARP Type: IDU	0	
	By MARP Type: MSM	91,982	
	Other Vulnerable Populations	302,594	
	Sum of MARP types	492,859	
P11.1.D	Number of individuals who received T&C	5,274,593	Redacted

	services for HIV and received their test results during the past 12 months		
	By Age/Sex: <15 Male	81,750	
	By Age/Sex: 15+ Male	1,973,700	
	By Age/Sex: <15 Female	122,625	
	By Age/Sex: 15+ Female	3,073,268	
	By Sex: Female	3,969,836	
	By Sex: Male	1,304,756	
	By Age: <15	204,375	
	By Age: 15+	5,070,218	
	By Test Result: Negative		
	By Test Result: Positive		
	Sum of age/sex disaggregates	5,251,343	
	Sum of sex disaggregates	5,274,592	
	Sum of age disaggregates	5,274,593	
	Sum of test result disaggregates		
C1.1.D	Number of adults and children provided with a minimum of one care service	3,212,944	Redacted
	By Age/Sex: <18 Male	389,177	
	By Age/Sex: 18+ Male	896,001	
	By Age/Sex: <18 Female	583,765	

	By Age/Sex: 18+ Female	1,344,001	
	By Sex: Female	1,927,766	
	By Sex: Male	1,285,178	
	By Age: <18	972,942	
	By Age: 18+	2,240,002	
	Sum of age/sex disaggregates	3,212,944	
	Sum of sex disaggregates	3,212,944	
	Sum of age disaggregates	3,212,944	
C2.1.D	Number of HIV-positive individuals receiving a minimum of one clinical service	1,173,523	Redacted
	By Age/Sex: <15 Male	21,409	
	By Age/Sex: 15+ Male	448,000	
	By Age/Sex: <15 Female	32,113	
	By Age/Sex: 15+ Female	672,001	
	By Sex: Female	704,114	
	By Sex: Male	469,409	
	By Age: <15	53,522	
	By Age: 15+	1,120,001	
	Sum of age/sex disaggregates	1,173,523	
	Sum of sex disaggregates	1,173,523	
	Sum of age disaggregates	1,173,523	
C2.2.D	C2.2.D Percent of	81 %	Redacted

	HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis		
	Number of HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis	947,481	
	Number of HIV-positive individuals receiving a minimum of one clinical service	1,173,523	
C2.3.D	C2.3.D Proportion 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.	57,027	
	Number of clients who were nutritionally assessed and found to be clinically malnourished during the reporting period.	0	
	By Age: <18	15,968	
	By Age: 18+	41,059	
	Sum by age	57,027	

	disaggregates		
C2.4.D	C2.4.D TB/HIV: Percent of HIV-positive patients who were screened for TB in HIV care or treatment setting	91 %	Redacted
	Number of HIV-positive patients who were screened for TB in HIV care or treatment setting	1,065,916	
	Number of HIV-positive individuals receiving a minimum of one clinical service	1,173,523	
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	3 %	Redacted
	Number of HIV-positive patients in HIV care who started TB treatment	35,531	
	Number of HIV-positive individuals receiving a minimum of one clinical service	1,173,523	
C4.1.D	C4.1.D Percent of infants born to HIV-positive women	80 %	Redacted

	who received an HIV test within 12 months of birth		
	Number of infants who received an HIV test within 12 months of birth during the reporting period	74,736	
	Number of HIV-positive pregnant women identified in the reporting period (include known HIV-positive at entry)	93,421	
	By timing and type of test: virological testing in the first 2 months	0	
	By timing and type of test: either virologically between 2 and 12 months or serology between 9 and 12 months	0	
C5.1.D	Number of adults and children who received food and/or nutrition services during the reporting period	656,700	Redacted
	By Age: <18	380,886	
	By Age: 18+	275,814	
	By: Pregnant Women or Lactating Women	39,402	
	Sum of age disaggregates	656,700	
T1.1.D	Number of adults and	176,278	Redacted

	children with advanced HIV infection newly enrolled on ART		
	By Age: <1	557	
	By Age/Sex: <15 Male	3,711	
	By Age/Sex: 15+ Male	66,800	
	By Age/Sex: <15 Female	5,567	
	By Age/Sex: 15+ Female	100,200	
	By: Pregnant Women	9,626	
	Sum of age/sex disaggregates	176,278	
T1.2.D	Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART)	592,175	Redacted
	By Age: <1	1,931	
	By Age/Sex: <15 Male	12,870	
	By Age/Sex: 15+ Male	224,000	
	By Age/Sex: <15 Female	19,305	
	By Age/Sex: 15+ Female	336,000	
	Sum of age/sex disaggregates	592,175	
T1.3.D	T1.3.D Percent of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral	85 %	Redacted

	therapy		
	Number of adults and children who are still alive and on treatment at 12 months after initiating ART	95,361	
	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.	112,189	
	By Age: <15	5,722	
	By Age: 15+	89,639	
	Sum of age disaggregates	95,361	
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 according to national or international standards	52	Redacted
H2.1.D	Number of new health care workers who graduated from a pre-service training	1,858	Redacted

	institution or program		
	By Cadre: Doctors	200	
	By Cadre: Midwives	284	
	By Cadre: Nurses	540	
H2.2.D	Number of community health and para-social workers who successfully completed a pre-service training program	220	Redacted
H2.3.D	The number of health care workers who successfully completed an in-service training program	93,103	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	500,000
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	2,431,980
10019	Safe Blood for Africa Foundation	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	443,281
10101	Excellence Community Education Welfare Scheme (ECEWS)	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	560,022
10107	American International	NGO	U.S. Department of Health and	GHP-State	400,000

	Health Alliance		Human Services/Health Resources and Services Administration		
10263	American Society for Microbiology	Private Contractor	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	550,000
12467	Salesian Mission Inc	FBO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	116,111
12831	African Field Epidemiology Network	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	3,029,698
12885	United Nations Children's Fund	Multi-lateral Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	700,000
13190	Institute of Human Virology, Nigeria	NGO	U.S. Department of Health and Human	GHP-State	1,257,747

			Services/Centers for Disease Control and Prevention		
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	5,064,417
13667	Center for Integrated Health Programs	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	11,211,601
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	1,587,714
13753	National Primary Health Care Development Agency	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	3,041,556
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	2,220,000
14055	Management Sciences for Health	NGO	U.S. Agency for International Development	GHP-State	3,424,265
14064	IntraHealth International, Inc	NGO	U.S. Agency for International Development	GHP-State	3,178,202
14115	Management Sciences for Health	NGO	U.S. Agency for International Development	GHP-State	12,197,246
14162	CDC Foundation	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	500,000
14169	Abt Associates	Private Contractor	U.S. Agency for International Development	GHP-State	804,119
14170	TBD	TBD	Redacted	Redacted	Redacted
14231	FHI 360	NGO	U.S. Agency for International Development	GHP-State	424,857
14250	KNCV Tuberculosis Foundation	NGO	U.S. Agency for International Development	GHP-State	1,296,380
14298	Deloitte Consulting Limited	Private Contractor	U.S. Agency for International Development	GHP-State	691,721
14302	John Snow, Inc.	Private Contractor	U.S. Agency for International Development	GHP-State	1,440,527

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	3,720,031
14384	Sesame Street Workshop	NGO	U.S. Agency for International Development	GHP-State	360,000
14444	TBD	TBD	Redacted	Redacted	Redacted
14446	The Mitchell Group	Private Contractor	U.S. Agency for International Development	GHP-State	1,500,000
14505	FHI 360	NGO	U.S. Agency for International Development	GHP-State	71,199,158
14575	Pact, Inc.	Private Contractor	U.S. Agency for International Development	GHP-State	3,769,838
14583	Chemonics International	Private Contractor	U.S. Agency for International Development	GHP-State	2,800,000
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	1,000,000
14658	TBD	TBD	Redacted	Redacted	Redacted
14664	Heartland Alliance for Human Needs and Human Rights	NGO	U.S. Agency for International Development	GHP-State	885,371
14666	TBD	TBD	Redacted	Redacted	Redacted

14668	Society for Family Health	NGO	U.S. Agency for International Development	GHP-State	9,354,801
14683	Gembu Center for AIDS Advocacy, Nigeria	NGO	U.S. Agency for International Development	GHP-State	199,151
14768	Partnership for Supply Chain Management	Private Contractor	U.S. Agency for International Development	GHP-State	134,600,000
14788	United Nations Children's Fund	Multi-lateral Agency	U.S. Agency for International Development	GHP-State	800,000
16797	TBD	TBD	Redacted	Redacted	Redacted
16827	Center for Integrated Health Programs	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	1,219,949
16828	AIDS Prevention Initiative in Nigeria, LTD	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	399,877
16838	University of Maryland Baltimore	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	399,877
16839	Institute of Human Virology, Nigeria	NGO	U.S. Department of Health and	GHP-State	1,200,000

			Human Services/Centers for Disease Control and Prevention		
16846	Institute of Human Virology, Nigeria	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	750,000
16848	Catholic Caritas Foundation of Nigeria (CCFN)	Implementing Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	11,007,306
16849	New Partner	TBD	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	750,000
16850	AIDS Prevention Initiative in Nigeria, LTD	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	22,574,228
16852	New Partner	TBD	U.S. Department of Health and Human	GHP-State	200,000

			Services/Centers for Disease Control and Prevention		
16853	New Partner	TBD	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	500,000
16854	New Partner	TBD	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	10,664,082
16855	Center for Integrated Health Programs	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	22,423,202
16871	Institute of Human Virology, Nigeria	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	48,965,375
16940	John Snow Inc (JSI)	Implementing Agency	U.S. Agency for International Development	GHP-State	1,000,000

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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 500,000	
Funding Source	**Funding Amount**
GHP-State	500,000

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	15,000

TBD Details

(No data provided.)

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	500,000	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: No
Global Fund / Multilateral Engagement: No	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 2,431,980	
Funding Source	**Funding Amount**
GHP-State	2,431,980

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.)

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	2,431,980	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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 443,281	
Funding Source	**Funding Amount**
GHP-State	443,281

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.)

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	443,281	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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 560,022	
Funding Source	**Funding Amount**
GHP-State	560,022

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)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
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**
Governance and Systems	HVSI	10,000	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	20,370	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	150,022	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	379,630	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: 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: American International Health Alliance	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 400,000	
Funding Source	**Funding Amount**
GHP-State	400,000

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.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**10107**

Mechanism Name:	American International Health Alliance Twinning Center		
Prime Partner Name:	American International Health Alliance		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	400,000	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: 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: No

Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 550,000	
Funding Source	**Funding Amount**
GHP-State	550,000

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	250,000

TBD Details

(No data provided.)

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	550,000	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: 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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 116,111	
Funding Source	**Funding Amount**
GHP-State	116,111

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: Gender Equality	11,611

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
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	116,111	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: AFENET**
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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 3,029,698	
Funding Source	**Funding Amount**
GHP-State	3,029,698

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	3,029,698

TBD Details

(No data provided.)

Key Issues

Malaria (PMI)

Child Survival Activities

Safe Motherhood

TB

Budget Code Information

Mechanism ID:	**12831**		
Mechanism Name:	**AFENET**		
Prime Partner Name:	**African Field Epidemiology Network**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	3,029,698	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: No
Global Fund / Multilateral Engagement: TA	
G2G: No	Managing Agency:

Total Funding: 700,000	
Funding Source	**Funding Amount**
GHP-State	700,000

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.

Cross-Cutting Budget Attribution(s)

Gender: GBV	350,000
Gender: Gender Equality	350,000

TBD Details

(No data provided.)

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	700,000	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 - Community-in-Action**
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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,257,747	
Funding Source	**Funding Amount**
GHP-State	1,257,747

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.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
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 - Community-in-Action**		
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	1,257,747	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**
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: No
Global Fund / Multilateral Engagement: No	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 5,064,417	
Funding Source	**Funding Amount**
GHP-State	5,064,417

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.

Cross-Cutting Budget Attribution(s)

Gender: Gender Equality	400,697
Human Resources for Health	300,000

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**13564**
Mechanism Name:	**Federal Ministry of Health**
Prime Partner Name:	**Federal Ministry of Health, Nigeria**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	900,000	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	2,160,929	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	2,003,488	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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 11,211,601	
Funding Source	**Funding Amount**
GHP-State	11,211,601

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.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
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	1,837,927	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	281,940	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	400,063	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	284,611	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	312,420	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	157,217	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	OHSS	0	0

Systems			

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	3,692	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	11,904	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	16,432	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	203,016	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	16,639	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	1,481,867	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.

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	0	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	5,421,194	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	782,679	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 Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Medical Laboratories Science Council of Nigeria	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 1,587,714	
Funding Source	**Funding Amount**
GHP-State	1,587,714

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.)

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	1,587,714	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: No
Global Fund / Multilateral Engagement: No	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 3,041,556	
Funding Source	**Funding Amount**
GHP-State	3,041,556

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.

Cross-Cutting Budget Attribution(s)

Gender: Gender Equality	304,155
Human Resources for Health	3,041,556

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
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	3,041,556	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: 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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 400,000	
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.)

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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 2,220,000	
Funding Source	**Funding Amount**
GHP-State	2,220,000

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	600,000

TBD Details

(No data provided.)

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	110,000	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	2,110,000	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: No
Global Fund / Multilateral Engagement: TA	
G2G: No	Managing Agency:

Total Funding: 3,424,265	
Funding Source	**Funding Amount**
GHP-State	3,424,265

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.

Cross-Cutting Budget Attribution(s)

Gender: Gender Equality	171,213

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
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	25,000	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	3,399,265	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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 3,178,202	
Funding Source	**Funding Amount**
GHP-State	3,178,202

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)

Gender: Gender Equality	89,278
Human Resources for Health	3,178,202

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
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	110,000	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	3,068,202	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: No
Global Fund / Multilateral Engagement: No	

G2G: No	Managing Agency:

Total Funding: 12,197,246	
Funding Source	**Funding Amount**
GHP-State	12,197,246

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)

Economic Strengthening	40,000
Education	50,000
Food and Nutrition: Commodities	40,000
Food and Nutrition: Policy, Tools, and Service	40,000

Delivery	
Gender: GBV	47,576
Gender: Gender Equality	71,363
Human Resources for Health	450,000
Renovation	80,000

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support

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	1,468,456	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	194,816	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	319,642	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	244,063	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	687,776	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	315,295	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	67,812	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	360,605	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	187,843	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	3,348,373	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	0	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	4,331,392	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	671,173	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: 14162	**Mechanism Name: African Center for Laboratory Equipments Maintenance**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: CDC Foundation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 500,000	
Funding Source	**Funding Amount**
GHP-State	500,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The broad goal of the this project is to develop an African Center for Laboratory Equipment Maintenance (ACLEM)

that will enable African countries to train technicians locally (within Africa) on the maintenance, certification, and repair of biosafety cabinets and other key laboratory equipment; enable laboratories to safely handle dangerous pathological agents; enhance laboratory abilities to prevent the accidental release of biological materials, by improving biological safety and security programs; strengthen personnel and environmental safety precautions as laboratories work to detect, diagnose, and report both natural and/or intentional disease occurrence and ensure the sustainability of the medical and laboratory equipment mainly through workforce development by training.
The project target will focus on training at least 45 individuals at the end of 2015 through a six month short course trainings. Two project managers and two admin assistants are to be hired to oversee the activities. An equipment survey will be condcuted and a curriculum will be developed based on the findings.
Two instructors will be recruited from University of Nigeria Enugu and Institute of Management and Technology Nigeria to work within the project. Four mentors will also provide mentoring program for the trainees.
Opportunities will be provided for stakeholders to meet on regular basis and a 7 member executive committee will be constituted with assigned roles and responsibilities. At the end of the project year, the project will be transitioned to government through close partnership with Federal/State Ministries of Health and private. There will be a monitoring and evaluation system for adequate quality data collection.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	25,000

TBD Details

(No data provided.)

Key Issues

Workplace Programs

Budget Code Information

Mechanism ID:	**14162**
Mechanism Name:	**African Center for Laboratory Equipments Maintenance**

Prime Partner Name:	CDC Foundation		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	500,000	0
Narrative:			
Under FY2012, CDC will support the African Center for Laboratory Equipment through the following activities which include setting up of office at Enugu, hiring of two managers, and two admin assistants (location – Abuja and Enugu), conduct equipment survey, train two instructors and a curriculum will be developed based on the findings for 487,342, plus 350,000 additional funding grated by OGAC for treatment.			

Implementing Mechanism Details

Mechanism ID: 14169	**Mechanism Name: Health Finance & Governance Project**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Abt Associates	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 804,119	
Funding Source	**Funding Amount**
GHP-State	804,119

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Inadequate funding allocation for HIV/AIDS by the GON remains the greatest challenge in sustaining HIV/AIDS programs in the country. Lack of capacity in generating and using information for budget negotiations at the national level continue to affect NACA's abilities to mobilize adequate internal GON resources for the national program. In addition, this is negatively impacting on how allocation decisions are made and on how resources are

used. This activity focuses on building the capacity of the GON in making evidence based decisions in resource mobilization and use. Capacity will be built in economic analysis and costing of providing, scaling-up and sustaining HIV/AIDS services, while also building the capacity in using such evidence to generate adequate internal resources for the national HIV/AIDS program. Support will particularly be provided to NACA's Resource Mobilization Department so that the agency can effectively deliver on its mandate of mobilizing adequate resources. In addition, the program will help the GON to link financing and budgeting to performance; and in improving transparency and accountability in resource allocation and utilization. Furthermore, the program will employ appropriate tools and methodologies to update all national HIV/AIDS service related cost data. All activities will be implemented in close collaboration with the FMOH, NACA and other relevant GON agencies as well as other stakeholders including but not limited to the World Bank. The activity will have an M&E system to track progress over time.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**14169**		
Mechanism Name:	**Health Finance & Governance Project**		
Prime Partner Name:	**Abt Associates**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	804,119	0
Narrative:			

This activity will support USG's effort to increase GON's contribution in funding the national HIV/AIDS program through building the capacity of NACA and FMOH and their corresponding structures at state levels to generate high quality evidence and skillfully use such information during budget negotiations at all levels. Such capacity will be built be built through providing tools trainings and mentoring. The program will particularly support the Resource Mobilization Department of NACA through seconding international and local health economists and health policy professionals who can build the capacity of the current staff in economic/policy analysis, budget negotiation, and financial planning and advocacy. Limited support will also be provided for equipment and office facilities for the unit. The activity is expected to significantly enhance NACA's ability in health financing and policy analysis to effectively engage in budgetary dialogue at the national level and to be able to plan and execute resource mobilization strategies. *In addition, the activity will support economic analysis and modeling to inform the design and implementation of cost effective HIV/AIDS interventions in the country. Costing studies will be conducted to understand the current cost and projected needs of providing and sustaining comprehensive HIV/AIDS services in Nigeria. The activity will promote Performance Based Budgeting to link resource allocation decisions to performance and health outcomes. Building on the interventions initiated by HS20/20 Project, this mechanism will work closely with all stakeholders to improve transparency and accountability in resource utilization in the public health sector through supporting the institutionalization of Financial Expenditure Reviews and Resource Tracking Systems and other innovative approaches. This activity will also help the USG to be able to monitor the progress towards achieving the GON financial contribution target set in the PF.*

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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 424,857	
Funding Source	**Funding Amount**
GHP-State	424,857

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)

Gender: Gender Equality	16,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms

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	3,188	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	421,669	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: 14250	Mechanism Name: TBCARE I
Funding Agency: U.S. Agency for International	Procurement Type: Cooperative Agreement

Development	
Prime Partner Name: KNCV Tuberculosis Foundation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: TA	
G2G: No	Managing Agency:

Total Funding: 1,296,380	
Funding Source	**Funding Amount**
GHP-State	1,296,380

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.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	350,000

TBD Details

(No data provided.)

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	1,296,380	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: No
Global Fund / Multilateral Engagement: No	

G2G: No	Managing Agency:

Total Funding: 691,721	
Funding Source	**Funding Amount**
GHP-State	691,721

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)

Gender: Gender Equality	30,000
Human Resources for Health	350,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
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	114,680	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	102,205	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	474,836	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	Mechanism Name: AIDSTAR-ONE Injection Safety Nigeria
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: John Snow, Inc.	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,440,527	
Funding Source	**Funding Amount**
GHP-State	1,440,527

Sub Partner Name(s)

(No data provided.)

Overview Narrative

IS TBD/Nigeria's goal is to prevent the transmission of HIV and other blood borne disease by promoting only safe and necessary injections and proper HCWM.

During FY12; project will continue interventions at 100 sites in Benue, Bauchi, Sokoto, Lagos, Cross River states and Federal Capital Territory including IP sites and reach an additional 100 primary healthcare (PHC) sites in collaboration with NPHCDA. IS TBD will conduct training of trainers, support training of health workers, logistic managers and waste handlers, including promotion of safe male medical circumcision messaging to appropriate audiences in North. IS TBD will also provide behavior change communication, commodity security, HCWM, and policy support to focal states. The project will also provide technical support to other PEPFAR treatment sites on IS and HCWM. The NPHCDA PHC focused HCWM framework and plan will be developed with partners and jointly implemented.

By September 2012, the project will have reached 200 healthcare sites including new NPHCDA PHCs. The National HCWM Policy approval will be a high priority this year and IS TBD will support its rollout. Data from supportive supervision, baseline and follow up assessments will be used to monitor impact of interventions and improve quality. Intervention planning, implementation and monitoring are coordinated with the FMOH and other stakeholders to ensure sustainability of interventions and cost effectiveness.

IS TBD will work closely with the MOH at all levels of the health system to ensure sustainability and ownership. IS TBD will use a combination of short- and long-term strategies in each technical area and continue to actively engage and support local stakeholders through the IS subcommittee to maintain a broad base of support for IS.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	278,053

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**14302**
Mechanism Name:	**AIDSTAR-ONE Injection Safety Nigeria**
Prime Partner Name:	**John Snow, Inc.**

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

Narrative:

Funding for this activity is from the PFIP funds. The IS TBD will establish an environment where patients, healthcare workers (HW) and the community are better protected from the medical transmission of HIV and other blood borne pathogens with Government of Nigeria (GON), US Government (USG) and other PEPFAR partners. Some of the guiding principles that will inform and direct IS TBD strategy and activities are:

• Support GON (National Primary Healthcare Development Agendy (NPHCDA)) to develop HCWM Framework and Plan

• Support GON in the distribution of national plans,guidelines and policies
• Work through the national injection safety technical working group
• Build partnership at national and state levels to foster collaboration
• Focus on tangible, discrete results in the near-term to lay the foundation for sustainability and long-term impact

Primary health care (PHC) is the foundation and corner-stone of the National Health Policy. The NPHCDA concept paper on HCWM reads "health care waste management at the PHC level has been a source of concern for the NPHCDA". IS TBD will work with NPHCDA to: institute behavioral change among PHC HWs through the production, distribution and placement of IEC materials; institutionalize the HCWM plan, guideline and policy including the minimum HCWM package; train HWs and waste handlers; procure seed stock of IS and HCWM commodities to jump start best practices after training; and support NPHCDA and selected LGAs to establish a health system for continuous monitoring and improvement of best practices. The Ward Development Association will be involved from the planning stage in implementation and M&E of this intervention.
POPULATIONS BEING TARGETED: include HWs, waste handlers, religious and community leaders, and community-based organizations. In addition, policy makers at facility, LGA, state and National levels will receive advocacy on relevant policies. Furthermore, these activities will indirectly target the general population who will be provided with information on safer HCWM practices.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMIN	1,440,527	0

Narrative:

The Injection Safety TBD objective is to continue technical assistance to GON and PEPFAR IPs in order to support the USG/MOH in ensuring IS commodity security in public facilities; implement the national HCWM policy; strengthen the policy environment; establish a monitoring system of injection practices; and monitor and and evaluate IS through supportive supervision and a follow-up HFA. IS TBD will continue the technical approach of: IS commodity security, capacity building, behaviour change and communication, and appropriate HCWM. In addition, IS TBD will support the GON and IPs in collaboration with stakeholders to promote safe childhood VMMC practices through integrated community outreach activities in the North. During FY12, the project will continue interventions at Old IS sites including IP sites as well as new sites. IS TBD will also provide technical support to other PEPFAR treatment sites on IS and HCWM.

Capacity building at HFs will be done through TOT, training of health workers, logistic managers and waste handlers. Implementation of the National BCC and advocacy strategies will continue while exploring areas of synergy with other USG partners, including reproduction and sharing of IEC materials, conducting joint advocacy and sensitization meetings and community outreach activities. IS TBD will continue to work with relevant regulatory bodies and professional associations to sensitize their members on IS best practices. New partnerships

will be forged and continue work with medical training institutions to update relevant curricula with IS modules. IS TBD will continue to facilitate the IS working group through quarterly meetings to: monitor the implementation of the National IS policies; advocate for use of safe IS commodities; advocate to the USG/MOH to increase access of PEP for HCWs and provide Hepatitis B vaccination for at-risk HCWs; and develop and implement plans for financial sustainability of IS activities. The GON and partners are involved with all IS stakeholders to ensure sustainability and political ownership.

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: No
Global Fund / Multilateral Engagement: TA	
G2G: No	Managing Agency:

Total Funding: 1,548,058	
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.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
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
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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 3,720,031	
Funding Source	**Funding Amount**
GHP-State	3,720,031

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)

Human Resources for Health	2,481,895
Motor Vehicles: Purchased	500,000
Renovation	465,000

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
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**
Prime Partner Name:	**U.S. Department of Defense (Defense)**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	347,495	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	95,222	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	37,771	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	748,140	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	253,926	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	201,266	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	5,332	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	8,706	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	12,453	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	74,383	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	274,282	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	532,204	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	0	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	1,024,981	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	103,870	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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 360,000	
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)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
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: 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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,500,000	
Funding Source	**Funding Amount**
GHP-State	1,500,000

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)

(No data provided.)

TBD Details

(No data provided.)

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	1,500,000	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: 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: No
Global Fund / Multilateral Engagement: Both	
G2G: No	Managing Agency:

Total Funding: 71,199,158	
Funding Source	**Funding Amount**
GHP-State	71,199,158

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.

Cross-Cutting Budget Attribution(s)

Gender: Gender Equality	1,920,453
Human Resources for Health	4,226,001

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms

Increase gender equity in HIV prevention, care, treatment and support

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	9,608,004	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	1,400,000	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	2,029,686	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	1,608,421	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	3,282,998	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	1,150,000	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.

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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	26,597	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	125,760	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	0	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	1,562,321	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	200,000	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	17,442,213	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	28,340,000	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	4,423,158	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: 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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 3,769,838	
Funding Source	**Funding Amount**
GHP-State	3,769,838

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 (NASFAT)	Methodist Care Ministry
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)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
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:			
Not Provided			
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	48,055	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	0	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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 2,800,000	
Funding Source	**Funding Amount**
GHP-State	2,800,000

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.)

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	2,800,000	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: 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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 4,329,012	
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)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
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	Procurement Type: Contract

Development	
Prime Partner Name: University Research Corporation, LLC	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,000,000	
Funding Source	**Funding Amount**
GHP-State	1,000,000

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.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
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	1,000,000	0
Narrative:			
Labour , workshop, travels fringe benefit			

Implementing Mechanism Details

Mechanism ID: 14658	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14664	**Mechanism Name: Integrated MSM Prevention Program**
Funding Agency: U.S. Agency for International	Procurement Type: Cooperative Agreement

Development	
Prime Partner Name: Heartland Alliance for Human Needs and Human Rights	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 885,371	
Funding Source	**Funding Amount**
GHP-State	885,371

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)

Gender: Gender Equality	27,000
Key Populations: MSM and TG	885,371

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms

Increase gender equity in HIV prevention, care, treatment and support

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	0	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 Systems	OHSS	0	0

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	0	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	135,371	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	750,000	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	**Mechanism Name: Strengthening HIV Prevention Services for MARPs**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Society for Family Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 9,354,801	
Funding Source	**Funding Amount**
GHP-State	9,354,801

Sub Partner Name(s)

Center for Right to Health	Pop Council	

Overview Narrative

MARPs including their clients & partners constitute about 3.4% of Nigeria's population but with their partners account for 41.3% of new infections (UNAIDS,2010). Significantly higher HIV prevalence rates with figures above the national median are recorded amongst brothel based female sex workers (BBFSW), non-brothel based female sex workers (NBBFSW) & men having sex with men (MSM) with estimated prevalence of rates of 27.4%, 21.7% 17.2% respectively. HIV prevalence among other MARPs is dropping while it is increasing among MSM – from 13.5% in 2007 to 17.4% in 2010 (IBBSS,2010). PEPFAR Nigeria prevention program for MARPs (FSW, MSM and IDU) focuses on increased access to comprehensive package of HIV sexual prevention activities at sufficient intensity, dosage & quality; improved continuum of community & facility-based prevention, care & treatment for targeted MARPs & it emphasizes improved use of data to strategically prioritize & plan HIV program interventions utilizing evidence based strategies. MARPs prevention program will address multiple & concurrent partnerships, transactional sex & low risk perception identified as critical risk factors in Nigeria HIV epidemic. Condom usage during risky sexual encounters will be addressed as reported condom use is still low. This program will provide high quality prevention interventions utilizing the combination prevention approach with specified minimum package

services targeted at each MARPs group. This includes Peer education & outreach, Risk reduction counseling, Condom & lubricant promotion & distribution, HTC, STI screening & referral for treatment & referral for HIV care and treatment. PLEASE NOTE: This TBD is expected to be awarded in March 2012.

Cross-Cutting Budget Attribution(s)

Gender: Gender Equality	400,000
Human Resources for Health	270,720
Key Populations: FSW	772,347
Key Populations: MSM and TG	878,496
Motor Vehicles: Purchased	658,410

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Family Planning

Budget Code Information

Mechanism ID:	**14668**
Mechanism Name:	**Strengthening HIV Prevention Services for MARPs**
Prime Partner Name:	**Society for Family Health**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	479,629	0

Narrative:

HVAB program partners will promote and strengthen media projects and interventions that targets youth age 15-24 years bracket that encourages them to increase HCT seeking behavior (to know their status), promote status disclosure, reduce stigma and discrimination, reduce alcohol & substance use, reduce multiple and concurrent partnerships and promote correct and consistent condom use.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	115,065	0

Narrative:

The goals and strategies for HCT (FY12 & FY 13) for HCT services in Nigeria are:

• To support the GON to ensure that 80% of Nigerians have access to quality HIV testing and counseling services that will enable them know their HIV status and make informed decision about HIV prevention as well as create linkages to care and treatment programs.

• Support implementation of HTC program that is sustainable, consistent with international minimum standards and best practices, owned and led by the host communities and government

Implementing Partners (IPs) will employ different models of HCT services to expand access, strengthen referral networks and linkages and increase collaboration with the basic care and treatment program. In addition it will leverage resources from other bilateral and multilateral donors (GF, MDG, and WB) to build the capacity of the GoN on MARPs HCT programming to ensure sustainability in-country. Priority models of service will include: Scale-up Provider Initiated Testing and Counseling (PITC) (opt-out) for MARPs. Mobile and Outreach HCT for targeted MARPs (FSWs, MSMs, PWID). This activity will provide HCT in settings where MARPs feel comfortable with assurance of strengthening linkages and referrals to appropriate follow-up services to initiate enrollment into care. Ensure every testing site is linked to an EQA program: This would ensure monitoring, supervision, general laboratory testing oversight, and external quality assessment to testing sites. Also support ongoing improvements on counseling quality. Laboratory activity will support GON in ensuring quality through the validation of rapid HIV test kits, the establishment of appropriate testing algorithm, post-market quality assurance of test kits, and continuous monitoring of kits quality. Support testing component of HCT and implementation of quality management system through continuous provision of training, control panels, retesting program, proficiency testing and onsite monitoring

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	8,760,107	0

Narrative:

Greater national priority is being accorded MARPs prevention programming over recent years and riding on this momentum the HVOP will continue to emphasize increase adoption of safer sexual behaviors by MARPs in selected high prevalence states in Nigeria, in order to reduce new HIV infections. Promotion of consistent and correct

condom use and provision of condom supplies will remain an essential component of programming with appropriate condom messaging; structured peer education using systematic training curricula,; STI management; interventions addressing vulnerability issues like income generation activities, essential life skills, HCT services; education of sex workers and MSMs on the use of water based lubricants, condom negotiation skills and use. Inclusion of messages related to alcohol use and its attendant disinhibition effects will feature in HVOP programs. IPs will utilize the Minimum Prevention Package Intervention approach a Nigeria led effort that requires prevention programs to 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 (the individual, community and structural levels) and these will be reinforced with mass media activities.

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: No
Global Fund / Multilateral Engagement: TA	
G2G: No	Managing Agency:

Total Funding: 199,151	
Funding Source	**Funding Amount**
GHP-State	199,151

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.

Cross-Cutting Budget Attribution(s)

Gender: Gender Equality	20,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
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	0	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	68,159	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	130,992	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	0	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: 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: No
Global Fund / Multilateral Engagement: Both	
G2G: No	Managing Agency:

Total Funding: 134,600,000	
Funding Source	**Funding Amount**
GHP-State	134,600,000

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.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

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	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	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	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	19,000,000	0

Narrative:

SCMS supports PEPFAR in Nigeria by providing increased access to quality HIV/AIDS commodities. This year SCMS will supply laboratory commodies for the DOD-WRP and other Nigeria programs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	10,200,000	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	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	17,400,000	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	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	88,000,000	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	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	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: No
Global Fund / Multilateral Engagement: TA	
G2G: No	Managing Agency:

Total Funding: 800,000	
Funding Source	**Funding Amount**
GHP-State	800,000

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.

Cross-Cutting Budget Attribution(s)

Gender: Gender Equality	140,000

TBD Details

(No data provided.)

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	800,000	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: 16797	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 16827	**Mechanism Name: Strenghtening Human Resources For Health(HRH) for the Provision of HIV/AIDS Services Through Pre-service**
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: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,219,949	
Funding Source	**Funding Amount**
GHP-State	1,219,949

Sub Partner Name(s)

(No data provided.)

Overview Narrative

By 2014, PEPFAR aims to train and support retention of at least 140,000 new Health Care Workers, with the objective of helping partner countries achieve staffing levels of at least 2.3 doctors, nurses, and midwives per 1,000, as called for by the World Health Organization (WHO). The Strengthening Skills and Competencies of Care Providers for Enhanced service Delivery: The SCOPE project is intended to contribute to addressing the current health workforce challenges in Nigeria and the PEPFAR goals for meeting HWF needs urgently. It will adopt locally viable strategic approaches aligned with PEPFAR priorities, including country ownership, sustainability, capacity building, innovation, and efficiency. The program will strengthen pre-service capacity at undergraduate and post graduate (MPH) levels across selected Nigerian health care training institutions. It will leverage CIHP's present collaboration with (ICAP-NYC) and potential technical partner to increase production of skilled nursing, community health and 300 MPH graduates to meaningfully contribute to high quality integrated services with a focus on comprehensive HIV care, support and treatment services across all levels of the Nigerian health system. CIHP and its partners will work with national and state governments, public and private faith based training institutions to design a pre-service HIV care, support and treatment training package to support a quality enhancement program that ensure that 4,800 graduates from selected schools of health technology, nursing and midwifery and post graduate schools of public health across selected states in Nigeria equipped with high

competency skills in the comprehensive clinical management of individuals and families living with; and affected by HIV/AIDS.

Cross-Cutting Budget Attribution(s)

Gender: GBV	28,193
Gender: Gender Equality	211,985
Human Resources for Health	184,058
Motor Vehicles: Purchased	133,756
Renovation	600,236

TBD Details

(No data provided.)

Key Issues

End-of-Program Evaluation

Budget Code Information

Mechanism ID:	**16827**
Mechanism Name:	**Strenghtening Human Resources For Health(HRH) for the Provision of HIV/AIDS Services Through Pre-service**
Prime Partner Name:	**Center for Integrated Health Programs**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	1,219,949	0

Narrative:

CIHP will support the strengthening of capacities of all categories of public health students in the

provision of comprehensive integrated HIV/AIDS services through competency based trainings.
• CIHP will support update of HIV/AID|S knowledge and skills of pre-service faculty through master trainers update the teaching, instructional design, student assessment skills of pre-service and upgrade health care facilities (clinical practical sites) where necessary to be able to serve as shared clinical training sites.
• CIHP will conduct desk review of the national HRH strategic plan to identify gaps and develop appropriate interventions
• CIHP will conduct training assessments at all pre service institutions selected including task analysis for current front line health workers at undergraduate and postgraduate levels.
• CIHP would support stake holders meeting for consensus building on national priorities and prioritization of evidence based programmatic intervention especially in the areas of task shifting and task sharing policies.
• CIHP would conduct a review of the current existing accreditation and other quality assurance mechanisms at public and privet training institutions looking at licensure processes and other continuing professional development mechanisms including rational deployment of appropriate personnel.
• Baseline survey of all PSE would also be conducted in the 4 project states of Kaduna, Benue, Gombe and Kogi state in line with the current accreditation criteria to identify gaps using the standard based management tool. gaps identified by this assessment would be improved upon using a programmatic and technical approach
• The project will collaborate with a local service internet provider to identify, develop and implement appropriate learning technologies in order to support distance learning for faculty and later for students. This approach would leverage on partnerships with local organizations providing MPH diploma programs, community health practitioners board to give them increased skill and responsibility over a period of 5 years.
• CIHP will integrate along new HIV and TB content into didactic and clinical teaching based on the educational strengthening frame work developed with WHO.
• CIHP will focus on developing HIV/AIDS competencies which are consistent with national needs and will work with national; professional associations to align graduation and licensing requirements to these same competencies.
• CIHP will also prepare for the rapid scale up by building upon in – country materials developed by NACSP.
• CIHP will collaborate with the accreditation and regulatory bodies and all other key stake holders including representatives of students to be a part of the process from the beginning to ensure buy-in.
• CIHP will work with partners to integrate new HIV content into the teaching components that develop competency by emphasizing clinical practice and assessment. Training institutions will be supported by CIHP to provide increased practice simulation training, adding clinical practice, site rotations and preparing faculty and preceptors and improving student assessment.

Implementing Mechanism Details

Mechanism ID: 16828	**Mechanism Name: Strengthening Laboratory Services for Sustainable HIV/AIDs Program**
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: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 399,877	
Funding Source	**Funding Amount**
GHP-State	399,877

Sub Partner Name(s)

(No data provided.)

Overview Narrative

APIN will support local institutions to develop, implement, monitor and manage a system for strengthening laboratory management towards accreditation. This will be achieved by building their capacity in the area of Quality Management System, accreditation, assessment and audit. Using the CLSI, ISO and SLMTA strategies with WHO-Afro accreditation checklist, APIN is currently preparing and strengthening five (6) supported laboratories for WHO-Afro accreditation. These laboratories are expected to be accredited by the end of 2013, having successfully undergone the SLMTA Roll-out process. APIN plans to replicate its existing QMS strategy by employing a hub and spoke approach whereby the laboratories being prepared for WHO-Afro accreditation will be used to mentor the secondary health facility laboratories. The primary targets are the secondary facility laboratories that will be used to establish a network of spokes to be mentored by the tertiary facility laboratories. State ministries of health laboratory personnel will also play a major role as assessors for the secondary health facility laboratories within their states. APIN will adopt a phased approach in the development and implementation of the accreditation process.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support

TB

End-of-Program Evaluation

Budget Code Information

Mechanism ID:	**16828**		
Mechanism Name:	**Strengthening Laboratory Services for Sustainable HIV/AIDs Program**		
Prime Partner Name:	**AIDS Prevention Initiative in Nigeria, LTD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	399,877	0

Narrative:

APIN will target three (3) divisions of the FMOH; the laboratory unit of the HIV/AIDS division of NASCP, the laboratory unit of Hospital services division and the laboratory unit of National TB and Leprosy Control Program with a view of strengthening their capacity. The objective would be to build their capacity in the areas of development of monitoring mechanisms and setting up quality management systems that will ensure standards of laboratory practice in the HIV/AIDS response in the country. This will also focus on subscriptions to international journals for best practices ; CME for bodies tasked with quality assurance. APIN will also target 3 states of Lagos, Oyo and Plateau where it is the lead IP with the same objective as above. APIN plans to engage directly with the State ministry of Health laboratory personnel who will in-turn support and drive the process at the facility laboratories. In Benue and Kaduna States,

APIN will engage directly with the State Ministries of Health and other implementing partners to provide the services. APIN will conduct advocacy visits to these state governments and management of the local institutions to sensitize and encourage their involvement. APIN will establish a quality management system by setting up a central accreditation planning committee for each supported institution that will be made up of a group of two or more laboratory personnel meeting to identify and solve a quality problem by working through a series of steps standard methods and tools. APIN will also develop an accreditation preparedness work plan for each participating institution to serve as key implementation framework. These institutions will be supported to develop quality management system documentation such as quality policies, manuals, SOPs, Job-aids, etc. These committees will be encouraged to develop quality management plans outlining the Lab Quality Program, including a clear indication of responsibilities and accountability, performance measurement strategies and goals, and elaboration of processes for ongoing evaluation and assessment of the Program. To implement, monitor and manage efficient laboratory Logistics Management Systems, APIN will provide technical assistance to Laboratory personnel in collaboration with FMoH (NACA, NASCP) using the approved national tools. This technical assistance will be in form of trainings which will relate to documentation of laboratory commodities (receipts, usage, balances and requests) using relevant LMIS tools. The approved tools are the Daily Usage Registers (DUR), Combined Report Requisition Issue and Result Form (CRRIRF – RTKs, CRRIRF-Reagents/consumables), Inventory control Cards/Bin cards. APIN will conduct regular Monitoring and Evaluation visits to assess the level of utilisation of the LMIS tools, their completeness and timeliness in each review period. APIN will monitor the resupply efficiency of commodities by partnering with NACA, in collating reports, analysis and submission.

Implementing Mechanism Details

Mechanism ID: 16838	**Mechanism Name: Strengthening Systems for Sustainable Comprehensive HIV/AIDs Prevention, Care and Support and Treatment Programs**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: University of Maryland Baltimore	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 399,877	
Funding Source	**Funding Amount**
GHP-State	399,877

Sub Partner Name(s)

Institute of Human Virology, Nigeria	Solina Health Ltd	

Overview Narrative

The Nigerian Alliance for Health System Strengthening (NAHSS) has five goals: 1) Assessment and strategic planning for sustainable health system strengthening; 2) Provide technical assistance to indigenous implementing partners (IPs) to align HIV program to comply with Nigerian National Guidelines; 3) Strengthen IP capacity to implement Hub-Spoke Cluster for decentralization of service delivery; 4) Bridge capacity of IPs and Government of Nigeria (GoN) for sustainable logistics and supply chain; 5) Develop capacity of GoN to plan and manage programs and investments on the path to sustainable transition. To achieve these goals University of Maryland (UMD) partners with HEALTHQUAL International, and three Nigerian indigenous organizations: Solina Health Ltd. (Health system assessment); General & Health Logistics International Ltd. (GHLI-L) (logistics management assessments and strengthening); and IHV-Nigeria (IHVN)(mentoring in quality improvement, and infrastructure support to the project). NAHSS is conceptually framed in the HEALTHQUAL Quality Management paradigm that engages both a Quality Management (Evidence-guided Quality Improvement) and a toolkit with broad application for data-driven problem solving to strengthen strategic planning and program management and guide continuous quality improvement (CQI).

Cross-Cutting Budget Attribution(s)

Gender: Gender Equality	39,987
Human Resources for Health	399,877

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Safe Motherhood
TB
Workplace Programs
End-of-Program Evaluation
Family Planning

Budget Code Information

Mechanism ID:	**16838**
Mechanism Name:	**Strengthening Systems for Sustainable Comprehensive HIV/AIDs Prevention, Care and Support and Treatment Programs**
Prime Partner Name:	**University of Maryland Baltimore**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	399,877	0

Narrative:

• UMB is required to continue providing technical assistance to the FMOH to be able to coordinate, regulate and provide oversight function on CQI activities across the country.
• IP should implement strategies aimed at strengthening HIV CQI system at the MOH level in at least 2 states with emphasis of implementing reliable and sustainable National/State CQI task teams.
• IP is required to support PEPFAR implementing partners to implement QA/QI program according to national guideline in at least all their secondary and tertiary health facilities
• IP should support the FMOH set-up system for HIVQual data collection and reporting
• IP should provide technical assistance to FMOH on the revision of the existing HIVQual software to a more user friendly version.

Implementing Mechanism Details

Mechanism ID: 16839	**Mechanism Name: Strenthening Human Resources for Health (HRH) for the provision of quality HIV/AIDS services through Pre-service**

	and In- Services Training for Laboratory Personnel
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: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,200,000	
Funding Source	**Funding Amount**
GHP-State	1,200,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This submission harnesses and synergizes the expertise of three key partners: The African Society of Laboratory Medicine, Association of Public Health Laboratories, and the General and Health Logistics Inc. Ltd under the leadership of the Institute of Human Virology Nigeria. The goal is to build sustainable and highly trained human resources through pre- and in-service lab training for high quality lab tests to support HIV prevention, care and treatment programs in Nigeria under the leadership of the government of Nigeria in line with the overarching goal of the USG Partnership Framework on HIV/AIDS, 2010 - 2015 for Nigeria to move towards sustainable and country owned program. The anticipated outcomes include a high quality and integrated national lab training curricula with strengthened Nigerian universities and institutions; a national lab HIV/AIDS and co-infection guideline supported by well-trained laboratorians and equipped training facilities and systems; and an efficient data managing and forecasting process to ensure a smooth transition to the government of Nigeria assisted by strengthened local institutions. This is achieved through 6 aims. 1) Outline HIV/AIDS and co-infection lab training needs for different cadre of lab workers. 2) Develop an integrated and comprehensive national lab training curriculum that integrates the national guidelines. 3) Ensure high quality lab HIV/AIDS and co-infection program through training. 4) Strengthen training in diagnosis and monitoring of HIV/AIDS and TB. 5) Train auxiliary lab support staff in biorespository, supply chain management, and equipment maintenance and repair. 6) Implement a cost effective transition plan that synergizes infrastructure, efforts and data to GoN supported by strengthened local Institutions.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	1,200,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**16839**		
Mechanism Name:	**Strenthening Human Resources for Health (HRH) for the provision of quality HIV/AIDS services through Pre-service and In- Services Training for Laboratory Personnel**		
Prime Partner Name:	**Institute of Human Virology, Nigeria**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	600,000	0

Narrative:

Using the National curriculum, training guidelines and training manual to conduct training on basic HIV diagnosis and monitoring, TB smear microscopy, equipment maintenance and laboratory assessors training. Using the National curriculum, training guidelines and training manual to conduct training to conduct advanced TB culture, enhanced technology for increasing case finding (molecular) and HIV molecular diagnosis- HIV DNA (EID), viral load and genotyping. Strengthen the human capacities of TB zonal reference laboratories for quality services. Develop the capacities of lab quality officers in developing and writing SOPs Conduct workshop/training on QMS, the 12 Quality System Essentials, ISO 15189, adult teaching techniques, and the ability to conduct a laboratory mentorship activity.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	600,000	0

Narrative:

Using the National curriculum, training guidelines and training manual to conduct training on basic HIV diagnosis and monitoring, TB smear microscopy, equipment maintenance and laboratory assessors training. Using the National curriculum, training guidelines and training manual to conduct training to conduct advanced TB culture, enhanced technology for increasing case finding (molecular) and HIV molecular diagnosis- HIV DNA (EID), viral load and genotyping. Strengthen the human capacities of TB zonal reference laboratories for quality services. Develop the capacities of lab quality officers in developing and writing SOPs Conduct workshop/training on QMS, the 12 Quality System Essentials, ISO 15189, adult teaching techniques, and the ability to conduct a laboratory mentorship activity. Support the scale up of pre-service curriculum harmonization to 5 more Universities offering medical laboratory sciences. Assessment of the implementation of harmonized pre-service curriculum in 11 universities already implementing. Support faculty members for University Exchange program at local/international accredited institutions. Conduct ToT workshop on research development, grant writing and publishing for faculty members and stakeholders in educational policy making and regulatory professional and certification bodies. Support faculties with supplies to enhance the implementation of the harmonized curriculum.

Implementing Mechanism Details

Mechanism ID: 16846	**Mechanism Name: Strenghtening Human Resources For Health(HRH) for the Provision of HIV/AIDS Services Through Pre-service**
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: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 750,000	

Funding Source	Funding Amount
GHP-State	750,000

Sub Partner Name(s)

University of Maryland School of medicine		

Overview Narrative

Since 2005, IHVN has successfully implemented HIV treatment and prevention programs at 139 medical facilities in Nigeria and trained over 29,000 health care workers largely through in-service training (Appendix page 19) and some 2% through pre-service training. IHVN leverages its experience in providing training, an extensive network of local organizations, universities and schools of nursing and midwifery and the internationally acclaimed Accordia Global Health Foundation as well as its Nigerian affiliate – the West African Infectious Diseases Institute - to implement a high quality pre-service training for the Nigerian health care system's "first- responders" at the PHC level through the SPEARHEAD program.

IHVN project is intended to contribute by addressing the current health workforce challenges in Nigeria and meeting PEPFAR goals to train and retain at least 140,000 new health care workers as well as improving the partner's capacity to deliver primary health care.
IHVN project will adopt locally viable strategic approaches aligned with PEPFAR priorities, including country ownership, sustainability, capacity building, innovation, and efficiency. The program will strengthen pre-service capacity at undergraduate and post graduate (MPH) levels across selected Nigerian health care training institutions.
IHVN will work with national, state governments and public training institutions to design a pre-service HIV care, support and treatment training package to support a quality enhancement program that ensure that graduates from selected schools of health technology, nursing and midwifery and post graduate schools of public health across selected states in Nigeria equipped with high competency skills in the comprehensive clinical management of individuals and fa

Cross-Cutting Budget Attribution(s)

Human Resources for Health	750,000

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Safe Motherhood
TB
Workplace Programs
End-of-Program Evaluation
Family Planning

Budget Code Information

Mechanism ID:	**16846**
Mechanism Name:	**Strenghtening Human Resources For Health(HRH) for the Provision of HIV/AIDS Services Through Pre-service**
Prime Partner Name:	**Institute of Human Virology, Nigeria**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	750,000	0

Narrative:

IP should develop and implement strategy aimed at institutionalization of the pre-service training program in Nigeria.
IP should also develop and implement innovative training strategies that are cost effect. An established electronic database of trainees is to be put in place and reports submitted to CDC on quarterly basis.

IHVN will work with its partners to integrate new HIV content into the teaching components that develop competency by emphasizing clinical practice and assessment. Training institutions will be supported by IHVN to provide increased practice simulation training, adding clinical practice, site rotations and preparing faculty and preceptors and improving student assessment. We intend conduct desk review of the national HRH strategic plan to identify gaps and develop appropriate interventions and conduct

training assessments at all pre service institutions selected including task analysis for current front line health workers at undergraduate and postgraduate levels. IHVN will support the strengthening of capacities of all categories of public health students in the provision of comprehensive integrated HIV/AIDS services through competency based trainings and support update of HIV/AID|S knowledge and skills of pre-service faculty through master trainers update teaching, instructional design, student assessment skills of pre-service and upgrade health care facilities (clinical practical sites) where necessary to be able to serve as shared clinical training sites. IHVN would work to support stake holders meeting for consensus building on national priorities and prioritization of evidence based programmatic intervention especially in the areas of task shifting and task sharing policies. IHVN will focus on developing HIV/AIDS competencies which are consistent with national needs and will work with national; professional associations to align graduation and licensing requirements to these same competencies.

Implementing Mechanism Details

Mechanism ID: 16848	**Mechanism Name: Engaging Indigenous Organisation to Sustain and Enhance Comprehensive Clinical Service**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Catholic Caritas Foundation of Nigeria (CCFN)	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 11,007,306	
Funding Source	**Funding Amount**
GHP-State	11,007,306

Sub Partner Name(s)

(No data provided.)

Overview Narrative

In FY2013 CCFN's Sustainable HIV Care and Treatment Action in Nigeria (SUSTAIN) will provide comprehensive HIV care, treatment and prevention services in twenty five (25) Partner Treatment Facilities, five (5) standalone PMTCT sites and three (3) Community Based Organizations in 12 states of Adamawa, Benue, Delta, Edo, FCT, Kaduna, Kogi, Nassarawa, Ondo, Oyo, Plateau, and Taraba. The focus in FY2013 is to maintain and expand to additional PTFs and satellite sites, with further emphasis on decentralization to community and home levels. Through primary and secondary faith-based facilities SUSTAIN will extend ART care and treatment services to underserved rural communities to reach 504 (new) and 1067 (current) children and 5,216 (new) and 39,278 (current) on ART by the end of the fiscal year. In setting and achieving these targets, consideration has been given to modulating SUSTAIN's rapid scale-up plans in order to concomitantly work towards continuous quality improvement. All PTFs will be strengthened in their capacity to provide comprehensive quality ART care and treatment services through a variety of models of care delivery. This includes quality management of OIs and ART, a safe, reliable and secure pharmaceutical supply chain, technologically appropriate lab diagnostics, treatment preparation for patients, their families and supporters and community based support for adherence. This technical and programmatic assistance utilizes on-site mentoring and preceptorship. A key component for successful ART is adherence to therapy and capacity building to improve the quality of services. SUSTAIN will strengthen Continuous Quality Improvement (CQI) to improve and institutionalize quality interventions.

Cross-Cutting Budget Attribution(s)

Gender: GBV	39,481
Gender: Gender Equality	118,444
Human Resources for Health	876,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources

Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	**16848**
Mechanism Name:	**Engaging Indigenous Organisation to Sustain and Enhance Comprehensive Clinical Service**
Prime Partner Name:	**Catholic Caritas Foundation of Nigeria (CCFN)**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	1,128,576	0

Narrative:

In FY2013 SUSTAIN will provide adult treatment, care and support services in 25 Partner Treatment Facilities (PTFs) and 10 satellite sites across the 12 states of Adamawa, Benue, Edo, FCT, Kaduna, Kogi, Nassarawa, Ondo, and Taraba. Through primary and secondary faith-based facilities AR in COP09 will continue to extend ART services to underserved rural communities to reach 4,770 new patients for a total of 30,150 active adult patients by the end of the year. Comprehensive package of care and support services will be provided to a cumulative 50,589 PLHIV and 101,178 PABAs in the same period. In setting and achieving COP09 targets, consideration has been given to consolidating on AR's rapid COP08 scale-up efforts in order to concomitantly work towards continuous quality improvement.
The package of care services provided to each PLHIV includes a minimum of clinical service with basic care kit and two supportive services in the domain of psychological, spiritual, and PHDP delivered at the facility, community, and household (home based care) levels in accordance with the PEPFAR and Government of Nigeria (GON) national care and support policies and guidelines. The basic care package for PLHIVs in SUSTAIN's partner sites include Basic Care Kit (ORS, LLITN, water guard, water vessel, gloves, soap and IEC materials,); Home-Based Care (client and caregiver training and education in self-care and other HBC services); Clinical Care (basic nursing care, pain management, OI and STIs prophylaxis and treatment, nutritional assessment- weight, height, BMI, micronutrient counseling and supplementation and referrals, Laboratory Services (which will include baseline tests - CD4 counts,

hematology, chemistry, malarial parasite, OI and STI diagnostics when indicated); Psychological Care (adherence counseling, bereavement counseling, depression assessment and counseling with referral to appropriate services); Spiritual Care (access to spiritual care); Social Care (support groups' facilitation, referrals, and transportation) and Prevention Care (Prevention with Positives). All PLHIVs' nutritional status will be assessed at contact and on follow-up visits, micronutrients will be provided as necessary, and those diagnosed as severely malnourished will be placed on a therapeutic feeding program. This will be done through wraparound services as well as direct funding. SUSTAIN will procure basic care kits through a central mechanism and OI drugs will be procured through mechanisms that ensure only NAFDAC approved drugs are utilized.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	394,816	0

Narrative:

In FY2013 SUSTAIN will ensure prioritized and focused interventions that address children's most critical care needs through family strengthening approaches. SUSTAIN's OVC primary strategy for achieving this will be strengthening parents and caregivers so they can provide for their children's basic needs. SUSTAIN will engage community based organizations with proven track records in OVC program implementation to support this strategy. SUSTAIN's OVC programming has several key elements: proactively seeking children at risk through a multi-pronged approach for increasing access to care and HCT and ensuring a holistic child focused and family-centered approach to care. Priority areas include education, psychosocial care and support, household economic strengthening, social protection, health and nutrition, child protection, legal protection and capacity building. SUSTAIN will place significant emphasis on strengthening services to OVC beginning with building skills in partner CBOs and community care providers to identify children who are vulnerable and provide them with appropriate services. SUSTAIN will adopt use of the Child Status Index to assess vulnerability and determine needs of the children. Households will also receive a preventive care package containing ITN, water guard, water vessel, soap, ORS sachets, and IEC materials on self-care and prevention of common infections according to GoN guidelines. These services will be underpinned by providing good supportive counseling for children and adolescents. AR will intensify collaboration with GON and other stakeholders to ensure prompt diagnosis of TB in children and facilitate provision of pediatric TB formulations. SUSTAIN will strengthen existing structures to build children support groups in saturation communities and expand their activities to include periodic social/recreational and educational activities with the involvement of uninfected children to address issues of stigma and discrimination. Nutritional services will include nutritional assessment, nutritional counseling and education and therapeutic feeding. SUSTAIN will expand its central OVC team to include a nutritionist who will assist in building capacity of HCW in nutritional assessment, establishing nutritional corners in all LPTFs for culture and region sensitive

counseling rehabilitation.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	245,658	0

Narrative:

CCFN SUSTAIN strategy for TB/HIV is to ensure that all HIV positive clients in Partner Treatment Facilities (PTFs) are routinely screened for TB while TB patients have access to HIV counseling and testing (HCT). Dually infected clients are offered appropriate care within and outside the PTF. SUSTAIN will support TB DOTS centers at PTFs and HCT services in stand-alone TB DOTS centers in focal states. SUSTAIN will continue to implement HCT in existing TB DOTS centers to provide HCT to all TB patients and suspects and will also ensure facility co-location of TB DOTS centers in all supported PTFs. TB DOT Centers will be supported to expand services to include care and support and follow up services. Referral mechanisms will ensure TB/HIV co-infected clients access supported HIV care and treatment services. SUSTAIN will implement the global 3 Is program of TB/HIV management strategy. Over 40,000 HIV positive patients in care at all supported sites will be rescreened for signs of TB clinically with symptom driven follow up laboratory screening. Isonizide Preventive Therapy (IPT) will be strengthened across all sites. The TB/HIV program will be in collaboration with State and National Tuberculosis and Leprosy control programs (STBLCP and NTBLCP). All clients offered HIV counseling and testing services from the TB DOTS centers will receive their results. Laboratory infrastructure will be upgraded and human capacity developed to ensure adequate TB diagnosis for HIV positive patients. SUSTAIN will continue to strengthen the pharmacy services at supported TB DOTS sites to improve forecasting and avoid stock outs, working with sites and State Government to recognize and eliminate stock outs due to facility level or government level TB logistic weaknesses, as an aspect of health systems capacity strengthening.

Through basic care and support services all TB/HIV patients will be put on co-trimoxazole prophylaxis therapy (CPT) according to the national guidelines. Community health care providers will trace family members of PLHIV accessing TB/HIV services and facilitate their TB screening and appropriate care. SUSTAIN will ensure proper patient triage, specimen collection & processing, waste disposal, proper ventilation and administrative control activities such as active identification of those with TB symptoms and patient segregation. TB infection prevention and control will be accomplished using these workplace practices, administrative and environmental measures. Patient and staff education will be routinely conducted to ensure program success. SUSTAIN will continue to use the developed joint adherence strategies for patients on ARVs and TB DOTS and strengthen the facilities' capacity to meet special needs of PLHIV on both ART and anti-TB treatment. Nosocomial transmission of TB to HIV+ patients as well as facility staff will be prevented through measures and principles such as basic hygiene, proper sputum disposal, and good cross ventilation at clinics. The national guidelines on TB infection control on

co-located sites will be implemented in all SUSTAIN supported sites. Patients screened and treated for TB and TB/HIV will be entered into the updated reporting tool provided by the NTBLCP with appropriate linkages of medical records between TB and HIV points of service. In support of the NTBLCP and STBLCP, AR will provide TB consumables, reporting & recording tools, ACSM materials in places where these are not available

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	174,686	0

Narrative:

SUSTAIN will support strategies to increase pediatric enrollment into care and treatment by strengthening linkages and referral at all service levels, reinforce and expand community based care for children, promote family centered care and treatment and provider initiated testing and counseling (PITC)for all children. ART clinics will be supported to initiate family days to provide opportunities to increase testing for children and provide comprehensive care. All exposed infants delivered in the PTF or identified through the family centered approach will be linked to the ART HIV Comprehensive Care clinic for enrollment into care and treatment. Aggressive community based activities will be put in place to identify exposed infants including those lost to follow up from the PMTCT program. The basic care package for HIV positive child/care givers in supported sites include Basic Care Kit (ORS, LLITN, water guard, water vessel, soap, IEC materials, and gloves); Home-Based Care (client and caregiver training and education in self-care and other HBC services); Clinical Care (basic nursing care, pain management, OI and STIs prophylaxis and treatment, nutritional assessment- weight, height, BMI, micronutrient counseling and supplementation and referrals, Laboratory Services (which will include baseline tests - CD4 counts, hematology, chemistry, malarial parasite, OI and STI diagnostics when indicated); Psychological Care (adherence counseling, bereavement counseling, depression assessment and counseling with referral to appropriate services); Spiritual Care (access to spiritual care); Social Care (support groups' facilitation, referrals, and transportation) and Prevention Care (Prevention with Positives).
All HIV positive children's nutritional status will be assessed at contact and on follow-up visits, micronutrients will be provided as necessary, and those diagnosed as severely malnourished will be placed on a therapeutic feeding program. SUSTAIN will provide DBS/DNA PCR technology for early infant diagnosis in addition to the logistic support for transportation of blood samples to designated laboratories in collaboration with other Implementing Partners. All infected children will be evaluated for ART using CD4 or CD4%. All SUSTAIN supported sites will have the capacity to determine CD4% for evaluation of immunological status of children less than 6 years. Based on available evidence on child survival and morbidities in relation to immunological staging, SUSTAIN will provide ARVs for all infected infants (less than 1 year) in addition to other revised ART guidelines tin accordance with revised National pediatric ART guidelines so as to prevent mortality and brain damage in rapid progressors. Appropriate

first and second line regimens that preserve future options with minimal toxicity profiles will be adopted for all PTF. SUSTAIN will intensify collaboration with GON and other stakeholders to ensure prompt diagnosis of TB in children and facilitate provision of pediatric TB formulations. All children on ARV will have at least monthly home visits to ensure adherence and assess need for intervention. Specific efforts and training will be made to develop adolescent friendly services for infected and affected children including linkages to reproductive health.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	674,364	0

Narrative:

This activity ensures that appropriate Lab support is provided for lab diagnosis, clinical monitoring and HIV testing. Linkages with HVSI will ensure tracking of lab infrastructure indicators. SUSTAIN will support Laboratory (Lab) infrastructure in all support partner treatment facilities (LPTFs). SUSTAIN will provide on-site capacity to testing for HIV, laboratory monitoring of disease progression and response to treatment, opportunistic infections (OIs) diagnosis and monitoring of antiretroviral drug (ARVs) toxicity. SUSTAIN will support the improved diagnosis of TB, PCP, cryptococcal infection, syphilis, hepatitis B (HBV), protozoal and bacterial infections. SUSTAIN does not routinely do Viral load (VL) testing but ensure that VL testing is done to make difficult therapy switch decisions as well as for program evaluation on a random 10% subset of our clients from each PTF who have been on therapy for a period of 6 -9 months annually by collaborating with other PEPFAR IPs with viral load capacity and at 1 of our PTFs with VL capacity. In addition, 2-3% of AR clients on ART would require VL testing based on clinical indications. SUSTAIN will also support expansion of early infant diagnosis (EID) at PMTCT supported facilities in accordance with the national EID scale up plan. SUSTAIN will participate in the USG-GON coordinated Laboratory Technical Working Group (LTWG) to ensure harmonization with other IP and GoN supported laboratory program. SUSTAIN will support the development of a common Lab equipment platform appropriate for each lab level.

In FY2013 SUSTAIN will provide support to 35 sites in a total of 12 states, all of these partner sites are secondary level and of these facilities have PCR capacity: 1) St Vincent's DOC (DREAM model) has bDNA VL testing supported by CRS private funding. SUSTAIN will provide automated CD4 testing equipment with capacity for processing large patient loads, cytosphere reagents using binocular microscopes that are easy to use and appropriate for secondary care centers for manual CD4 testing as backup in place of automated CD4, hematology analyzers and chemistry machines. All labs will be supported to test for syphilis, PCP, TB, HBV, hematology, chemistry, cryptococcosis and CD4. SUSTAIN will provide an additional 5 LPTFs with fluorescent microscopes for enhanced TB and malaria diagnosis, and support necessary training and reagent procurement for these equipment at all 15 labs. A SUSTAIN

Lab Specialist will be dedicated with the overall responsibility for equipment installation and maintenance. All SUSTAIN Lab Specialists have received training and will continue to receive updated trainings from CD4 manufacturers and other lab equipment manufacturers as maintenance engineers to support the servicing of CD4 and other machines. SUSTAIN will use its reagent forecasting tools at all levels to determine consumption and predict need, to forestall stock outs. Working with SCMS and CHAN Medi-Pharm, SUSTAIN will centrally procure lab reagents from manufacturers locally and abroad and distribute to PTFs. HIV Test kits will be provided directly by the USG through the SCMS mechanism. SUSTAIN will work with locally certified QA experts to implement the Lab EQA program

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	499,680	0

Narrative:

SUSTAIN's SI activity incorporates program level reporting and implementation of both paper-based and computerized Health Management Information Systems (HMIS) in PTFs. This activity is supported by Futures Group. Using in-country networks and available technology, SUSTAIN will continue to strengthen PTFs' Patient Management Monitoring (PMM) systems with added emphasis on harmonization with the Government of Nigeria's (GON). As part of capacity building and contribution to program sustainability SUSTAIN will continue to provide logistical support for automated PMM to local partner facilities by providing them with computers and other logistical support systems and will continue to expansion of these services in FY2013. SUSTAIN will support the process of harmonizing its existing IQCare PMM system with the LHPMIP with a view to actualizing efficient PMM-PME integration. SUSTAIN will continue to strengthen its program for Continuous Quality Improvement (CQI) in order to improve and institutionalize quality interventions. This has included standardizing patient medical records to ensure proper record keeping and continuity of care at all PTFs.

SUSTAIN will provide TA to PTFs and personnel to adapt and harmonize existing tools to meet the standards of the GON having conducted proper roll-out of GON's revised M&E tools thus ensuring that monitoring and evaluation of the SUSTAIN program is consistent with the national plan for patient monitoring. SUSTAIN's SI team will work with CQI specialists to conduct site visits at least quarterly during which evaluations of the utilization of National tools and guidelines, proper medical record keeping, efficiency of clinic services and referral coordination were conducted. Data flow including data collection, management and reporting was assessed and recommendations for improvement given. Supportive supervision and mentoring has been provided to all on-site staff that collect and utilize data (e.g., clinicians, pharmacists, data entry personnel, administrators). All of these activities will continue to be supported in COP09 with more frequent on-site TA and follow-up monitoring visits to address any weaknesses identified during routine monitoring visits. State M&E officers shall be informed of, and

involved in the monitoring processes and the training programs in order to instill a sense of ownership and ensure sustainability of these efforts. Data Demand and Information Use (DDIU) trainings will be expanded to include respective SACAs and LACAs. SUSTAIN will conduct quarterly Date Quality Assessment in all sites.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMBL	2,000	0

Narrative:

SUSTAIN will support the linkage of supported Partner Treatment Facilities (PTF) and their satellite sites to the National Blood Transfusion Service (NBTS) zonal centers across the country. In FY2013 SUSTAIN will support 25 PTFs and 1o satellite sites in 10 states (Adamawa, Benue, Delta, Edo, FCT, Kaduna, Kogi, Nassarawa, Ondo, Plateau, Taraba and Oyo). Blood transfusions occur at all 25 PTFs. SUSTAIN will work closely with the National Blood Transfusion Service (NBTS) and Safe Blood for Africa Foundation (SBFA) in all aspects of its blood safety program. SUSTAIN will support the NBTS in implementing its primary objective of migrating fragmented hospital-based blood services to centralized NBTS-based blood services nationwide. A key feature of this program is the development of a nationwide voluntary donor recruitment system. NBTS, through linkages its zonal centers will develop with SUSTAIN and its supported facilities, will provide TA for blood donation drives held by these SUSTAIN-supported hospital facilities. In addition, SBFA will train nurses and medical laboratory scientists in these facilities to recruit repeat voluntary blood donors from the ranks of current family replacement donors. SUSTAIN will work with the PTFs to ensure management buy-in for the NBTS blood services program, to create support of blood donor organizers, and to strengthen health facility and community focused blood drive activities. CCFN will draw upon its unique position in working with mainly faith-based facilities to facilitate blood donation activities within parishioner communities. SUSTAIN will support the distribution of IEC/BCC materials obtained from NBTS and SBFA to promote the need for voluntary non-remunerated blood donation. In addition, SUSTAIN will establish blood transfusion committees to oversee blood use based on national algorithms and standards in the health facilities.

This linkage will include regular delivery of donated units of blood to NBTS for screening in conjunction with a regular delivery of screened units of blood to the facility. NBTS will pick up unscreened blood units from the PTFs and will transport these units back to NBTS centers where they will be screened for the 4 transfusion transmissible infections (TTIs) of HIV I and II, hepatitis B, hepatitis C and syphilis using ELISA techniques. In addition to collecting unscreened units, NBTS will deliver to the PTFs their requested order of screened units for blood banking and use at the facilities. NBTS will also provide monthly feedback on rates of the 4 TTIs found by ELISA screening of blood units collected by each facility. All PTFs that do blood transfusions will ensure appropriate facility-level collection of blood. Directed and voluntary donors will be prescreened with the NBTS donor screening questionnaire and

donors will be deferred as necessary based on their responses. Deferred donors will be offered HCT. At least 2,500 blood donors will be screened using the National HCT testing algorithm, thereby utilizing the blood donor setting as another point of service for HCT during pre-donation. A PEPFAR-supported evaluation of the current emergency-based transfusion system will provide insight into rates of TTIs, including HIV, that go undetected in emergency screened blood.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMIN	6,447	0

Narrative:

SUSTAIN Partner Treatment Facilities (PTFs) consist largely of primary and secondary healthcare institutions located within communities that are poor and underserved in all areas of social infrastructure including healthcare. A proportion of HIV infections are still transmitted within these healthcare facilities through unsafe injection practices. In FY2013, SUSTAIN will expand to support safe injection activities at all PTFs in the focal states. SUSTAIN injection safety activities encompass the training of infection control personnel from each supported facility on universal precautions and medical waste management. Healthcare workers trained in collaboration with John Snow Inc. /Making Medical Injections Safer (JSI/MMIS) will step down the training to ensure sustainability and behavioral change. It is expected that a total of 120 personnel will be trained. This step down training to other PTF staff, including nurses, doctors, laboratory staff, hospital cleaners, laundry workers and waste managers, will include topics such as proper techniques for giving injections, drawing blood, dispensing blood into laboratory bottles for laboratory testing, and disposal of used needles, sharps and other materials contaminated by blood and other biohazardous materials. SUSTAIN will obtain and use MMIS supplied manuals to conduct follow-up on-site training at AR-supported LPTFs. Behavioral change communication (BCC) activities will be carried out to reduce unnecessary use of injections. SUSTAIN will provide supportive supervision to all trained staff in supported facilities.

SUSTAIN will collaborate with JSI/MMIS to supply and distribute single-use needles, safety boxes and personal protective equipment to all supported PTFs. This activity will involve the provision of retractable needles and syringes, sharps containers and liquid hand washing soap in LPTF wards, clinic rooms, laboratory work stations and strategic areas to encourage their use. This activity will also provide personal protective equipment (PPE) for health workers and ancillary hospital staff who come into contact with sharps and contaminated materials. SUSTAIN will work with each PTF to improve access to water at each hand washing point. For sustainability purposes, AR will ensure that these activities are integrated within each facility's overall infection prevention and control and workplace safety programs. SUSTAIN will also support post-HIV exposure prophylaxis (PEP) programs at all sites. Health care waste management will be supported in this activity. Incinerators will be repaired and fueled where they are available and constructed where there are no incinerators. SUSTAIN will strengthen its program for

Continuous Quality Improvement (CQI) to improve and institutionalize quality interventions. CQI specialists and Laboratorians will conduct team site visits at least quarterly during which there will be evaluations of infection control practices, waste management procedures, proper record keeping, and use of standard operating procedures for injection safety.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	40,965	0

Narrative:

All HIV programs supported by SUSTAIN promote abstinence until marriage, and mutual fidelity within marriage. SUSTAIN does not finance, promote or distribute condoms. In line with its HIV Policy, however, SUSTAIN does provide age-appropriate, complete and accurate information about condoms to its partners as part of its HIV activities. SUSTAIN will implement its AB programming activities in line with the overall PEPFAR Nigeria goal of providing prevention services to individuals reached through a balanced portfolio of prevention activities. SUSTAIN will provide full accurate information on prevention services. The program will support partner treatment facility (PTF) activities targeting HIV + clients, their families and communities who access care at these points of service. And community based organizations to target out school youths. Prevention priorities will include behavior change for risk reduction and risk avoidance, counseling and testing. All SUSTAIN supported PTFs will provide education and training to patients and community health volunteers on secondary prevention. There will be structured peer education that includes systematic training curricula, refresher training, and training on essential life skills. In addition, age appropriate abstinence only messaging and secondary abstinence messaging will be conveyed to adolescents and adolescents, especially orphans and vulnerable children receiving both facility and home based support. This service will also be extended to schools and National Youth Service Corps orientation camps. SUSTAIN will cover communities with AB messages conveyed through multiple media.

The program aims to cover communities targeted with messages conveyed through multiple fora. Utilizing such a methodology, a large number of people will be reached with messages via one method or another, but the counted group will be those individuals that would have received AB messaging: (1) on a regular basis and (2) via the three strategies (community awareness campaigns, peer education models and peer education plus activities). Fidelity in relationships will be promoted through information, education and communication (IEC) materials and enlisting the support of religious leaders in community-led peer education plus activities. A family-centered approach will provide opportunities to maximize prevention messaging to all family members. SUSTAIN will draw on culturally appropriate prevention messaging material for these activities. Training will be an integral part of this program and will be directed at facility staff, community level staff and religious leaders to be able to promote abstinence and being faithful messages to patients, their families and communities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	523,544	0

Narrative:

SUSTAIN will increase support for counseling and testing services in 25 Partner Treatment Facilities (PTFs), 10 satellite and three Community Based Organizations in FY2013. An emphasis will be placed on satellite decentralization clinics and family members of In-care clients. SUSTAIN will build the capacity at existing and new PTFs to enable them integrate HCT services within care and treatment systems and obtain resources from the GoN and other agencies to increase uptake of HCT services in all points of service in the facilities. All HCT service outlets will be branded with the “Heart to Heart” logo. SUSTAIN will support Provider Initiated Testing and Counseling (PITC), opt-out testing and point of service testing in all supported healthcare facilities. These approaches to HCT will be strengthened by technical and programmatic staff through onsite mentoring /preceptorship of providers and the engagement of leadership at supported facilities. SUSTAIN will scale-up couples counseling and testing in all supported sites through organized training, family centered testing and on site mentorship. Referrals to outlets that provide other prevention services not available at supported facilities will be provided and tracked. All HCT sites will provide same day results and will use the current National serial testing algorithm. For infants and children less than 18 months Early Infant Diagnosis (EID) will be available at PMTCT sites according to the national scale up plan. Rapid HIV test kits provided by the USG through SCMS will be distributed to PTFs by our warehousing and distribution agent based on utilization. Sites will be actively linked to Government of Nigeria and other donor agencies to access extra kits and supplies needed and supported to maintain their regular usage and feedback through the above mentioned strategies. Sites will be trained on forecasting and stock control using bin cards and will maintain a three month buffer. PTFs will report on inventory and forecasting to the central office on a bimonthly basis.

In FY2013 SUSTAIN will target the provision of HCT services mainly to PABAs - especially children, as well as to STI patients and TB DOT clients at the PTFs and satellite clinics. SUSTAIN will target women of reproductive age with combined HCT and STI screening and provide HCT services as a routine component of blood transfusion services. All HCT clients will be linked to prevention services, as well as treatment, care and support services where applicable. SUSTAIN will train and retrain PTF staff on counseling and testing using the GON HCT training curriculum. Counselor training will include couples counseling to strengthen this aspect of the program. This will ensure the availability of a pool of trained counselors to promote continuity. In addition, providers will be sensitized on the adoption of PITC, opt-out testing and point of service testing in their facilities. Non-laboratorians will be used at multiple points of service for facility based HCT where appropriate and when allowed by national policy. To expand HCT services within the network of faith based organizations and increase rural access to HCT, SUSTAIN will support community and family based HCT and advocate for greater use of trained non-laboratory staff to conduct testing in the community setting as well.

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

Narrative:

Not Provided

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	3,507,309	0

Narrative:

In FY2013 CCFN SUSTAIN will increase the PMTCT services to at least 5 additional facilities SUSTAIN with other IPs, will support the implementation of the PEPFAR-Nigeria Local Government Area (LGA) coverage strategy, ensuring the provision of PMTCT services in at least one health facility in every LGA. This is a critical step toward universal access to PMTCT services. Through its PMTCT services SUSTAIN will provide testing, counseling and results to 104,000 pregnant women. Antiretroviral (ARV) prophylaxis will be provided to 3,870 women. This activity will include, as a part of the standard package of care, routine provider initiated opt-out HIV counseling and testing (HCT) in antenatal clinics (ANC) for all presenting women and in labor and delivery wards (L&D) and the immediate post-delivery setting for women of unknown HIV status. Same day results will be provided to clients. SUSTAIN will use group health information, individual pre-test and post- test strategies and rapid testing based on the National testing algorithm. Partner testing and couple counseling will be offered as part of PMTCT services to enhance disclosure. SUSTAIN through community linkages, will utilize community and home based care services to promote partner testing. Clients will have access to free laboratory services including CD4 counts and STI screening. Free medications including those for OIs as needed and hematinics will also be provided. PMTCT regimen for mother and baby will be provided based the current national guidelines. AR will use its community linkages and mother-to-mother support groups to encourage HIV+ pregnant women to deliver in a health facility. For those HIV+ women who choose not to do so and deliver at home, the same community volunteers will follow-up and identify them for needed postpartum services. SUSTAIN will engage traditional birth attendants (TBAs) in addition to the mother-to-mother support groups to reach HIV+ women who choose to deliver outside of the health facility. A focal person at each PTF will be responsible for tracing HIV+ mothers and their infants in the community and linking then back to care. The HIV+ mothers and their infants will be linked postpartum to ART care and support services which will utilize a family centered care model. AIDSRelief will offer HIV early infant diagnosis (EID) in line with the National Early Infant Diagnosis scale-up plan from 6 weeks of age using DBS. Implementation of the EID scale-up will be done under the guidance of the GON and in conjunction with other IPs who will be conducting the laboratory testing. SUSTAIN will collaborate with GoN as appropriate for commodities and logistics support of the EID program. Exposed infants will be actively

linked to pediatric care and treatment, while their families will be referred to age-appropriate OVC services. SUSTAIN will strengthen mother and baby follow up strategies to reduce loss.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	0	0

Narrative:

In FY2013, SUSTAIN utilize first and second line ARV drugs to treat over 35,000 patients including children in 25 PTFs and 10 satellite clinics in 12 states of Nigeria. An estimated 25% of PLHIV already enrolled in care will qualify for and be placed on ART during the year. An estimated 5% of ART clients will require 2nd line treatment. In setting and achieving FY2013 targets, consideration has been given to modulating SUSTAIN scale up activities in order to concomitantly work towards continuous quality improvement. SUSTAIN's supply chain management system will ensure that the necessary infrastructure, systems and skills are in place for efficient forecasting, distribution, storage, and distribution of quality and efficacious ARVs to supported PTFs with effective monitoring and evaluation. Assessment of new sites will follow the SUSTAIN Information Gathering Tool and the Pharmacy Support and Assessment Standards Checklist. Pharmacies will be refitted to improve commodity security. Technical support to PTFs to institutionalize standard operating procedures (SOPs) for drug management will be supported and we will train and retrain 30 pharmacists and 30 other health workers including pharmacy technicians or assistants in the use of developed SOPs which are in line with national guidelines. These SOPs include drug requests, receipts, recording, dispensing, discrepancy reporting, temperature control and disposal of expired drugs. In-depth training of the PTF staff in the utilization of SOPs, forecasting and quantification for ARVs and general drug management issues will be conducted. All ARVs received from the Supply Chain Management Systems are warehoused and distributed transported under air-conditioned environments and have in-transit insurance coverage. Procurement procedures for other commodities will follow USG and NAFDAC regulations and are consistent with National Treatment Guidelines. SUSTAIN will have service contracts with CHAN Medi-Pharm for warehousing and distribution. The Pharmaceutical Management Team manages country operations with a Therapeutic Drug Committee (TDC) comprising of clinicians, pharmacists, palliative care specialists, strategic information advisors and program managers. The TDC reviews drug utilization patterns across all PTFs, assesses scale-up progress and develops required technical support plans. SUSTAIN will support the strengthening or establishment of Therapeutics Drug Committees (TDC) at all Partner Treatment Facility. The TDC will have the key responsibility of developing policies for managing medicines use and administration, evaluating the clinical use of drugs and managing a formulary system. The TDC will promote rational use of medicines (RUM) through the medication use reviews, provision of drug information to patients, monitoring medication errors, development, and implementation of Pharmacovigilance plan (data gathering activities relating to detection, assessment and understanding of

adverse drug events / reactions i.e. ADEs or ADRs and treatment failure). The SUSTAIN technical team will provide technical assistance through training and on site mentorship for these committees

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	3,328,874	0

Narrative:

All PTFs will consolidate on their capacity to provide comprehensive quality ART services through evidence based models of care delivery. This includes quality management of OIs and ART, a safe, reliable and secure pharmaceutical supply chain, technologically appropriate lab diagnostics, treatment preparation for patients, their families and supporters and community based support for adherence. This technical and programmatic assistance utilizes on-site mentoring and preceptorship. It also supports the development of site specific work plans and ensures that systems are in place for financial accountability. AR will adhere to the Nigerian National ART service delivery guidelines including recommended first and second line ART regimens. In addition, SUSTAIN will partner with the Government of Nigeria and Global Fund as appropriate to leverage resources for providing antiretroviral drugs to patients. SUSTAIN will continue to strengthen institutional and health worker capacity through the training, retraining and mentoring of health service providers to provide care and treatment services at the facility and community levels. Doctors, pharmacists, nurses, counselors, and community health extension workers will receive training and onsite mentoring that will allow them to provide comprehensive care. Training will maximize use of all available human resources including a focus on community nursing and community adherence. Care and Treatment trainings will be based on the national curricula. SUSTAIN will collaborate with the GoN and other stakeholders to develop task shifting strategies to enable nurses and community health officers to provide ART.

SUSTAIN will conduct 2 week intensive didactic and practical trainings preceding site activation followed by regular onsite mentoring. SUSTAIN will also train community volunteers including PLHIV and religious leaders to provide peer education counseling, psychosocial and spiritual counseling, respectively. SUSTAIN will use GON/USG recommended standardized training curriculums, manuals and training aides for all trainings. Information, education and communication materials will be provided to enhance these trainings. SUSTAIN will work closely with the USG and GoN team to monitor quality improvement at all sites and across the program. Over 90 Health care workers will benefit from these trainings referred to above in HIV Care, Treatment and Support. A key component for successful ART is adherence to therapy at the household and community levels. PLHIV on treatment are encouraged to have a treatment support person such as a family member to whom he/she had disclosed HIV status to improve support in the home and increase adherence. SUSTAIN will continue to build and strengthen the community components by using nurses and counselors to link health institutions to communities. Each PTF will appoint a staff member to coordinate the linkages of patients to all services. This will also build the

capacity of PTFs for better patient tracking, referral coordination, and linkages to appropriate services. These activities will be monitored by the SUSTAIN technical and program management regional teams.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	480,387	0

Narrative:

SUSTAIN will provide broad based access to HCT for all children through a multi-pronged approach; family centered approach to care and treatment, PITC (provider initiated testing and counseling for all children) and community mobilization. All exposed infants delivered in the PTF or identified through the family centered approach will be linked to the ART clinic for enrollment into care and treatment. Intensive community based activities will be put in place to identify exposed infants including those lost to follow up from the PMTCT program. SUSTAIN will provide DBS/DNA PCR technology for early infant diagnosis in addition to the logistic support for transportation of blood samples to designated laboratories. All infected children will be evaluated for ART using CD4 or CD4% as all sites will be equipped with capacity to determine CD4% for evaluation of immunological status of children less than 6years. Based on available evidence on child survival and morbidities in relation to immunological staging, AR will provide ARVs for all infected infants (less than 1 year) to prevent mortality and brain damage in rapid progressors. Appropriate first and second line regimens that preserve future options with minimal toxicity profiles will be adopted for all PTF. SUSTAIN will ensure adequate adherence at the home level with enhanced home visits proceeded by intensive treatment preparation for identified caregivers. All children on ARV will have at least monthly home visits to ensure adherence and assess need for intervention. SUSTAIN will build the capacity of CCFN technical staff and at the PTFs to establish adolescent programs for infected and affected children including linkages to reproductive health.

Non ART eligible children will be enrolled into care for periodic follow-up, including laboratory analysis at least every 6 months, to identify changes in ART eligibility status. All enrolled children will be linked to the OVC program to access an array of services including nutritional support, preventive care package (water sanitation/treatment education, ITN) and psychosocial support. All PTFs will be empowered with training and tools to ensure nutritional assessment. ART sites at PTFs are co-located in facilities with TB DOTS centers to facilitate TB/HIV service linkages. SUSTAIN will collaborate with GON and other stakeholders to ensure prompt diagnosis of TB in children and facilitate provision of Paediatric TB formulations. A key component for successful ART is adherence to therapy at the household and community levels. SUSTAIN will ensure intensive treatment preparation directed at an identified caregiver to ensure strict adherence and will continue to build and strengthen the community components by using nurses and counselors to link health institutions to communities. Focal staff in PTFs will be trained using national curriculums to ensure quality care and treatment. Training topics include paediatric ART clinical care; treatment adherence and laboratory monitoring based on available evidence

based best practices. Emphasis will be placed on early identification and treatment of lymphoid interstitial Pneumonitis, HIV encephalopathy and other diseases peculiar to infected children. Training will maximize use of all available human resources including a focus on community nursing and community adherence to ensure care is decentralized to the home level.

Implementing Mechanism Details

Mechanism ID: 16849	**Mechanism Name: Strenghtening Human Resources For Health(HRH) for the Provision of HIV/AIDS Services Through Pre-service**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: New Partner	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 750,000	
Funding Source	**Funding Amount**
GHP-State	750,000

Sub Partner Name(s)

University of Maryland School of medicine		

Overview Narrative

The Center for Clinical Care and Clinical Research Nigeria (CCCRN), in collaboration with local teaching institutions, will seek to more closely align USG-funded HIV/AIDS efforts with the national programs through a program called Partnership for Medical Education and Training (PMET). PMET is a comprehensive solution to HIV/AIDS and other infectious disease training gaps in Nigeria.

PMET's goal is to create a network of health training institutions that will assist State and Federal Governments to develop their health care systems through enhancing training capacity in prevention, care and treatment of HIV disease, opportunistic infections, the appropriate use of antiretroviral therapy, and the implementation of

community-based care; and strengthening the human and organizational capacity of their health systems to sustainably address emerging new HIV challenges or for any related illness. This goal will be achieved by reaching these Strategic Objectives (SO):
1. INDIVIDUAL: Educating individual health professionals at pre-service and post-graduate levels in appropriate knowledge and skills;
2. POLICY: Working with the Federal and State Governments plus professional associations, regulatory bodies and others to develop and implement policies that will enable and facilitate the vision and goal of this program; and
3. SYSTEMS: Strengthening the capacity of target training institutions so that, ultimately, they are capable of providing enhanced education, clinical mentorship, distance based e-learning, curriculum development and all other elements required for continuous improvement in HIV training and education based on locally generated new knowledge and practice.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	750,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**16849**
Mechanism Name:	**Strenghtening Human Resources For Health(HRH) for the Provision of HIV/AIDS Services Through Pre-service**
Prime Partner Name:	**New Partner**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and	OHSS	750,000	0

Systems			

Narrative:

PMET's goal is to create a network of health training institutions that will assist State and Federal Governments to develop their health care systems through enhancing training capacity in prevention, care and treatment of HIV disease, opportunistic infections, the appropriate use of antiretroviral therapy, and the implementation of community-based care; and strengthening the human and organizational capacity of their health systems to sustainably address emerging new HIV challenges or for any related illness.

SO1 Health care workers are empowered to provide comprehensive HIV care services

SO2 Health systems are strengthened to provide capacity building

SO3 Training institutions sustain capacity building activities beyond the life of the grant. The CCCRN pre service training award commenced on 30th September with the aim of equipping undergraduate nurses, community health workers and MPH students with the skill sets required to meet the growing challenges and complexities of HIV/AIDS management. A key element of the award is to institutionalize training structures in a sustainable manner that will engender increased government investment in capacity building. The trainings will build on existing national infrastructure, master trainers and national curricula in the relevant fields of HIV/AIDS management such as Adult ART, Pediatric ART, PMTCT, HCT and TB/HIV. Trainings will also be offered in Leadership, Program Management, Quality Improvement and other areas necessary for a sustainable and comprehensive approach to HIV/AIDS care and treatment programs.

Implementing Mechanism Details

Mechanism ID: 16850	**Mechanism Name: Engaging Indigenous Organisation to Sustain and Enhance Comprehensive Clinical Service**
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: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 22,574,228	

Funding Source	Funding Amount
GHP-State	22,574,228

Sub Partner Name(s)

(No data provided.)

Overview Narrative

During COP12, the transition of management responsibility for former Harvard sites to APIN was concluded, and APIN provided HIV care and treatment services at 46 comprehensive sites, 100 PMTCT sites and 58 DOTS centers in 9 states. The comprehensive sites include 12 new ones that were activated during the period. In COP 13, APIN will concentrate efforts on supporting the HIV/AIDS response in 3 states (Lagos, Oyo and Plateau) where APIN has been designated the lead PEPFAR IP, in line with the USG regionalization policy. APIN and its sub-partners will target hard-to-reach communities and HIV high-burden populations for the scale-up of HIV/AIDS service delivery, as well as contribute to the strengthening of health systems to implement sustainable HIV/AIDS programs in these states.

As part of assuming the role of State Lead IP, stakeholder meetings were convened by APIN to map out strategies for successful project implementation for each state. The process for the development of a one-year state implementation plan has been commenced. There is an on-going HIV/AIDS capacity assessment, after which a capacity building plan will be developed for each state. A 5-year sustainability plan is also being developed. In order to enhance the capacity of the state to manage the program and ensure ownership and sustainability, a State Implementation Team has been constituted for each state, with inputs from all the stakeholders. The team will be responsible for planning, implementation, coordination, resource mobilization, monitoring and supervision of project activities. Also, sites that were previously managed by other IPs in the state have been transitioned to APIN and the provision of support to these sites has been commenced.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	125,000
Gender: GBV	85,668
Gender: Gender Equality	342,675

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
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
End-of-Program Evaluation
Family Planning

Budget Code Information

Mechanism ID:	**16850**
Mechanism Name:	**Engaging Indigenous Organisation to Sustain and Enhance Comprehensive Clinical Service**
Prime Partner Name:	**AIDS Prevention Initiative in Nigeria, LTD**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	2,479,478	0

Narrative:

In COP 13, APIN will continue to provide a continuum of care services that will include CD4 assessment, clinical care, provision of basic care kits, prevention and management of opportunistic infections and STIs, assessment and management of pain and other symptoms, nutritional assessment and support (nutritional counseling and food demonstration and provision of therapeutic supplements), screening for TB, safe water interventions and laboratory services. Other services include supportive services (both

facility- and community-based support group activities), Positive Health Dignity and Prevention (PHDP) and various types of counseling, and social care services such as stigma reduction.

Risk assessment and behavioural counseling will be provided to achieve risk reduction through individual counseling and community outreaches by PLHIV support groups and collaborating CBOs. Facilities will be supported to provide PHDP services such as HTC for family members and sex partners, counseling for discordant couples, disclosure, healthy lifestyles and positive living, prevention messages, alcohol and substance use assessment, assessment and treatment of STIs, pregnancy/family planning intentions and provision of condoms and IEC materials.

Tracking of defaulting patients will be strengthened through established tracking teams, and the use of site appointment database system. The proposed operational research on strategies to improve the retention of pre-ART clients will be conducted once the necessary approval is given. Referral networks will be established and existing ones strengthened to improve linkages to and fro the communities and the facilities through the use of national referral tools and coordination by a designated referral coordinator.

With the activation of new sites, there will be need to build the capacity of the staff at those sites to provide qualitative and comprehensive care services, and also the need to procure and distribute care commodities such as HBC kits, basic care kit (containing long lasting insecticide net, water disinfectant, water vessel, IEC materials, condoms and soap) to clients both at the facilities and communities. Fortified food supplements will be distributed to vulnerable groups such as underweight HIV+ pregnant and lactating women, mild and moderately malnourished children, and HIV+ adult patients with BMI <18.5. In addition, Cotrimoxazole prophylaxis will be provided to eligible PLHIVs according to the national guideline.

PLHIV support groups will be supported to provide home based care, track defaulting patients and provide adherence counseling to their peers. Economic strengthening for members will be done through the establishment of savings and loans associations, with possible linkages to microfinance initiatives. The operational research on the benefits of the support group membership will be conducted once the necessary approvals are obtained and the findings disseminated appropriately.

APIN will continue to support the national and state governments to carry out its coordinating and oversight functions, and to ensure that PLHIVs are provided with qualitative care services to improve their quality of life, according to national guidelines.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Care	HKID	856,688	0

Narrative:

In COP 13, APIN will continue to provide qualitative and comprehensive 6 + 1 services in the 3 supported states (Lagos, Oyo and Benue) to all enrolled vulnerable children (VC), 0-17 years of age, and their households, in various communities using the household-centered approach on a needs basis through partnership with Community Based Organizations (CBOs).

The services to be provided will include food and nutritional support (nutritional assessment, counseling and supplementation), and education and vocational skill training, for older and out-of-school children. The type of educational support services to be provided will include enrolment of children into non-tuition paying government schools, provision of school bags, scandals, uniforms, books, stationaries and payment of levies for VC that do not receive waivers. Older out-of-school children will be enrolled into formal skill acquisition trainings such as hair dressing, fashion designing, auto mechanic and carpentry.

Other services include healthcare (through the provision of basic care kits, such as water vessels, water disinfectants and insecticide treated nets (ITNs), and the prevention and treatment of minor childhood ailments) and rendering psychosocial support for the caregivers and the VC mainly through formation of kids/adolescent clubs which provide recreational activities and life building skills. Shelter, economic strengthening and protection services will also be provided through referral to wrap-around services. The caregivers will meet regularly at a forum, where they will be educated on the care for the children, good personal hygiene and environmental sanitation, preparation of nutritionally adequate meals using locally available foods, and also empowered with income generating activities.

APIN will partner with CBOs through an umbrella organization, Association of OVC NGOs in Nigeria (AONN) in the 3 supported states (Lagos, Oyo and Plateau). Advocacy visits will be conducted to stakeholders in these states, especially to the State Ministries of Women Affairs & Social Development (SMWASD), Commissioners for Women Affairs, Health & Education, LGA chairmen and selected community leaders. Joint assessment visits, review meetings and technical assistance will be conducted by APIN, AONN and state representatives to the CBOs. The capacity of the CBOs, SMWASD and LGA desk officers (technical and organizational) will be strengthened, via trainings and work tools provided for qualitative service delivery and better coordination. APIN will roll out the national electronic database for the management of Vulnerable Children which has been adopted by the FMWASD to its collaborating CBOs.

APIN will scale up Household Economic Strengthening (HES) at individual, household and community levels, through training of individuals on income generating activities (IGA), the establishment and

strengthening of Village Savings & Loans Associations (VSLA), cooperative societies and linkages to microfinance schemes, both at the household and community levels, to achieve sustainability. APIN will continue to collaborate with key stakeholders on OVC, to promote management of qualitative OVC programming in Nigeria, through its active participation in the national OVC technical working group (TWG).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	539,709	0

Narrative:

In COP 13, APIN will continue to provide support for TB/HIV services to PLHIVs in line with WHO three Is (intensified TB case finding, isoniazid prophylactic therapy and TB infection control) at all its supported comprehensive care and treatment sites and DOTS centres in the 3 supported states (Lagos, Oyo and Benue). Intensified TB case-finding among HIV patients will be carried out using the national TB screening algorithm, including TB symptom screening for all HIV+ persons at every clinic visit. To enhance TB diagnosis, fluorescence microscopes and digital x-ray machines will be provided to some high TB burden facilities to be identified in collaboration with the various State TB Control Programs. TB/HIV co-infected patients will receive TB treatment at co-located or affiliated DOTS centers, in line with national guidelines. They will also be provided with CPT in order to reduce mortality among them.

Universal access to HTC services will be scale-up for TB suspects/patients at DOTS centers in supported sites, in order to increase their HTC uptake. All HIV+ persons identified at these DOTS centers will be provided with TB treatment and linked to ART clinics for comprehensive HIV treatment and care. Isoniazid preventive therapy (IPT) will be provided for HIV patients who screen negative for TB, thereby reducing the risk of TB transmission and the mortality rate among them.

APIN will implement TB infection control measures to prevent nosocomial transmission of TB to HIV+ patient: patient education on basic hygiene, cough etiquette and proper sputum disposal, and education of facility staff on personal protective measures. Clinics and laboratories will be renovated and upgraded to ensure adequate cross-ventilation and to acceptable biosafety standards and APIN will facilitate the integration of TB infection control into the facility infection control plan.

APIN will collaborate with the NTBLCP to conduct training on TB DOTS for facility staff in order to further improve their capacity for effective case management. There will also be training of state and LGA TB staff on LMIS in Plateau State, as has been done in Lagos, Oyo and Benue States. APIN will support TB/HIV collaborative activities and contribute to the national MDR-TB program scale-up, including institution of routine surveillance in accordance with national MDR-TB case-finding policy. The TB

National reference laboratory (NIMR) will be supported to function at bio-safety levels 3, and SW (UCH) and SE (UNTH) zonal reference laboratories at level 2+; and for TB culture, drug susceptibility testing (DST) and molecular assay (Hain's assay); and to improve their quality system management for WHO SLIPTA accreditation. UNTH will receive infrastructure upgrade for an MDR-TB treatment center. To improve diagnosis of TB and MDR-TB, GeneXpert machines will be provided to TB high burden sites in each state, in collaboration with STBLCP.

APIN will collaborate with CBOs to implement community TB care (CTBC) in order to increase case detection and treatment success in the 3 supported states. ACSM activities will be carried out to create awareness and to promote community involvement and participation. Community volunteers (CV) will be trained to carry out active TB case-finding in the community, screen TB suspects and contacts of TB patients for TB (and HIV) and will supervise family/community members acting as treatment supporters.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	383,905	0

Narrative:

APIN will continue to provide comprehensive pediatric care and support services to all HIV positive children at all its supported sites in the 3 states (Lagos, Oyo and Benue) in COP 13. The identification of HIV-positive children will be achieved through various strategies outlined in the pediatric recruitment section of the national guidelines. HIV-exposed babies will be screened for HIV. All HIV+ children will be evaluated clinically and with laboratory investigations, and ART-eligible children provided with ART services.

All enrolled HIV-infected children will receive a minimum care package made up of clinical care, basic care kit and supportive services in accordance with national guidelines. Clinical care includes CD4/CD4% assessment, cotrimoxazole prophylaxis, nutritional assessment, nursing care, prevention and management of OIs, prevention and management of STIs, TB screening and treatment, and malaria prevention. To reduce morbidity and mortality, cotrimoxazole prophylaxis will be provided to all HIV-exposed infants, HIV-infected children and adolescents, in line with national pediatric guidelines. Pediatric care and support services will be integrated into MNCH and immunization services, and TB/HIV co-infected children referred appropriately to DOTS centers.

Nutritional assessment (using anthropometric measurement etc.) and counseling will be provided and ready-to-use therapeutic food (RTUF) given to malnourished children. Basic care kit (comprising of long-lasting insecticide net, water disinfectant, water vessel, soap, hand gloves, and IEC materials) will be provided. Older HIV-infected children and their families will receive PHDP services, including HTC

services for family members (parents and siblings), prevention messages, and counseling (for HIV status disclosure, treatment adherence, high risk sexual behaviors, and assessment for STI). They will also be provided psychosocial and spiritual support as appropriate.

APIN will continue to strengthen facility- and community-based support groups for children (kids clubs). Community home-based care services will be provided, with linkages between facility and community OVC services strengthened through collaboration with CBOs. They will also be linked to youth-friendly centers and other wrap-around services in the community to ensure continuum of care. A child-friendly environment will be developed at the supported facilities by providing support for identification and renovation of suitable spaces within the clinic as play rooms and providing materials such as toys, age-appropriates books, audio-visuals and other learning materials. As the children grow to the age of 15 years, they will be migrated to the adult ART section and will continue with adult type of care. This will also promote retention in care.

Supported facilities will receive supportive supervisions and technical assistance through mentorship by program officers and sharing of updates, best practices, evidence-based clinical decision making process and implementation of national guidelines.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	2,848,221	0

Narrative:

During COP12, in addition to the existing 18 sites and 43 Oyo State DOT Centers; APIN assumed management responsibility for the 15 remaining Harvard sites namely: ABUTH, JUTH and its 13 satellites. In COP2012, APIN provided support for laboratory development at 34 treatment sites (9 tertiary care, 25 secondary sites), 100 PMTCT and 58 DOT sites. During this period, APIN also commenced the activation of comprehensive ART laboratory services at 15 new health facilities namely: General Hospital Lassa, GH Ngala, GH Briyel, GH Ugba, GH Obarike –Ito, GH Idekpa, Police Hospital Falomo, Ancilla Hospital, St. Kizito, Family Health Center Oke-Ilewo, Seventh Day Adventist Hospital Ile-Ife, Baptist Medical Center Shaki, St Virgillus, GH Gashua, and CHC Madagali distributed across 7 states (Benue, Plateau, Borno,Yobe ,Ogun,Oyo Lagos). APIN will continue to strengthen its existing laboratory systems and build the capacity of the new ones to provide quality services.
APIN will continue to collaborate with the USG to develop the framework for PCR lab network to support other IPs without the capabilities. The three (3) APIN supported Drug Resistance Monitoring (DRM) labs will be integrated into the national DRM program, while working with FGON to develop a develop HIVDR prevention and assessment strategies in accordance with WHO recommendations. A systematic

approach will also be established to ensure the attainment of WHO accreditation for these sequencing laboratories. 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. Following the huge success recorded in our in-house biomedical maintenance program, APIN plan to expand this service to make it more effective.

In furtherance of the PEPFAR II goals, APIN will continue to collaborate with the SLMTA team to prepare the six (6) participating labs towards attaining the WHO-AFRO accreditation. In addition, APIN will collaborate with SLMTA Nigeria team to register and prepare five (5) more labs for the next round of WHO SLIPTA program. APIN will also continue to work with the MLSCN to get all APIN labs accredited nationally using a structured approach to cascade the gains of the WHO-AFRO SLIPTA program to all the labs. APIN will continue to support the LIS at the labs with technical support from our data management team, using FileMaker Pro data software a program that 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.

Having temporarily taken over the responsibility of procuring EID lab commodities for the PEPFAR PMTCT programs, APIN will continue to collaborate with partners to ensure adequate quantification and timely ordering and delivery of these commodities. In addition, APIN will collaborate with SCMS to implement pooled procurement of Lab commodities and support the commodity unification program. APIN will develop inventory system software while also adopting the national LMIS tools to strengthen laboratory inventory management.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	624,424	0

Narrative:

During COP 13, APIN will scale up electronic medical records to 30 supported secondary and high volume primary health care facilities in the 3 states of operation that do not presently have that capability in line with CDC Nigeria requirements. This will involve supply of computers and accessories, computer skills and database management training for identified focal persons at the sites. Data staff from existing supported sites will receive training to further build their capacity in data cleaning and management. APIN will scale up biometric patient registration using finger print capture to all CDC supported HIV service delivery points in the three states of operation, to avoid double counting of clients receiving services, allow for easy transfer of clients between service delivery points without loss of clinical data and reduce the percentage of self-transfers counted as loss to follow up. Due to staff attrition and postings; APIN will conduct 2 basic database management trainings for new hires at the sites during the

year. Each service delivery point will receive at least 2 data aquality Audits will be conducted in collaboration with SMOH and SACA staff during the year.
APIN will support the each state of operation to establish a multi stakeholder quality management infrastructure at the ministry of health which will provide strategic direction on HIV care and service quality issues at the state in line with the national HIV quality framework. Each HIV service delivery point in the state will be supported to measure the quality of care provided to patients and mentored to implement quality improvement activities. Quarterly state level review meetings will be supported to facilitate peer learning, spread of change and best practises deriving from implementation of quality improvement activities. Trained QI coaches from older APIN sites will support state government staff to coach QI focal persons at sites. Due to staff attrition and postings; APIN will conduct 2 quality improvement trainings for new hires at the sites during the year
APIN will provide technical support to LGA and State M&E desk officers in all 3 states to analyse the M&E data from the state electronic data ware house (DHIS2.0). This will enable states to make evidenced based programme management and policy decisions regarding their HIV response. Clinical and M&E staff will be mentored on simple data analysis to further promote data use at service delivery points. Due to staff attrition and postings; APIN will conduct 2 monitoring and evaluation trainings for new hires at the sites during the year. M&E and programme area focal persons at newly activated sites will be trained on using the national data collection tools.
States will be provided financial and technical support to hold quarterly data validation meetings involving all HIV service delivery facilities including those who are not supported by IPS especially the private sector. This will allow the state to report a more robust and complete HIV data and contribute to better reporting of the national HIV response. APIN will also strengthen the states' M&E TWG by providing financial and technical support for quarterly meetings

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMBL	24,502	0

Narrative:

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 supported sites to provide qualitative blood safety services. Training gaps at the facilities will be identified and appropriate training connducted for HCW responsible for blood transfusion services in collaboration with NBTS and SBFA on appropriate clinical use of blood and other topics. Trained HCW will be supported to step down the trainings 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.Support will be provided for institutions to collaborate with NBTS in ensuring that the practices of family replacement donors is completely replaced by voluntary non remunerated donors. Advocacy to hospital managers to 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 will be intensified. Support will be provided for new facilities with blood banks to upgrade RTK based tests to 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	89,874	0

Narrative:

APIN will implement injection safety in all supported sites in 3 states (Lagos, Plateau and Oyo). This activity provides the initiation of intensive training program in injection safety practices for HCWs at all 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. APIN will conduct series of trainings including a TOT on the 'newly' approved infection prevention and control in clinical setting, with hand hygiene and phlebotomy components. This TOT will be 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 renovation and construction 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	256,405	0

Narrative:

The AB prevention programs will be implemented utilizing the minimum prevention package strategy in line with the National prevention plan and will focus on delivering key prevention messages including abstinence and be faithful messaging to target key populations consisting of in and out of school youths, intending couples, outpatient STI patients, border traders, fashion designers, young male market agents, and motor mechanics and MARPS. APIN will partner with existing CBOs in Plateau, Oyo and Lagos

states (Karale Lagos, Humanity Lagos, PAC Ogbomosho, AHI Lagos etc.) to reach population for AB messages within the communities, schools and other key places like markets. 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 build the capacity of the NGOs and CBOs to target MARPs, including using a combination of biomedical, behavioral and structural interventions. As in previous COP years, APIN will continue to focus on improving the integration of prevention activities into the HIV care and treatment settings.
APIN will collaborate with PLWHA support groups at these sites to build their capacity to implement AB activities among its members and surrounding communities.Support will be provided for the training of youth peer educators to serve as role models to help in the provision of prevention messages to a wide range of audience especially youths aged 15-24 years old.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	968,959	0

Narrative:

APIN will support the provision of facility-based comprehensive HIV counseling and testing (HTC) services, outreach campaigns, stand-alone HTC centers in 3 states while expanding services to high burden locations within the states. The HCT outreach campaigns will target hard to reach areas and will focus on MARPs, clients and their partners. Individuals 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 at facilities;support will be provided for the establishment of multiple HCT points within facilities and integration of prevention into broader RH/MNCH services. APIN will support the integration of HTC into TB DOTS centers in Oyo, Lagos and Plateau states to enable patients receiving TB services get counselled and tested for HIV.

Individuals identified as positive during outreach campaigns and facilities will be referred to PMTCT and ART clinics for treatment and palliative care services. APIN sites will continue to use family counselling sessions and “love letter” strategies to encourage partners of HIV-infected patients to access HCT so that couples receive HIV counselling and testing together.
To ensure improved quality of service at the sites, APIN will strengthen referrals and linkages, provide strong M&E and implement HCT quality assurance programs in line with the National HCT quality assurance guidelines.
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 counsellors to provide quality HCT services at the community level. For new facilities without HIV service delivery experience and where necessary, refresher training will be conducted for counsellors using the National HIV training curriculum. HIV testing will be 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 as part of contributions to National scale up response.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	1,339,739	0

Narrative:

APIN will continue to provide support for prevention implementation strategy by engaging NGOs and CBOs to provide services at the community level in addition to the facility based services being provided in existing 46 treatment sites and additional new sites to be activates.These NGOs and CBOs (Mashiah, HALT AIDS, ARFH, CAHLI Jos, CCC Jos, Karale Lagos, Humanity Lagos, PAC Ogbomosho and AHI Lagos) are spread across three (3) states of Lagos, Oyo and Plateau.
In COP13, 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) and other key drivers of the epidemic. APIN will also target high risk communities like trailler parks, garages and brothels 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.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	3,793,057	0

Narrative:

APIN will support Lagos, Plateau and Oyo states to scale up PMTCT services integrated into other RH/MNCH services in public and private health facilities; the PMTCT scale up plan will target

communities, PHCs, secondary health, tertiary and private medical facilities. At least 70 new PHCs and 32 secondary facilities will be targeted for activation for PMTCT services in the first year of the grant.
The grant will support implementation of strategies to reduce the rate of new infections among women and men of reproductive age groups by leveraging on prevention programs addressing delay in sexual debuts, safe sex practices and other prevention methods. Targeted HCT in ANC will be supported to identify pregnant women infected with HIV and appropriate ARV prophylaxis or treatment for maternal disease will be offered. Disease monitoring will be implemented to support PMTCT intervention by providing CD4, Viral load, chemistry,heamatology, TB and STI screening for pregnant women where appropriate and indicated.
The grant will also support the strenghtening of health systems as well as build the capacity of state officer to manage, cordinate and implement PMTCT programs in their respective states. Support wil be provided for a functional state PMTCT TWG to support the implementation and coordination of PMTCT programs in the states. Additional emphasis will also be placed on working with the states towards greater ownership of programs, improved funding and sustainability of programs with gradual handover of program and sites to be managed and funded wholly by states.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	0	0

Narrative:

The goal of the Pharmacy unit remains to strengthen systems to select, procure, store, track, distribute and provide ARTs.
APIN currently rents and utilizes a facility for warehousing in Lagos. A major thrust of APIN's sustainability plan in terms of Commodity Logistics (warehousing, storage and distribution) is to partner with an indigenous organization to handle warehousing and the Logistics of commodity distribution across facilities. This will substantially reduce the cost for warehousing, storage and distribution. The regionalization of implementing partners to states of the Federation, has led to APIN working in 3 states (Lagos, Oyo and Plateau). APIN has identified with the states through strategic meetings the areas that require significant attention towards building capacity and ensuring sustainability of service provision in the states.
APIN Pharmacy/Supply Chain Management Unit will seek to enhance the capacity of the State Central Pharmacy and Logistics team in warehousing, drug distribution and monitoring. Central level trainings in Warehouse Management, Inventory management and Logistics Management of Health Commodities (LMHC) will be conducted for appropriate personnel.

APIN will continue to provide mentorship and direct on-site, hands-on competency development of Pharmacists and Pharmacy Technicians, on clinical care and management of HIV/AIDS patients using

pharmacy curriculum modules, the FMOH Logistics Management of HIV/AIDS Commodities, and the Site, and warehouse management handbook by JSI. APIN will also embark on renovation of existing state and facility warehouses as required.

APIN will continue to support the provision of Pharmacovigilance services by providing trainings build capacity identified facility state level personnel, and ensuring the collation and submission of reports to the National Pharmacovigilance Centre in NAFDAC. The APIN Drug Information Centre (ADREC) will continue to answer queries regarding HIV medicines in an unbiased and evident based manner. APIN aims to extend the services of ADREC to other IPs and the public. APIN will continue to create and sustain the awareness of ADREC through periodic newsletters on issues of HIV/AIDS. The incorporation of pharmacovigilance activities within ADREC will reduce the number of discrepancies between NAFDAC ADR and APIN toxicity reports. ADREC will be positioned to also act as a resource for the training of state and National DIC staff.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	7,313,527	0

Narrative:

APIN will build on the gains of its ART program implementation to scale-up ART in the 3 supported states (Lagos, Oyo and Benue) in COP 13. HTC services will be scaled up at all APIN supported sites. Baseline evaluations will be done to determine eligibility for ART and to provide for the management of opportunistic infections and other co-morbidities. Patients will also receive scheduled monitoring of CD4, haematological and chemistry parameters and viral load.

Patients with CD4 count <350 will be commenced on first line ARVs, in accordance with national guidelines. Follow-up care instituted to ensure adherence to treatment while evidence of adverse drug reactions and failures are actively monitored. Clinicians at the sites will be mentored for effective patient management and sites will be supported to hold monthly clinical review meetings to discuss patient management and challenges across all program areas and to plan solutions to address them. Adherence counseling will be offered to new patients initiating ARVs and intensified to support existing patients on medications. Patient escort services will be used from point of diagnosis to the comprehensive sites in order to promote retention of patients in care.

APIN has already started provided full support to comprehensive sites that were recently transitioned to it by other partners, in Lagos (4 sites) and Plateau (3 sites) because of the USG rationalization program. In COP13, APIN will activate additional ART sites in order to scale up ART services in the 3 states focusing on high-burden, low-coverage populations. Working with the State HIV/AIDS program, priority sites for

HIV/AIDS service delivery will be identified. The activation process will involve baseline assessment of the facilities, infrastructure upgrade, provision of clinic and laboratory equipment to support service delivery, staff trainings in all aspects of patient care and setting up of laboratory and M&E systems. As part of the scale-up, APIN is engaging sub-partners that are specifically targeting the private sector for HIV/AIDS service provision. APIN is also undertaking a special project to provide ART services hard-to-reach communities within Jos metropolis in Plateau State through a faith-based group. A total of 23 private faith-based facilities within these communities have been identified and are currently being assessed. After this, the facilities will be upgraded and equipment and supplies provided. Training for commencement of HCT and subsequently some will commence PMTCT and ART services. They will be linked in a hub-and-spoke model of service delivery. A key challenge faced by patients to remain in care is the socioeconomic burden of seeking care at secondary and tertiary facilities; this will be eased by decentralizing ARV services to PHCs using the hub and spoke model of service delivery. Patients that meet the set national criteria will be referred downward to PHCs close to their place of residence.

The strategies for capacity building will be hinged on increased joint supportive supervision for ART service delivery with the officials of the State Control Program, training of health care workers and provision of technical assistance to sites, provision of on-site mentoring and supervision. The capacity of the officials of the State Program will also be developed to carry out these functions in order to promote program sustainability.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	1,055,740	0

Narrative:

In COP 13, the comprehensive treatment and care sites in the 3 supported states (Lagos, Oyo and Benue) will continue to be provided with support to implement pediatric treatment in accordance with national guidelines. As part of the strategy to improve pediatric enrolment, PITC will be offered at multiple points within the facility: children's outpatient clinics and emergency rooms, infant welfare and immunization clinics, and postnatal clinics. HTC was also expanded to children of HIV-positive women. The genealogy form will also be used at the sites to ensure that all the children of HIV+ women are screened for HIV. Information on HTC for their children will be provided to these women during clinic visits and support group meetings and through CBOs collaborating with APIN on OVC service provision. Enrolled OVC and their siblings and other family members will be offered PITC.

HIV-exposed infants will be routinely followed up and provided with ARV prophylaxis as appropriate, as well as cotrimoxazole prophylaxis. Systems have been put in place for the collection and transportation of DBS samples to PCR laboratories for EID, and to ensure a short turn-around-time for DNA PCR results

that allows for prompt diagnosis and initiation on ART of exposed infants. HIV-positive children less than 2 years will be promptly enrolled into the pediatric treatment program through the implementation of the test and treat policy for this category of children, in line with national guidelines. Children of ages 2-5 years are initiated on ART at a CD4% of <25% while those of ages 5-15 years are initiated at a CD4 count of < 350. First line ARVs are commenced for newly diagnosed children while care is taken to identify those exposed to maternal prophylaxis and ARV combinations adjusted accordingly. Clinical and laboratory monitoring of the children will be done in line with national guidelines. Growth monitoring chart and anthropometric measurement will be used to ensure adequate weight gain as treatment progresses. Nutritional education will be given to care givers and food supplement (Grandvita product) provided to malnourished children. Children on treatment will be monitored closely for adverse drug reactions. Training of health care providers on the pediatric guidelines will be conducted while there will be supportive supervision for ART service delivery and provision of technical assistance and on-site mentoring.

Implementing Mechanism Details

Mechanism ID: 16852	**Mechanism Name: Development of a Laboratory Network and Society to Implement a Quality Systems**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: New Partner	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 200,000	
Funding Source	**Funding Amount**
GHP-State	200,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Goal :Sensitize country leadership on SLIPTA
By the end of year 2013, sensitize 15 leaders in Nigeria responsible for laboratory accreditation. ASLM will communicate MoH/WHO Country office in Nigeria to assign MOH SLIPTA Focal Point and Contact the assigned SLIPTA Focal Point to plan activities for implementation.ASLM will organize a 2-day SLIPTA orientation and guidance meeting with 15 Participants (one MOH SLIPTA Focal Point, WHO representative and CDC Laboratory staff and other US agencies (USAID and DoD).

Goal 2: To train SLIPTA Auditors : March- September 2013
By the end of 2013 train 25 SLIPTA auditors. ASLM will organize SLIPTA training for selected candidates in Nigeria after review of application.Invitation letter will be sent to selected candidates and then rraining conducted. Post training audit practicum will be organized by ASLM, MOH SLIPTA FP, and CDC-country office after which certificates are awarded to successful participants

Goal 3: To audit laboratory and award stars recognition
Laboratories that graduated from SLMTA process will apply for SLIPTA audit. Applications will be reviewed and laboratories will be enrolled for the SLIPTA audit. Identified auditors are communicated to MOH SLIPTA Focal Point for logistics arrangement and these auditors are then deployed to to Nigeria to audit laboratories that have applied. After the audit ASLM will submit the Audit reports to Independent Accreditation Committee for Star level determination.
8. Issuance of certificate by ASLM based on IAC recommendation and Information on the audited laboratories will be posted on ASLM website6labs audited, March – December 2013
Goal 4: To train 50 laboratory mentors in Nigeria to support laboratory improvement and accreditation efforts between March -September 2013.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	50,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	16852
Mechanism Name:	Development of a Laboratory Network and Society to Implement a Quality Systems
Prime Partner Name:	New Partner

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	200,000	0

Narrative:

ASLM will work with CDC Nigeria to plan for a meeting to sensitize country leadership (FMOH) on SLPTA and by the end of year 2013, 15 sensitization meeting would have taken place.
Communicate MoH/WHO Country office in Nigeria to assign MOH SLIPTA Focal Point and ASLM to contact assigned SLIPTA focal person. ASLM will organize a 2-day SLPTA orientation and guidance meeting for 15 Participants (one MOH SLIPTA Focal Point, WHO representative and CDC Laboratory staff and other relevant stakeholders)
Goal 2: To train SLPTA Auditors : March- September 2013
By the end of 2013 train 80 SLPTA auditors
1. Organize SLPTA training and appeal of application.
2. Application reviewed and candidates selected
3. Invitation letter sent to selected candidates
4. Conduct training
5. Post training audit practicum will be organized by ASLM, MOH SLIPTA FP, and CDC-country office
6. Certificates awarded to successful participants
7, 25 SLPTA Auditors trained in Nigeria
Goal 3: To audit laboratory and award stars recognition
3. Application will be reviewed and laboratories will be enrolled
4. Identification of auditors and communicated to MOH SLIPTA Focal Point for logistics arrangement.
5. Deployment of auditors
6. Lab audition

7. Submission of Audit reports to Independent Accreditation Committee for Star level determination. 8. Issuance of certificate by ASLM based on IAC recommendation. 9. Information on the audited lab will be posted on ASLM website6labs audited, March – December 2013

Implementing Mechanism Details

Mechanism ID: 16853	**Mechanism Name: Strenghtening Human Resources For Health(HRH) for the Provision of HIV/AIDS Services Through In-service Training**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: New Partner	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 500,000	
Funding Source	**Funding Amount**
GHP-State	500,000

Sub Partner Name(s)

Institute of Human Virology, University of Maryland School of Medicine (IHV-UMSOM)		

Overview Narrative

Partnership for Medical Education and Training (PMET) goal is to create a network of health training institutions that will assist State and Federal Governments to develop their health care systems through enhancing training capacity in prevention, care and treatment of HIV disease, opportunistic infections, the appropriate use of antiretroviral therapy, and the implementation of community-based care; and strengthening the human and organizational capacity of their health systems to sustainably address emerging new HIV challenges or for any related illness.

SO1 Health care workers are empowered to provide comprehensive HIV care services

SO2 Health systems are strengthened to provide capacity building
SO3 Training institutions sustain capacity building activities beyond the life of the grant

By the end of the five-year project period, PMET establish the systems, curricula and capacity-building infrastructure to implement comprehensive HIV in-service education through locally developed and trained Master Trainers who are not only able to deliver trainings but support the infrastructure to assess, update and review curricula based on the emerging needs of the epidemic and health systems.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	500,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**16853**
Mechanism Name:	**Strenghtening Human Resources For Health(HRH) for the Provision of HIV/AIDS Services Through In-service Training**
Prime Partner Name:	**New Partner**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	500,000	0

Narrative:

PMET's goal is to create a network of health training institutions that will assist State and Federal Governments to develop their health care systems through enhancing training capacity in prevention,

care and treatment of HIV disease, opportunistic infections, the appropriate use of antiretroviral therapy, and the implementation of community-based care; and strengthening the human and organizational capacity of their health systems to sustainably address emerging new HIV challenges or for any related illness. SO1 Health care workers are empowered to provide comprehensive HIV care services SO2 Health systems are strengthened to provide capacity building SO3 Training institutions sustain capacity building activities beyond the life of the grant By the end of the five-year project period, PMET establish the systems, curricula and capacity-building infrastructure to implement comprehensive HIV in-service education through locally developed and trained Master Trainers who are not only able to deliver trainings but support the infrastructure to assess, update and review curricula based on the emerging needs of the epidemic and health systems

Implementing Mechanism Details

Mechanism ID: 16854	**Mechanism Name: Engaging Indigenous Organisation to Sustain and Enhance Comprehensive Clinical Services**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: New Partner	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 10,664,082	
Funding Source	**Funding Amount**
GHP-State	10,664,082

Sub Partner Name(s)

Christian Health Association of Nigeria	Institute of Human Virology, University of Maryland School of Medicine (IHV-UMSOM)	Solina Health Ltd

Overview Narrative

The Center for Clinical Care and Clinical Research (CCCRN), with its partner organizations will build upon existing and new strategic partnerships with the public and private sector to support Nigerian health institutions in developing, implementing, monitoring, evaluating and managing HIV/AIDS prevention, care and treatment programs. CCCRN proposes to manage a program that provides HIV/AIDS prevention, care, treatment and laboratory services to HIV infected patients in Imo, Ebonyi and Enugu States called the Service Expansion and Early Detection for Sustainable HIV Care Project (SEEDS). SEEDs will apply innovative, sustainable and cost effective strategies that include decentralization, saturation and continuous quality improvement to ensure maintenance of services in existing facilities and rapid expansion to new ones in assigned states. Leveraging on its prior PEPFAR experience with the AIDSRelief and CHARIS projects, CCCRN will work in Government, Faith Based and Private institutions at primary, secondary and tertiary levels to expand reach of quality HIV care and treatment services.

The ultimate goal of SEEDS is to reduce mortality and morbidity from HIV in assigned states of Nigeria. By the end of the project period,

SO1: The incidence of HIV infections in the target population is reduced.

SO2: Target population persons living with HIV (PLHIV) and their families receive quality HIV care and treatment services.

SO3: Service Delivery Facilities (SDFs) have strengthened organizational and technical capacity to provide and support the provision of high quality HIV and AIDS care and treatment services.

SO4: Service Delivery Partners collaborate with government authorities to sustain HIV and AIDS care and treatment programs.

Cross-Cutting Budget Attribution(s)

Gender: GBV	91,459
Gender: Gender Equality	137,188
Human Resources for Health	347,923

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Malaria (PMI)
Child Survival Activities
Mobile Population
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**16854**
Mechanism Name:	**Engaging Indigenous Organisation to Sustain and Enhance Comprehensive Clinical Services**
Prime Partner Name:	**New Partner**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	1,210,097	0

Narrative:

Comprehensive package of basic care and support services will be provided to 35,298 PLWHA . The package of services provided to each PLWHA includes a minimum of one clinical service and two supportive services delivered at the facility, community, and household (home based care) levels in accordance with the PEPFAR and Government of Nigeria (GON) national palliative care policies and guidelines. The basic care package for PLWHAs include Basic Care Kit (ORS, ITN, water guard, cotton wool, gloves, soap, Vaseline, GV, Methylated spirit); Home-Based Care (client and caregiver training and education in self-care and other HBC services); Clinical Care (basic nursing care, pain management, OI and STIs prophylaxis and treatment, nutritional assessment, nutritional counseling and education, and supplemental or therapeutic feeding support), Laboratory Services (which will include baseline tests - CD4 counts, hematology, chemistry, malarial parasite, OI and STI diagnostics when indicated); Psychological Care (support groups' facilitation, adherence counseling, bereavement counseling), Mental Health (anxiety and depression assessment and counseling with referral to appropriate services); Spiritual Care (access to spiritual care); Social Care (linkages and referrals, and transportation support) and Prevention Care (Prevention with Positives)

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Care	HKID	457,295	0

Narrative:

CCCRN will provide comprehensive OVC services through community based organizations in its focus states. The project will sustain the use of the Child Status Index to assess vulnerability and provide services to OVC. All 4706 children will receive a minimum package of 3 core services from SEEDS which includes health, nutrition and psychosocial support services.
CCCRN will strengthen existing structures to provide access to health services including HIV Counseling and Testing (HCT) prevention and treatment of common infections. All OVC households will receive a preventive care package containing ITN, water guard, water vessel, soap, ORS sachets, and IEC materials on self care and prevention of common infections according to Government of Nigeria (GoN) guidelines. In addition, CCCRN will continue to collaborate with NPI and local government health authorities to ensure free and appropriate immunization to all OVC less than 5 years. Adequate health care will include strengthening linkages and referrals to other facility services (maternal/child health, inpatient and outpatient departments).
Nutritional assessment and demonstration activities will continually be provided for all OVC while rehabilitation of malnourished children will be implemented as a wrap around service leveraged from GoN and other organizations including Clinton Foundation and Markets for the provision of plumpy nut and food supplements respectively.
Psychosocial support will continually be enhanced for OVC with structured home visits, support group activities and provision of age specific educational/recreational kits. CCCRN will support expansion of kid support groups to all SDFs and expand their activities to include periodic social/recreational and educational activities to address issues of stigma and discrimination.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	263,405	0

Narrative:

CCCRN will implement WHO 3Is strategy of decreasing the burden of TB among HIV positive patients and strategies for decreasing the burden of HIV among TB patients. CCCRN will ensure routine clinical and symptom driven laboratory screening of all HIV positive clients in Local Partners Treatment Facilities (LPTFs) for TB while TB patients will continue to have access to HIV counseling and testing (HCT). Co infected clients will be offered appropriate care within and outside the LPTF.
35,298 HIV positive patients in care at all supported sites will be screened for TB with clinical symptoms driven laboratory tests. From these , 705 patients are expected to be diagnosed with active disease and will be treated for TB. The TB/HIV program will be in collaboration with State and National Tuberculosis and Leprosy control programs (STBLCP and NTBLCP). Laboratory infrastructure will be upgraded and

human capacity developed to ensure adequate TB diagnosis for HIV positive patients. Improved TB diagnostics, GeneExpert will be provided for Imo State to complement the 2 existing machines in Enugu and Ebonyi.
All TB/HIV patients will receive cotrimoxazole prophylaxis therapy (CPT). AR Community Based Treatment Support Service (CBTS) Specialists will work with Community health care providers to ensure contact and defaulter tracking of co infected cases on treatment and also trace family members of PLWHA accessing TB/HIV services to facilitate their TB screening and appropriate care.
CCCRN will continue to implement TB infection control in accordance with the national guidelines on TB infection control by ensuring proper patient triage, specimen collection & processing, waste disposal, proper ventilation and administrative control activities such as active identification of those with TB symptoms and patient segregation.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	187,442	0

Narrative:

CCCRN will provide HIV care and support services to 5805 children in all its comprehensive facilities. To increase pediatric enrollment into care and support, CCCRN will strengthen linkages among all service components in its supported SDFs as well as expand community outreach. This activity will require sustaining staff training/retraining and strengthening referral linkages. CCCRN will consolidate on its multi-pronged approach to increase the number of children enrolled into care and support: organization of services to provide family centered care and treatment, PITC (provider initiated testing and counseling) and community mobilization.
The package of care services provided to each HIV positive or exposed child includes a minimum of clinical service with basic care kit and two supportive services in the domain of psychological, spiritual, and PwP delivered at the facility, community, and household (home based care) levels in accordance with the PEPFAR and Government of Nigeria (GON) national care and support policies and guidelines. The basic care package for HIV positive child/care givers in partner sites include Basic Care Kit (ORS, LLITN, water guard, water vessel, soap, IEC materials, and gloves); Home-Based Care (client and caregiver training and education in self-care and other HBC services); Clinical Care (basic nursing care, pain management, OI and STIs prophylaxis and treatment, nutritional assessment- weight, height, BMI, micronutrient counseling and supplementation and referrals, Laboratory Services (which will include baseline tests - CD4 counts, hematology, chemistry, malarial parasite, OI and STI diagnostics when indicated); Psychological Care (adherence counseling, bereavement counseling, depression assessment and counseling with referral to appropriate services); Spiritual Care (access to spiritual care); Social Care (support groups' facilitation, referrals, and transportation) and Prevention Care (Prevention with Positives). All HIV positive or exposed children's nutritional status will be assessed at contact and on

follow-up visits, micronutrients will be provided as necessary, and those diagnosed as severely malnourished will be placed on a therapeutic feeding program. This will be done through wraparound services as well as direct funding.
CCCRN will continue to build and strengthen the community components by using nurses and counselors to link health institutions to communities. New and refresher training will be provided for LPTF staff in adherence monitoring. Each LPTF will appoint a specific staff member to coordinate the linkages of patients to all services. This will also build the capacity of LPTFs for better patient tracking, referral coordination, and linkages to appropriate services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	671,027	0

Narrative:

CCCRN will provide automated CD4 testing equipment, hematology analyzers and chemistry machines to 20 new comprehensive SDFs. All these labs will be supported to test for syphilis, PCP, TB, HBV, hematology, chemistry, cryptococcosis and CD4. CCCRN will provide on-site capacity for HIV testing, laboratory monitoring of disease progression and response to treatment, opportunistic infections (OIs) diagnosis and monitoring of antiretroviral drug (ARVs) toxicity. CCCRN will continue to support the improved diagnosis of TB, PCP, cryptococcal infection, syphilis, hepatitis B (HBV), protozoal and bacterial infections. CCCRN will provide clinical viral load (VL) testing for difficult therapy switch decisions and program evaluation. CCCRN laboratory services will support expansion of early infant diagnosis (EID) at PMTCT supported facilities in accordance with the national EID scale up plan by providing standardized training and commodity supplies for collection and transport of dried blood spots (DBS) and clinical samples. To support pediatric diagnostic and treatment, GoN will provide DBS collection material, transportation of specimens/results.
CCCRN will expand diagnostic test menu at treatment site laboratories to include improved TB diagnostics using Gene Expert in Imo State while supporting the 2 machines existing in Enugu (Annunciation Hospital) and Ebonyi (Mile 4 Hospital). SEEDS will continue to support xx satellite facilities with laboratory capacity for HIV rapid testing hematology, CD4 directly or through sample logging.
A lab specialist will be dedicated with the overall responsibility for equipment installation and maintenance in conjunction with approved vendors.
CCCRN will undertake a full-scale implementation of clinical laboratory Quality Assurance (QA) protocols based on local and international practice guidelines; these protocols will include supporting all CCCRN supported labs to meet USG specifications, setting up regional laboratories for training and as quality assurance centre, inter-laboratory testing, laboratory infrastructures ,trainings on proper waste management protocols, subscription to external laboratory system audits, electronic networking of the

laboratory documentation system i.e. solving documentation error, quarterly vertical audits of site quality preparation of LPTF laboratories for local & international accreditations subscription to a locally organized EQA scheme for testing not covered by the USG funded testing i.e. hematology and chemistry.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	449,305	0

Narrative:

CCCRN SI activity incorporates program level reporting and implementation of both paper-based and computerized Health Management Information Systems (HMIS) for SDFs. CCCRN will continue to strengthen SDF Patient Management Monitoring (PMM) systems using GoN tools and registers. CCCRN will support Electronic Medical Record(EMR) systems for all secondary health facilities. This will include providing training, equipment and other logistical support systems.

CCCRN will strengthen its program for Continuous Quality Improvement (CQI) in order to improve and institutionalize data quality and quality interventions. CCCRN SI team will continue to provide TA to SDFs and personnel to adapt and harmonize existing tools to meet the standards of the GON thus continuing to ensure that monitoring and evaluation of the program is consistent with the national plan for patient monitoring. The The SI team will wor relevant State and Local Government agencies to conduct joint site visits during which evaluations of the utilization of National tools and guidelines, proper medical record keeping, efficiency of clinic services and referral coordination shall be conducted. Data flow including data collection, management and reporting would also be assessed and recommendations for improvement given. Supportive supervision and mentoring is being provided to all on-site staff that collect and utilize data (e.g., clinicians, pharmacists, data entry personnel, administrators). Quarterly M&E form will be conducted in all states of operation to improve national data quality for evidence based interventions.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMBL	12,284	0

Narrative:

SEEDS will ensure linkage with the National Blood Transfusion Service (NBTS) and Safe Blood for Africa Foundation (SBFA) in all aspects of its blood safety program. The project will support the NBTS in implementing its primary objective of migrating fragmented hospital-based blood services to centralized NBTS-based blood services nationwide. In addition, SEEDS will train nurses, medical laboratory scientists and community volunteers in its facilities to conduct community education for blood donation, recruit repeat voluntary blood donors from the ranks of current family replacement donors. In this plan SEEDS will be instrumental in working with hospital management and staff at all LPTFs to develop buy-in

for the NBTS blood services program, to create support of blood donor organizers, and to strengthen health facility and community focused blood drive activities. SEEDS will support the distribution of IEC/BCC materials obtained from NBTS and SBFA to promote the need for voluntary non-remunerated blood donation. In addition, CCCRN will work closely with SDF management to establish blood transfusion committees to oversee blood use based on national algorithms and standards in the health facilities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMIN	39,602	0

Narrative:

CCCRN will support capacity building at SDFs for universal precautions and appropriate disposal of infectious materials. Linkages will be built with other mechanisms for the distribution of commondities including sharp containers, needle destroyers and incinerators.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	30,486	0

Narrative:

Sexual Prevention services will be offered through 13 existing facilities, 20 new comprehensive ART facilities & satellites in Enugu, Ebonyi & Imo states. All programs will promote abstinence until marriage, and mutual fidelity within marriage. It will also include procure education on and distribution of condoms. CCCRN will implement its AB programming activities in line with the overall PEPFAR Nigeria goal of providing prevention services to individuals reached through a balanced portfolio of prevention activities. Through this activity, PEPFAR Nigeria will extend its reach with AB services in more states and communities

The program will support SDF activities targeting HIV + clients, their families and communities who access care at these points of service. Prevention priorities will include behavior change for risk reduction and risk avoidance, counseling and testing. All supported SDFs will provide education and training to patients and community health volunteers on secondary prevention. These will include encouraging status disclosure, counseling for sero-discordant couple, risk reduction, adherence to ART and training for health workers and peer outreach workers. Programs will include reducing societal stigma through appropriate health education at facility and community levels and reducing gender based violence. There will be structured peer education that includes systematic training curricula, refresher training, and training on essential life skills. In addition, age appropriate abstinence only messaging and secondary abstinence messaging will be conveyed to adolescents, especially orphans and vulnerable children receiving both facility and home based support. This service will continue to be extended to schools and

NYSC camps. CCCRN through this program will cover communities with AB messages conveyed through multiple media and fora. Utilizing such a methodology, a large number of people will be reached with messages via one method or another, but the counted group will be those individuals that would have received AB messaging: (1) on a regular basis and (2) via the three strategies CCCRN will employ (community awareness campaigns, peer education models and peer education plus activities). CCCRN will reach 62751 people as direct people reached through community awareness campaigns, peer education models and peer education plus activities; indirect beneficiaries as those who receive messages via other multiple media.

Prevention activities will include distribution of patient education materials, community sensitization, increased couple testing, promotion of SDF couple support groups, and advocacy for risk reduction strategies for discordant relationships. High risk reduction measures will include treatment of sexually transmitted infections (STIs) and to a lesser extent on drug abuse. Couples will be treated at SDFs or other referral centers that offer specialized treatment for STIs where necessary.

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Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	500,534	0

Narrative:

CCCRN will increase support for counseling and testing (HCT) services to a total of 80 sites. An emphasis will be placed on satellite decentralization clinics and family members of in care clients. A target of 235,318 persons will benefit from HCT and receive their result. CCCRN will build the capacity at existing and new SDFs to enable them integrate HCT services within care and treatment systems and obtain resources from the GoN and other agencies to increase uptake of HCT services in all points of service in the facilities.

SEEDS will also scale-up couples counseling and testing in all supported sites through organized training, family centered testing and on site mentorship. SEEEDS will promote HCT as a necessary and important arm of HIV prevention in terms of averting new infections and providing treatment for those in need, and post-test counseling will be strengthened to lay emphasis on prevention for positives. Posttest counseling will include full and accurate information on all prevention strategies.

Sites will be actively linked to the Government of Nigeria and other donor agencies to access extra kits and supplies needed, and supported to maintain their regular usage and feedback through the above mentioned strategies. Sites will be trained on forecasting and stock control using bin cards and will maintain a three month buffer stock. SDF will report on inventory and forecasting to the CCCRN and SCMS.

In addition to the general population, SEEDS will target the provision of HCT services to PABAs - especially children, TB patients, STI patients and MARPS. At rural satellite clinics, the project will also

target women of reproductive age with combined HCT and STI screening.
SEEDS will train staff on counseling and testing using the GON HCT training curriculum.
Non-laboratorians will be used at multiple points of service for facility based HCT where appropriate and when allowed by national policy. To this effect CCCRN will train HCW (counselors, nurses and outreach workers) that will be supervised by onsite laboratorians to assure quality.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	35,410	0

Narrative:

The program will support SDF activities targeting HIV + clients,MARPs & their families and communities who access care at these points of service. Prevention priorities will include behavior change for risk reduction and risk avoidance, counseling and testing. All supported SDFs will provide education and training to patients and community health volunteers on secondary prevention. These will include encouraging status disclosure, counseling for sero-discordant couple, risk reduction, adherence to ART and training for health workers and peer outreach workers. Programs will include reducing societal stigma through appropriate health education at facility and community levels and reducing gender based violence. There will be structured peer education that includes systematic training curricula, refresher training, and training on essential life skills. In addition, age appropriate abstinence only messaging and secondary abstinence messaging will be conveyed to adolescents, especially orphans and vulnerable children receiving both facility and home based support. This service will continue to be extended to schools and NYSC camps. CCCRN through this program will cover communities with AB messages conveyed through multiple media and fora. Utilizing such a methodology, a large number of people will be reached with messages via one method or another, but the counted group will be those individuals that would have received AB messaging: (1) on a regular basis and (2) via the three strategies CCCRN will employ (community awareness campaigns, peer education models and peer education plus activities). CCCRN will reach 62751 people as direct people reached through community awareness campaigns, peer education models and peer education plus activities; indirect beneficiaries as those who receive messages via other multiple media.
Prevention activities will include distribution of patient education materials, community sensitization, increased couple testing, promotion of SDF couple support groups, and advocacy for risk reduction strategies for discordant relationships. High risk reduction measures will include treatment of sexually transmitted infections (STIs) and to a lesser extent on drug abuse. Couples will be treated at SDFs or other referral centers that offer specialized treatment for STIs where necessary.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	2,722,398	0

Narrative:

CCCRN will provide PMTCT services in 33 comprehensive ART facilities and 60 satellite sites in Enugu, Ebonyi and Imo states. CCCRN will provide counseling, testing and results to 156,878 pregnant women. Antiretroviral (ARV) prophylaxis will be provided to 5805 women. This activity will include routine provider initiated opt-out HIV counseling and testing (HCT) for all women presenting in antenatal clinics (ANC),labor and delivery wards (L&D) in addition to immediate post-delivery settings for women of unknown HIV status. Counseling will be provided using group and individual pre/post- test counseling strategies and rapid testing based on the National testing algorithms. Same day results will be provided to clients. As part of PMTCT services, partner testing and couple counseling will be strengthened with the provision of “Partners’ Slip” and initiation of facility based monthly “Couples Forum” to enhance disclosure and male involvement. CCCRN through its community and faith-based linkages, will continue to utilize community and home based care services to promote partner testing. Clients will be provided access to free laboratory services including CD4 counts, STI screening (VDRL), Urinalysis, MP and Ultrasound Sound Screening (USS). Free medications including those for OIs and hematinics will also be provided. Strong referral systems that incorporate active follow-up will be strengthened to ensure that women requiring HAART are not lost during referral for ARV services. Referral coordinators will be identified in all our sites and the communities with their capacities built in collaboration with other IPs.
CCCRN will use its community linkages, mother-to-mother support groups and the provision of incentives to encourage HIV+ pregnant women to deliver in a health facility. The incentive package (“Mama and Baby Packs”) contains basic delivery consumables and immediate baby care items including suctioning bulbs, cord clamps, disinfectant, mackintosh, baby soap and face flannel. All infants of HIV positive woman will be referred to OVC services in order to facilitate care to all affected children.
CCCRN will support the utilization of traditional birth attendants (TBAs) in referral services in addition to the mother-to-mother support groups to reach HIV+ women who deliver outside of the health facility. This activity will help increase referrals, patient tracking and universal precautions to improve PMTCT outcomes.
HIV+ women will be provided infant feeding counseling in pre and postnatal periods with options of exclusive breast feeding with early cessation or exclusive BMS if AFASS criteria can be met using the WHO UNICEF curriculum adapted for Nigeria. Women accessing family planning services will be offered HIV Counseling and Testing. Infants of positive mothers will be linked to immunization and well child care services. Cotrimoxazole prophylaxis will be provided to infants from 6 weeks of age until definitive HIV status can be ascertained.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	0	0

Narrative:

CHARIS will support the unification process for ARV procurement and distribution to its facilities in Enugu, Ebonyi and Imo States. As part of its expansion plan, CCCRN will support 13 existing facilities, 20 new comprehensive facilities and 60 PMTCT satellites with necessary systems and infrastructure upgrade and ensure skills are in place for efficient forecasting, procurement, storage, distribution of quality anti-retrovirals (ARVs) and improve commodity security. Continuous technical support to SDFs for drug management will continue. This support will include SOPs and training for drug requests, receipts, recording, dispensing, discrepancy reporting, temperature control and disposal of expired drugs.

CCCRN will establish Therapeutic Drug Committees (TDC) comprising of clinicians, pharmacists, palliative care specialists, strategic information advisors and program managers. The TDC reviews drug utilization patterns across all SDFs, assesses scale-up progress and develops required technical support plans. The TDC is replicated at the SDF level to ensure that the ARV supply chain management is clinically informed and logistically supported. Quality assurance covers the entire spectrum from procurement to dispensing. All sites will be provided with ongoing TA by CCCRN Pharmacy & Supply Chain team.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	3,569,332	0

Narrative:

As part of CCCRN decentralization and state saturation strategy, SEEDS will expand treatment to XXX satellites (primary in Enugu, Imo and Ebonyi. SEEDS will provide ARV treatment services to 7844 new patients for a total of 35,298 active adult patients by the end of the year. All PLWHA will be managed in accordance with National standard of care to include CD4 counts and other lab investigations to be performed at baseline, 6monthly and when needed. AR sites will continue integration of prevention with positives (PwP) activities including: adherence counseling; syndromic management of STIs in line with National STI control policy and guidelines; risk assessment and behavioral counseling to achieve risk reduction; counseling and testing of family members and sex partners; counseling for discordant couples; IEC materials and provider delivered messages on disclosure. Cotrimoxazole prophylaxis will be provided for PLWHAs according to the National guidelines.
All SDFs will provide including management of OI management, ART, reliable and secure pharmaceutical supply chain, technologically appropriate lab diagnostics, treatment preparation for patients, their families and supporters and community based support for adherence. SEEDS will adhere to the Nigerian National ART service delivery guidelines including recommended first and second line ART regimens.
SEEDS will strengthen institutional and health worker capacity through the training, retraining and mentoring of health service providers to provide care and treatment services at the facility and community

levels. Doctors, pharmacists, nurses, counselors, and community health extension workers will receive training and onsite mentoring that will allow them to provide comprehensive care.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	515,465	0

Narrative:

In FY13, 784 children will be provided ART. All SDFs will be strengthened in their capacity to provide comprehensive quality treatment services through a variety of models of care delivery. This includes quality management of OIs and ART, a safe, reliable and secure pharmaceutical supply chain, technologically appropriate lab diagnostics, treatment preparation for patients, their families and supporters and community based support for adherence. This technical and programmatic assistance utilizes on-site mentoring and preceptorship.

Clinical viral loads for children with suspected treatment failure and clinico-immunologic discordance will be supported through leverage. All infected children will be evaluated for ART and followed up using CD4 or CD4% and other laboratory tests as required. AR will provide DBS/DNA PCR technology for early infant diagnosis in addition to the logistic support for transportation of blood samples to designated laboratories in collaboration with GoN.

All ART eligible children will receive treatment following National guidelines. ARV logistics will be supported through the harmonized USG mechanisms for drug supply

CCCRN will continue to build and strengthen the community components by using nurses and counselors to link health institutions to communities. Community Based Treatment Services (CBTS) specialists will continue to support extension of treatment services to the home and community level. The CBTS Specialists will develop a community volunteer structure in collaboration with the Volunteer Services Organization (VSO) in to ensure sustainability of services at LPTFs to include mental health support (psychotherapeutic, psychosocial, depression and substance abuse management) and home based care.

Implementing Mechanism Details

Mechanism ID: 16855	**Mechanism Name: Engaging Indigenous Organization to Sustain and Enhance Comprehensive Clinical Services**
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: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 22,423,202	
Funding Source	**Funding Amount**
GHP-State	22,423,202

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The BRIDGES_PLUS is a locally driven effort to ensure the continued improvement, expansion, and long-term sustainability of comprehensive, family-centred, quality-focused HIV prevention, care, and treatment services in six high HIV prevalent states in Nigeria currently supported by CIHP under the BRIDGES project, these states demonstrate gaps in accessing HIV AIDS care and treatment from the National figures and have high populations of PLWHIV who require care/treatment.

The BRIDGES_PLUS aims to provide community and hospital based care and treatment using an integrated approach, effective linkages (e.g. "hub and spoke" model) and service coordination to ensure continuity of comprehensive service delivery; local capacity building for stewardship to sustain services on the long term. Service delivery activities will be supported through 275 service delivery entities, including public and private health facilities and CBO. The project will make an important contribution to PEPFAR's 3–12–12 global targets and take significant strides towards sustainability. CIHP will implement quality HIV care, support and treatment services across all thematic areas in line with national guidelines, protocols, and regimens. We will build on our role as CDC's lead implementing partner for PMTCT to leverage and expand partnerships to harmonize PMTCT support and promote a combination prevention approach, prioritizing youth MARP and with balanced gender-sensitive messaging to address the identified barriers to prevention. In addition, CIHP through the project will increase access to care and support activities through provision of ongoing health-facility and community/home-based services to optimize the quality of life for HIV-infected clients and their families.

Cross-Cutting Budget Attribution(s)

Gender: GBV	56,387
Gender: Gender Equality	593,136

Human Resources for Health	3,264,085
Renovation	1,957,672

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Malaria (PMI)
Child Survival Activities
Military Population
Mobile Population
Safe Motherhood
Workplace Programs
End-of-Program Evaluation
Family Planning

Budget Code Information

Mechanism ID:	**16855**
Mechanism Name:	**Engaging Indigenous Organization to Sustain and Enhance Comprehensive Clinical Services**
Prime Partner Name:	**Center for Integrated Health Programs**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	3,675,855	0

Narrative:

• CIHP will facilitate the establishment of community based support groups, Home based Care teams made up of volunteers with prior medical experience will be formed within each support group

• CIHP will train these volunteers on all aspects of HBC including Adherence and psychosocial counselling, provision of PHDP services, Basic nursing, pain and OI management, and routine screening and syndromic management of STIs
• CIHP will provide HBC kits and establish relevant linkages with CBOs, primary and secondary health facilities.
• Integrate BCK logistics system into other existing commodities management system such pharmacy and logistics team., and follow up closely with the
• Facility based HBC focal persons will be identified in comprehensive facilities and selected PHCs to coordinate community home based care (CHBC) activities and referrals.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	563,879	0

Narrative:

• CIHP will identify VC using the national child status index (CSI) tools to increase access to services for VC and their caregivers through Health facilities and CBOs
• CIHP will organize and conduct meetings to train, educate/mentor and coach staff at CBOs, members/jurors of the family courts, village heads/chiefs, child protection committee members and coalition committee members, State Federal Ministry of Women Affairs Desk officers and Social Welfare Officers.
• Provide schools fees and educational materials to selected children in primary, secondary and vocational training institutions across the 4 states through the CBOs
• Conduct quarterly site visits to mentor and coach CBOs program staff on developing gender audit tools, gender sensitive indicators, budgets, PEFPAR selective and age based criteria for identifying and selecting vulnerable children.
• CIHP will support CBOs to conduct educational programs for families on the needs of vulnerable children, Identify and link them to sources of community social support (community food banks, micro-credit, education, legal and health institutions
• Support CBOs to maintain linkages and partnership with other programs USG's MARKETS to build capacities of families in approaches of ensuring that food is available all the year round

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	800,127	0

Narrative:

CIHP will support the intensification of TB case finding among PLHIV at all supported sites by providing clinical screening for TB for all clients accessing HIV counselling and testing
• CIHP will collaborate with the National TB Control program and State TB control program for the regular

supply of INH for eligible PLHIV on the IPT program.
• Train TB care providers/site clinicians on TB/HIV management and support the printing and supply of TBIC materials, SOPs and guidelines to the supported sites
• Institute TB contact-tracing mechanisms at DOTS sites.
• Establish TB infection control activities by facilitating TBIC meetings on a quarterly basis at the supported sites.
• Provide supervision and mentorship on TBIC activities to the HCWs of the supported sites.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	569,221	0

Narrative:

• CIHP will emphasize the early identification and enrolment of children into care and treatment services from multiple sources including paediatric wards, out-patient departments and labor wards
• Voluntary counseling and testing of adolescents will be encouraged by setting up adolescent friendly clinics.
• HIV-infected children will receive a standardized “preventive care package” including basic care kits, LLITN, Water Guard, water vessels, ORS, disinfectant and soap.
• Infants and children who are eligible for ART will receive appropriate first or second-line therapy and will be regularly monitored for drug efficacy and toxicity
• Those not yet eligible for ART will be monitored for growth and development, screened for TB and given prophylaxis (IPT) for TB when indicated, receive cotrimoxazole prophylaxis (CPT) following national guidelines and managed for opportunistic infections as needed. Ready-to-Use-Therapeutic Feeding” (RUTF) using criteria agreed upon by the USG in-country and GON teams will be provided
• CIHP will conduct paediatric ART trainings, ongoing CMEs and Continuous Quality Improvement (CQI) activities

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	624,839	0

Narrative:

• Renovate and equip laboratories to have capacity to perform clinical laboratory tests.
• Build lab personnel capacity to procure, supply lab reagents; and maintain equipment.
• Implement lab quality management plans and strategies for a sustainable quality management system; build lab personnel capacity on the quality management system; mentor facility lab quality officers on development of site-specific SOP, quality manuals, safety manuals, and related documents
• Promote and support laboratory service integration by establishing linkages between ART and non-ART

general laboratory units.
• Train and mentor HCW on universal precautions/PEP per national guidelines

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	314,435	0

Narrative:

CIHP will establish monthly data review meeting at community-based organizations and facilities through the use of data for planning and decision making.
• Provide capacity building and supportive mentorship to state and facility staff to carry out secondary analysis of service statistic to use data for programmatic decision making
• Provide computers and computer accessories to all new supported comprehensive sites to support electronic database platforms
• Provide capacity building and supportive mentorship to state and facility staff to carry out secondary analysis

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMBL	7,385	0

Narrative:

CIHP will build capacity of HCW on appropriate use of blood and blood products, safe blood collection procedures, provision of commodities, increase community awareness and strategic linkages with other partners working with SBFA/ lead IP in blood safety. –
• CIHP will collaborate with the National Blood Transfusion Services (NBTS) to promote blood safety and strengthen linkages of safe blood facilities to the nearest NBTS centres according to the National hospital linkage program to ensure appropriate screening of blood for TTIs with EIA.
• CIHP will establish blood transfusion committees in facilities as well as create new ones in newly supported sites. Blood transfusion committees will be integrated with existing safe injection and waste disposal comities to ensure efficiency and harmonization of activities.
• CIHP will develop a pool of low risk voluntary, non-remunerated blood donors by collaborating with NBTS in the development of a nationwide voluntary donor recruitment system, organizing and providing technical support for blood donation drives in supported hospital facilities and nearby communities.
• CIHP will use standard questionnaire for donor screening and work with lead blood safety IP and NBTS to develop standard counselling messages for donor counselling and care.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMIN	23,807	0

Narrative:

• CIHP will promote biomedical prevention through the promotion of safe injections and proper disposal of infectious waste generated in all facilities it supports, targeting directly health care workers at these facilities and surrounding communities.
• CIHP will build capacity by training and retraining all health care providers (doctors, nurses, lab personnel, waste handlers) in safe injections and waste disposal.
• CIHP will provide protective and waste disposal commodities and devices waste handlers and other HCW; these commodities will include: industrial boots, gloves, face masks, vacutainers, protective goggles, face masks, protective aprons and lamina hoods as well as other commodities such as sharp containers, bench absorbent pads, biohazard bags, spill kits and hazard neutralization materials.
• CIHP will renovating/repair existing incinerators and providing new incinerators where required to promote appropriate waste disposal and ensure that bio-medical and other infectious waste generated from all its supported sites are properly disposed.
• 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 to 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.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	32,864	0

Narrative:

Capacity of peer health educators will be built to form abstinence clubs in the community providing platform for increasing knowledge on adolescent sexual and reproductive health
• CIHP will integrate prevention counselling and other services for PLWH into family planning and MNCH clinics as part of the PHDP intervention and build the capacity of HCW to identify and manage STIs
• CIHP will support the provision of job aidS, IEC materials and prevention commodities to promote facility based combination prevention activities

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	406,032	0

Narrative:

CIHP will promote biomedical prevention through the promotion of safe injections and proper disposal of infectious waste generated in all facilities it supports, targeting directly health care workers at these facilities and surrounding communities.
• CIHP will build capacity by training and retraining all health care providers (doctors, nurses, lab

personnel, waste handlers) in safe injections and waste disposal.
• CIHP will provide protective and waste disposal commodities and devices waste handlers and other HCW; these commodities will include: industrial boots, gloves, face masks, vacutainers, protective goggles, face masks, protective aprons and lamina hoods as well as other commodities such as sharp containers, bench absorbent pads, biohazard bags, spill kits and hazard neutralization materials.
• CIHP will renovating/repair existing incinerators and providing new incinerators where required to promote appropriate waste disposal and ensure that bio-medical and other infectious waste generated from all its supported sites are properly disposed.
• 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 to 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.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	33,278	0

Narrative:

CIHP will implement PHDP activities were implemented at the facilities by providing oTI commodities and Lab reagents..
• CIHP will promote safer sex through the distribution of condoms to CBO and facilities with emphasis on 'being faithfu'l, correct and consistent condom use with non-marital partners for general population and constant condom usage for PLHIVs
• CIHP will reach most at risk persons with comprehensive combination prevention intervention.
• Capacity of CBOs will be built to address behaviour change and deliver prevention messages to MARPS and PLHIV

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	2,963,734	0

Narrative:

CIHP will provide comprehensive package of intervention to pregnant women attending ANC and implement the triple regimen prophylaxis FOR pregnant women in all comprehensive sites and high volume PHCs
• CIHP will build the capacity of HCWs in Kaduna, Benue and Gombe and Kogi states to carry out high quality PMTCT services while facilities will be supported with PMTCT guidelines
• CIHP will utilize the services of CBOs to create demand for PMTCT services and TBAs capacity will also be built on referral of the pregnant HIV positive women who patronize them.
• The CIHP will introduce the use of cohort PMTCT registers to improve longitudinal tracking of mother

and baby pair interventions.
• CHIP will establish “mother to mother” support groups in all comprehensive facilities and high volume PHCs and train mentor mothers to provide peer adherent support to the newly diagnosed HIV infected pregnant women to reduce LTFU.
• CIHP will provide transport and logistic support to state officials to conduct PMTCT joint quarterly facility mentoring visits.
• Implement test and treat policy in all the PHCs to overcome challenges with delay in providing ARV prophylaxis in HIV infected pregnaneal time CD4’’ results

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	0	0

Narrative:

Ensure the collection and timely reporting of accurate Logistics data from sites; by ensuring that all SDPs utilize appropriate LMIS tools for their routine handling of commodities,
• Build the capacity of Program staff in other thematic areas (PMTCT, Adherence and M&E) on LMHC to increase collaboration for site level support in the area of logistics
• CIHP will coordinate the quantification exercise for commodities (ARVs, OI drugs, laboratory supplies, BCK materials, Mama packs etc) and develop procurement plans
• Collaborate with SCM, PEPFAR and MOH to train facility staff on Logistics Management of HIV/AIDS Commodities (LMHC).
• Conduct regular stock audit, document and report all discrepancies noticed also provide feedback to sites on such discrepancies
• Ensure use of job aids on guidelines for proper storage of commodities to supported stores

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	10,842,388	0

Narrative:

CIHP will work with GON to expand access to comprehensive ART services through activation new sites in underserved areas.
• Strategically ensure prompt enrolment of eligible patients on treatment through various innovative approaches .
• Ensure periodic assessment of program performance and quality by facilitating biannual SOC assessment exercise, and other CQI activities including DQA.
• CIHP will build capacities of designated PHCs to provide onsite ART refills and follow up for stable patients devolved from overwhelmed comprehensive facilities
• Coordinate and facilitate the training and mentorship of health care providers on HIV/AIDS treatment

• Monitor service quality via quarterly review of priority indicators with facility staff and state officials. • Ensure availability of National Adult treatment guidelines, job aids and SOPs in the various states

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	1,565,358	0

Narrative:

Train and mentor health care providers on PEDIATRICS HIV/AIDS treatment. as well as provide periodic guidance through CMEs at facility level, focused mentoring and preceptor ship
• CIHP will strategically focus on early identification of HIV infection status and reaching HIV positive children needing treatment through various innovative approaches. These include the support of paediatrics HIV diagnosis; enhanced and focused paediatric case finding and referral to treatment
• Support the provision paediatrics IEC materials, SOP, national guidelines and job aids (dosing guides, cue cards, patient flowcharts, and management algorithms) to comprehensive facilities
• Ensure access to appropriate laboratory tests (CD4 %, chemistry, and haematology) in all comprehensive sites.
• Establish youth friendly/ paediatric services and support groups to provide psychosocial support for children of PLHIV and reinforce adherence

Implementing Mechanism Details

Mechanism ID: 16871	**Mechanism Name: ENGAGING INDIGINOUS ORGANIZATIONS TO SUSTAIN AND ENHANCE COMPREHENSIVE CLINICAL SERVICES**
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: Yes
Global Fund / Multilateral Engagement: PR/SR	
G2G: No	Managing Agency:

Total Funding: 48,965,375	
Funding Source	**Funding Amount**
GHP-State	48,965,375

Sub Partner Name(s)

(No data provided.)

Overview Narrative

ACTION Plus Up will build on ACTION Plus' network of over 200 mainly GON facilities at primary, secondary and tertiary levels of care in 23 States and the FCT.
HCT will continue to serve as the entry point to care, treatment and support with counseling and testing services provided to 989,899 clients via outreaches to hard to reach communities, couples counseling, moonlight HCT with community 'hot spot' mapping, evening service delivery and home testing of family and friends of index PLHIV.
Combination prevention (behavioral, biomedical and structural interventions) will be employed in preventing new cases of HIV by collaborating with implementing agencies who provide direct community level based prevention intervention services (peer education, peer education plus, ABC approach to prevention, HCT/mobile HCT, syndromic management of STIs, condom messaging and distribution and community awareness campaigns) that are evidence- based to MARPS and In- school youths utilizing the Minimum Prevention Package.
The Nigerian FMOH ART treatment guidelines adapted from the 2010 WHO ART treatment guidelines including the new recommendations for ART in pregnant women will be fully implemented at all sites, integrating OI, STI, TB prevention and treatment services and PEP. Focus will be on maintaining and expanding high quality services for care, treatment and prevention for existing clients in these states through continuous clinical improvement activities.
Emphasis will also be placed on early identification of treatment failure through the empowerment of the ART Switch Committees. Patients suspected of ART treatment failure will access viral load testing through one of IHVN's supported 11 PCR laboratories and viral genotyping (for those failing second-line ART).
To address gap

Cross-Cutting Budget Attribution(s)

Gender: GBV	112,165
Gender: Gender Equality	448,663
Human Resources for Health	135,000
Renovation	2,845,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
Mobile Population
Safe Motherhood
TB
End-of-Program Evaluation
Family Planning

Budget Code Information

Mechanism ID:	**16871**
Mechanism Name:	**ENGAGING INDIGINOUS ORGANIZATIONS TO SUSTAIN AND ENHANCE COMPREHENSIVE CLINICAL SERVICES**
Prime Partner Name:	**Institute of Human Virology, Nigeria**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	5,996,816	0

Narrative:

IHVN/ACTION Plus Up will provide a minimum of one clinical/Palliative care service to PLWHA and persons affected by AIDS at over 200 ACTION Plus Up supported sites.
Some available services include:
• Pain/symptom assessment and management using the C&S assessment and intervention tools
• laboratory services for CD4, hematology, blood chemistry, LFT, OI and pregnancy testing and targeted HIV viral load testing
• OI prophylaxis, diagnosis and management
• access to appropriate TB diagnostics and linkages with DOTS programs
• Screening for hepatitis B, malaria, diarrhea, cryptococcal infection and urinalysis for all HIV+ persons if

indicated
• Nutritional assessment, counseling and support (NACS)
• Preventive services - Basic care kits plus at least two other services in the domains of HBC, psychosocial, spiritual, partner/couple HTC, risk reduction and support and STI assessment, diagnosis and management using syndromic management
• Structured treatment preparation to support ART adherence
• Home based nursing/visits/tracking provides care to the bedridden & tracks clients back to boost retention in care.
• Home based HTC for family members and friends (PABA)
• Specific and targeted services for PABA including Health Education talks, preventive, psychosocial and IGA through outreaches and seminars.
• Community outreaches/seminars for stakeholders (Religious, traditional, general population, men etc) to promote behavior change towards HIV related issues
Reproductive health/Family planning needs of PLWHAs' will be identified and appropriate referrals and linkages made to RH/FP clinics and FBO/NGO. Support Groups and Positive Health Dignity and Prevention (PHDP) will be championed by Peer Educators/TSS/ PLWHA. Singles (youths & unmarried) and Association of women living with HIV/AIDS (ASHWAN) support groups will be facilitated at community and facility level. IHVN will collaborate with FIDA and Legal AID Council for the provision of legal support and fundamental human rights for women and children.
Appointment system using registers, patient hand cards and appropriate use of PEPFAR ID, SMS reminders, and closed user group (CUG) and effective completion of ART and Pre-ART registers will be strengthened to reduce LTFU. Registers, referral tools and Community resource directories for appropriate documentation, transfers and linkages for wrap around services to CBO/FBO/NGO will be developed.
Catchment area mapping of ALL ACTION Plus Up supported sites will continue to create and maintain a data base of geographical areas and client load to be served at each facility/community.
Emphasis areas include: human capacity building for sustainability; local organization/CBO capacity building and partnership; TB-related wraparound programs; decentralization of care and treatment services to satellite.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	1,121,658	0

Narrative:

In COP13, ACTIONPlus up will focus on consolidation of comprehensive high quality community-based VC services to 85,729 HIV infected and affected children including adolescents.
The focus of this VC scale up will be to expand community-based VC programming with emphasis on the

most vulnerable children living without adequate adult support, living outside of family care, or living in a situation where they are marginalized, stigmatized, or discriminated against. The minimum package of VC services based on the National Guidelines and Standards of practice, appropriate for age shall be offered to 0 - 5, 6 -12, 13 – 17 years. All children who require VC services will be identified through household surveys, self and community referrals.

ACTIONPlus up will continue its collaboration with the States Ministry of Women Affairs VC units and the Local Government Council Social Welfare departments in facilitative supervision of VC services in each state.
ACTIONPlus up will build the capacity of LGA Social Welfare Officers in Coordination and Supervision for sustainability and ownership of the VC program in their LGAs and Communities. Community Based and Faith Based organizations will also be empowered to identify and care for VC within the Networks. These Faith Based Centers will create a sustainable mechanism for community care where there are no orphanages and so become a vehicle for transition of street based children into family care.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	1,305,330	0

Narrative:

ACTION Plus Up is supporting the global as well as national strategy of strengthening the focus on three strategies for reducing the burden of TB in HIV-infected individuals (the 3 I's); intensified case finding (ICF), isoniazid preventive therapy (IPT) and infection control (IC).
Intensive case finding is the primary focus area whereby every HIV client IS to be screened for TB at every clinic visit with four questions (current cough, fever, night sweats and weight loss) recommended by the national TB/HIV guideline and WHO. Chest x-ray is supported for sputum smear negative clients with persistent symptoms. With the expansion of distribution of geneXpert machines in most parts of Nigeria, they will also be used for the diagnosis of difficult sputum smear negative cases in our HIV positive clients. Task shifting and sharing will follow. 'Integrated HIV/TB services' is another primary area of focus in COP13. This is to ensure that all HIV/TB co-infected clients receive care on the same day, if possible at one clinic('one stop shop') reducing the number of visits to the clinic.
Isoniazid preventive therapy (IPT); clients found negative after TB screening with the above four questions will be provided with IPT through the HIV clinic along with pyridoxine. All HIV/TB clients will also receive co-trimoxazole, irrespective of their CD4 counts.
ACTION has piloted use of mini X-ray for active TB case finding. In COP13 ACTION Plus Up/ IHVN will scale up the mini X-ray facilities to support hospitals that don't have functioning X-ray on a caseload basis. The TB clinics will be supported to provide holistic patient care according to national guidelines, in addition to support for TB infection control (the third component of 3 I's) using established modified tools

created through collaboration with other implementing partners (IPs), Government of Nigeria (GoN) and various partners.
Strengthening linkages between HIV and TB services is one of the main focus areas of IHVN. Other areas include increased strength of diagnostic capacity of HIV, TB & DR-TB, and intensified case finding for TB, community mobilization for the counseling and testing of HIV, increased uptake of IPT and pediatric TB/HIV.
IHVN will continue to maintain its membership in the National TB/HIV working group and the MDR-TB committee and will continue to be actively involved in national TB/HIV planning, implementation, monitoring and supervision.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	928,653	0

Narrative:

Pediatric care and support (C/S) targets HIV-exposed and -infected children 0-15 years of age.
All services will be delivered using family centered and MCH integrated approaches.
Some of the services to be provided include:
• Growth monitoring using supplied growth charts with nutritional assessment and counselling, as well as supply of multivitamins, mineral supplements and Plumpy nut.
• Provision of basic health care package (BCP) to all HIV-infected children as well as HIV-exposed infants receiving services
• Laboratory monitoring for all HIV exposed and-infected children - CD4 counts, haematology, and chemistry. For TB/HIV co-infected/suspect children, baseline and diagnostic chest x-rays. Paediatric infectious disease experts will equip clinicians with skills to effectively clinically diagnose TB in children, since TB diagnostics are often unrevealing in children. EID will be supported and available at all PMTCT points of service to improve the identification of HIV+ children for linkage into care and treatment services.
• INH prophylaxis will be provided for HIV-infected children at the National TB Program DOTS centres. Supervision will be carried out by Home-Based Care/Community teams.
• Home-Based care (HBC) for children is linked to HBC for adults and provided in all network areas.CSS teams support parents with ART adherence for children in the home through education, addressing adherence barriers, and supporting transition to FDCs. They also link family members to PMTCT, community immunization and family planning services. ACTION Plus Up will continue to strengthen psychosocial support for children by improving the quality of counselling available for vulnerable children.
• Site-based adolescent clinics staffed by both adult and paediatric personnel will be established, to take care of their special needs and help transition them fully into adult care. Each clinic will ideally be staffed by adherence counsellors. Specifically under OVC activities, community-based Adolescent

Clubs/Support will be formed
Pediatric Care and Support will be integrated with routine paediatric care, nutrition services, and maternal health services. Efforts will be made to have maternal and pediatric HIV services including OVC and Nutrition/Infant Feeding Counselling geographically proximal to immunization and, PMTCT/ANC clinics, and other points of routine paediatric and maternal care. Through renewed paediatric PITC efforts, HIV testing for all children with unknown status will be offered at all points of routine and HIV care services. Quality monitoring will be undertaken through regular site mentoring and supportive supervision using existing assessment tools, DCT and routine monitoring and evaluation indicators.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	5,303,608	0

Narrative:

IHVN will support ARV Services, Basic Care and Support (BC&S), OVC, TB/HIV, PMTCT, and HCT programs by improving on lab infrastructure and training staff to accurately diagnose, stage and monitor patients, according to national and international standards. Using an integrated, tiered referral laboratory network model, IHVN will provide laboratory services at a minimum of 120 testing facilities with 234 HIV testing points (HCT, PMTCT, Blood safety, and TB clinic). All laboratory activities and methods will be based on standard operating procedures (SOPs) and manuals of operations (MOPs) developed, including policies and procedures for logistics. All sites will continue to participate in IHVN Quality Assurance program and Digital Proficiency Testing (AFRIQUAL Lab).
IHVN will partner with facilities' Managements, Medical Laboratory Science Council of Nigeria and USG PEPFAR LTWG in enhancing the process of national/international accreditation of a minimum of 40 laboratories.
Thirteen functional PCR laboratories supported by IHVN will provide EID, Viral Load (VL) and HIV genotyping services to sites (IHVN, GON, GF and other IPs) geographically proximate to them and will roll-out VL testing for all ART patients in care to have a minimum of two tests per year. PLASVIREC (IHVN training and reference Centre) will continue to provide QA for the national EID and coordinate CDC external DBS proficiency testing for all EID labs in Nigeria.
IHVN will utilize mobile laboratories as part of standard of care and develop validation protocols for laboratory testing procedures and rapid point of care (CD4 & Gene Xpert) diagnostics platforms in high incidence/prevalence Local Government Areas (LGAs).
IHVN will activate 130 high TB burden sites and implement enhanced and cost-effective TB diagnostics services (e.g LED fluorescence microscopy, molecular assays, and genotyping) participate in national MDR surveillance, provide technical assistance to national TB program.
IHVN will organize biomedical engineering workshop for 30 laboratory scientists and biomedical

engineers to improve on equipment maintenance and usage at sites.
IHVN will conduct monthly comprehensive laboratory data analyses, share scientific data and findings to support/guide prevention and treatment programs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	833,715	0

Narrative:

The SI department will implement electronic medical records system- Open MRS and DHIS for patient level and aggregate data reporting at all secondary and tertiary supported sites to improve patient management and monitoring and at the same time provide high quality data for reporting. The HMIS team of the department will continue to provide technical support to the sites on EMR. The SI department will conduct a patient audit at all supported sites to account for all patients provided with service during the COP year and continue to maintain the database generated during the exercise.
To ensure high quality in data generated and reported there will be routine data quality assessment exercises at all supported sites; ensuring feedback of DQA exercises are communicated and followed up.
The department will be conducting focused supportive supervision and mentoring at supported sites to ensure quality in monitoring and evaluation processes at sites. The SI department will continue to work with the clinical team in ensuring continuous quality improvement activities at supported sites.
Routine data collection, analysis and reporting will be ongoing; there will be site expansions and the SI team will form part of the site assessment and activation teams. We will continue to ensure compliance to national tools, reporting lines and platforms.
We will continue to collaborate with the Government of Nigeria to strengthen the health system and improve the response; we will participate and provide technical assistance in the annual joint DQA and data validation exercises.

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

Narrative:

IHVN is the Lead IP in Delta, Ekiti, FCT, Katsina, Nasarawa, Ogun,Ondo and Osun and the co-Lead IP in Kano and Benue States
Concept of lead IPs
PEPFAR-supported implementing partner with key and lead role in facilitating support to enhance the capacity of sub-national levels of government towards improving the coverage and quality of HIV/AIDS services:

• Takes a lead role as USG State Liaisons in facilitating support to enhance the capacity of sub-national levels of government.
• Lead partner becomes accountable for service delivery and health system strengthening in the assigned state.
• Engage government at the State as well as LGA level to secure support for HIV/AIDS services and saturation – Prevent, Care, and Treat
• Provide government (State and LGA) with platform for coordination donor support and HIV/AIDS response within the State
• Support SMoH (SASCP and SACA) to lead in planning, implementing, managing, monitoring, reporting and evaluation HIV/AIDS services
• Build the capacity of states in managing partnership involving health programs to ensure sustainability (when the benefits of a project continue)
• Provide technical, programmatic and other support to establish sustainability mechanisms (to continue the benefits of a project)
• Strengthen HMIS and coordinate the harmonization of HIV/AIDS data reporting systems
• Build capacity of State and LGAs to manage health commodities and drug logistics including ARVs, HIV test kits etc.

Lead IP Expected outcomes
• Increase state capacity to coordinate donor activities
• Increase government responsiveness and ownership of health programs
• Improve capacity of states to develop plans, implement activities, monitor and evaluate health programs.
• Improved health systems
• Ensure statewide coverage to meet the HIV/AIDS unmet needs.
• Development of fundable activities, State Strategic and Costed Plans for appropriate resource mobilization including State Government funding
• States ownership through planning, coordination and gap analysis for basis of scale up of HIV/AIDS services

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMBL	31,483	0

Narrative:

To support the centrally coordinated blood transfusion services 50 IHVN site laboratory Blood Banks will be supported to fully implement the National Guidelines for blood transfusion in Nigeria and linked to

zonal National Blood Transfusion Service (NBTS) for blood exchange/supply through the NBTS-Hospital linkage program. All collected units of blood will be screened for the four transfusion transmissible infections (TTIs) (HIV, Hepatitis B virus, Hepatitis C virus and syphilis) using ELISA techniques. Tertiary facility Blood Bank laboratories with ELISA equipment will in collaboration with NBTS be supported to screen all their collected family replacement donor units for the four TTIs using ELISA in their facilities under the Hospital Linkage Program (HLP). Also under the Hospital linkage program, all facility Blood Bank laboratories without ELISA capability will be linked to proximate tertiary sites with ELISA capability or proximate zonal NBTS centers for ELISA screening of collected family replacement units and for blood exchange/supply. Blood donation drives will be conducted in collaboration with NBTS at supported facilities and surrounding communities. Blood donation counseling will be included as part of post-test counseling for HIV negative clients.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMIN	109,652	0

Narrative:

The main goal of Injection Safety Program in FY13is to reduce exposure to blood borne pathogens particularly HIV, and the incidence of medical transmission of these pathogens. Health care workers targeted for this activity include physicians, nurses, community health extension workers (CHEWs), laboratory workers and waste handlers.

ACTION Plus Up will collaborate with GoN/JSI/MMIS to provide Safe Injection programming to 204 supported sites in 23 states annually.

ACTION Plus up will strengthen and or facilitate the establishment of Infection Control Committees in all sites to supervise biomedical prevention services.

All exposed individuals to needle sticks and other sharps in facilities will be linked to the Post Exposure Prophylaxis (PEP) services. ACTION Plus Up staff in collaboration with supported facilities will incorporate PEP services into the Community Support Services (CSS). Advocacy visits and community mobilization to gatekeepers and the Police Force will be carried out to report real time cases of rape and link such individuals for free PEP services at the network of facilities providing HIV/AIDS care and treatment

ACTION Plus Up in collaboration with CCCRN will support follow-up and step down site level Basic trainings on Infection Prevention control in the context of Injection Safety and Universal Precaution to physicians and nurses from the inpatient wards, clinics, labor and delivery rooms, and the surgical theaters. In addition, HCT counselors performing rapid tests, laboratory scientists, blood bank staff, and waste handlers will also be trained. A follow-up of trainees and on-site retraining based on performance evaluation at sites will be paramount.

The oversight of this program area will be provided by a dedicated ACTION Plus Up Program Officer with

the support of regionally based medical and nursing Program Officers.
ACTION Plus Up will procure and continue to provide personal protective commodities including gloves, eye shields, boots, and aprons. and will take on the new role of logistic supplier of seed stock for injection safety commodities and recurrent stock of Universal Precaution materials for all sites. ACTION Plus Up will supply seed stock color coded bin liners and waste bins for effective waste segregation. Commodities will be provided to sites based upon a pull system using a site level inventory control system linked to the Institute of Human Virology Nigeria (IHVN) warehouse logistics management information system.
ACTION Plus Up staff will implement ongoing quality assessment of implementation by direct observation and by training a local staff member to monitor compliance in harmony with hospital policies to be developed to promote sustainability.
To achieve /monitor the effectiveness of the program, an appraising monitoring tool developed will be used to evaluate the program

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	281,722	0

Narrative:

ACTION Plus Up will build on the successes of ACTION Plus in targeting young girls of 10 -17 years of age in Faith Based Organizations especially Girls brigade and NASFAT to continue providing prevention services employing the Minimum Prevention Package (MPP) strategies of: - Community Awareness campaigns, Peer education, Drama and Focus Group Discussions to other targeted youths/young adults 15 – 24 years considered to be the highest prevalence age. The overall goal of AB activities is to provide a comprehensive package of prevention messages at selected states with high HIV prevalence which seeks to empower youths in Tertiary Institutions, Islamic Schools, Girls Brigade and other youth Organizations to make an informed decision to practice primary or secondary abstinence or mutual fidelity.
Teachers, guidance counselors and peer educators will be trained to provide effective prevention interventions inclusive of AB messaging; the Family Life Health Education (FLHE) will also be adopted in addition for the training by the collaborating FBOs. In FY13, ACTION Plus Up will strengthen the linkages between appropriately balanced ABC services, condoms and other prevention activities. AB activities will be linked to and contribute to the general overall goal of HTC activities by providing testing to youths during program implementation. All those testing HIV positive will be linked to care and treatment. Scale up plans will include working with the Boys Brigade and YMCA
Baseline surveys will be conducted in each intervention community after which a quarterly monitoring system will be put in place to determine the progress of the intervention in terms of knowledge gained and behavior change. ACTION Plus Up will equally provide service at the community level through established youth organizations to complement the school based approach. Anti- AIDS clubs will be

established in the institutions with the office of the HIV desk Officer being the Patron while the parent religious organizations (Churches and Mosques) will be advocated to for program ownership to foster sustainability.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	1,240,879	0

Narrative:

HTC will continue to serve as an entry point to treatment, care and support programs. HIV Testing and counseling teams will utilize various models viz integrated, stand alone and mobile/outreach to achieve set targets.

Several strategies to be employed to reach a wide range of targeted populations include scaling up testing and counseling to multiple points of services in facilities for easy access, stepping up couple testing and counseling, engagement of well-trained community based outreach counselors to provide services to hard to reach communities and amongst MARPs, provision of services at odd hours during the night 'moonlight testing and counseling' to cater for mobile or non – resident sex workers and their partners. Mapping out hot spots in communities and reaching out to the population. Home testing and counseling services are also to be provided by the Community Home Based Care team to family and friends of the index PLHIV patients. Continuous proficiency testing will be provided to sites and outreach teams to check and assure quality of services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	3,786,719	0

Narrative:

C & OP activities will continue to play a significant role in preventing new incidences of HIV infections amongst MARPs groups namely Female Sex Workers and their Clients, Long Distance Truck Drivers, MSM, Out of School Youths, Drug Users and those who engage in Alcohol and Substance Abuse. These services will be provided in line with the Minimum Prevention Package (MPP) strategies of: - Peer education, STI Syndromic management, Condom education & distribution and HTC as enshrined in the National Prevention Plan. ACTION Plus Up will build on its collaboration with local NGOs in states with high HIV prevalence to scale up Community Level Based Prevention Intervention service provision including the establishment of condom outlets in these MARPs communities for free condom distribution. Part of the scale-up plan for FY13 will involve placing locally made wooden condom dispensers in each outlet to make male and female condoms available while assigning trained peer educators as the custodians of these boxes for accountability purpose.The distribution method will be based on a pull system where the NGOs will be responsible for making condoms available to the

targeted MARPs communities.
Also in FY13 Community HTC services will be re-inforced and scaled up to include provision of house to house testing in these intervention communities. Those testing positive to HIV will be linked to care and treatment. ACTION Plus Up will also target out of school youths through community centers and organized activities supported through Vulnerable Children programming. C & OP programming will be balanced with AB intervention messages for youths in these settings. Baseline surveys will be conducted in each intervention community. A quarterly monitoring system will be put in place to determine the progress of the intervention in terms of knowledge gained and behavior change.
For program sustainability; the capacities of the collaborating NGOs will be built while Community Advisory Boards (CAB) will be established to promote the program and serve as the link with the communities. Trained peer educators in each target group will form small CBOs for program ownership and ACTION PlusUp will brand all the intervention communities with HIV prevention messages to complement other activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	7,782,994	0

Narrative:

144 PMTCT sites from COP12, located in 24 states of Akwa Ibom, Anambra, Bauchi, Benue, Cross Rivers, Delta, Edo, FCT, Gombe, Imo, Jigawa, Kaduna, Kano, Katsina, Kogi, Kwara, Lagos, Nasarawa, Niger, Ogun, Osun, Plateau, Sokoto and Rivers will be maintained and expanded on. PMTCT care centres are linked to secondary and tertiary “hub sites” that provide more complex lab services in a network model. In this network, PMTCT stand alone points are linked to adult and pediatric ARV care through utilization of a PMTCT focal person in each hub, network referral standard operating procedures (SOPs), monthly PMTCT network meetings, training and incorporation of team approaches to care in all training and site monitoring. In COP13, 315,715 pregnant women will receive PMTCT counselling & testing and receive their results using provider-initiated opt-out testing with same day results. Same approach will be adopted for mobile PMTCT services to women in hard to reach communities.
HIV-positive pregnant women who require HAART will be linked to an ART point of service. This program will work closely with the care and support team to engage community based PMTCT model of care and ARV linkages to reduce loss of clients along the PMTCT cascade. In addition, each HIV-positive pregnant woman will be referred to OVC services in order to facilitate care for all of her affected children. An anticipated 9,307 HIV-positive pregnant mother –child pair will be identified and provided with a complete course of ARV prophylaxis on-site or by referral in line with the national guidelines, including CD4 counts without charge. Cotrimoxazole suspension will be provided to all exposed infants pending a negative virologic diagnosis. All HIV-positive women will be counselled pre- and post-natally regarding infant feeding practices in line with the National policy and linked to support groups (Mentor mothers) to

increase access and retention in care. ACTION-Plus Up will provide safe nutritional supplements for HIV exposed infants.
ACTION-Plus Up will train and re-train HCWs including community-based health workers, TBAs and mentor mothers in the provision of PMTCT services using the national curriculum.
Program linkages will be operationalized at the site and program level, including linkages to adult and paediatric ART, OVC, Basic care and support services. ACTION-Plus Up will continue to provide Technical Support to Federal, State and Local Government for ownership and sustainability. Quality monitoring will be undertaken in line with national policy. In addition to routine monitoring and evaluation activities, ACTION Plus Up will continue to provide TA for the National PMTCT MIS and contribute to a multi-country PHE that will evaluate and document best program models to increase access to ART.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	0	0

Narrative:

In COP13 ARV drugs will be procured so that ARV treatment can be provided to 142,656 adults and 15,582 children (77,675 new) at over 200 clinical sites in 23 states in Nigeria through a pooled prcurement system. The first component of this activity includes forecasting and procurement of ARV drugs. As part of the COP13 budgeting process, a forecast will be jointly carried out by ACTION Plus Up and SCMS and utilized to project COP13 ARV requirements. It is estimated that 90% of patients begun on EP-provided ARVs will be adults and the remaining 10% will be children. Patients on ARVs include those started on ARVs in prior years, patients in care who roll over into treatment, and newly diagnosed patients needing ART. Overall, it is assumed that 5% of both adults and children begun on ARVs during prior years will ultimately require second line treatment under COP13. Forecasting and pipeline is reviewed and adjusted if necessary monthly based upon site level consumption data provided by GHLIL/SCMS.
ACTION Plus Up will follow the National Treatment Guidelines in the provision of ARV regimens for adults and children. The regimen mix has been forecasted based on current utilization and balancing best clinical evidence with scalability. The present preferred first line adult regimen is zidovudine/lamivudine/NNRTI with the alternative regimen tenofovir/emtricitabine/NNRTI with stavudine rarely employed. PEPFAR and FDA-approved generic formulations will be utilized whenever available, and we anticipate 99% of the budget will be utilized to purchase generics. For all regimens, a four-month buffer stock is maintained to minimize the likelihood of problems with drug supplies. ACTION Plus Up staff develop ARV projections, and plan procurements accordingly. In COP13 all purchases of First line drugs and possibly Co-Trimoxazole will be purchased via PEPFAR (SCMS) pooled procurement mechanism, in line with current guidance.

The second component of this activity includes expediting commodities through the port of entry, followed by storage, distribution, and management of the commodities. This includes site assessment of pharmacies and storage facilities with corrective recommendations and actions. Needed site renovations for proper security and storage conditions in pharmacy stores will be undertaken by ACTION Plus Up. Storage and distribution of ARVs, maintenance of a site level commodities management system, and instruction to site staff regarding the system, have been subcontracted to the GHLIL. GHLIL collects drug utilization data and documents proper storage conditions at the central warehouse, regional warehouses, and site level

ACTION Plus Up will pilot the involvement of Community pharmacies as patient drug counseling and pick up sites in the mobile care strategy network in COP 13 to strengthen the GON ART decentralization policy.

Quality control involves routine monitoring visits by ACTION staff from the central Abuja office or from regional offices to all sites every six months to review the implementation of SOPs and to compare reported usage based on monitoring and evaluation data with local manifests and pharmacy logs. The ACTION Plus Up training department analyzes data for patterns of deficiencies as well as individual site deficiencies in order to improve training and target weaknesses to address through retraining.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	17,688,351	0

Narrative:

For COP 13, ACTIONPLUS UP will build on ACTION's national network of over 200 mainly GON facilities at primary, secondary, and tertiary levels of health care in 23 states and the FCT through continued provision of comprehensive care, treatment, and wrap around services to over 115,372 HIV-positive adults. The Nigerian FMOH ART treatment guidelines adapted from the 2010 WHO ART treatment guidelines including the new recommendations for ART in pregnant women will be fully implemented at all sites, integrating OI, STI, TB prevention and treatment services and PEP. Focus will be on maintaining and expanding high quality services for care, treatment and prevention for existing clients in these states through continuous clinical improvement activities. Emphasis will also be placed on early identification of treatment failure through the empowerment of the ART Switch Committees. Patients suspected of ART treatment failure will access viral load testing through one of IHVN's supported 11 PCR laboratories and viral genotyping (for those failing second-line ART).

To address gaps in retention in care, and loss to follow up, ACTIONPLUS UP deploys an interlocking cadre of facility—and community-based client advocates. Network Coordinator (tertiary site and Hub-based); the Case Manager/Mother Mentor (PHC-based) and Community Health Extension Workers (CHEWs)/Adherence Partner (community-based) work in concert to link clients across the health systems managed by the federal, state and local governments and support down- and up-referrals with active

feedback to ensure quality services are rendered and data captured. Linked to reliable client level data is ACTIONQual, a quality improvement framework based on the GON HIVQual and enhanced by IHVN which serves as a uniform tool for empowering site-based QI Committees to objectively evaluate performance and develop corrective interventions.
In line with the National Strategic Framework and the NPHCDA's National Decentralization of HIV/AIDS Services Plan, overcrowding at hub sites as a barrier to quality ART treatment access and retention is reduced through monitored down-referral of stable clients to PHCs where capacity for safe and high quality task-shifting will be built. CBO-based clinics for most-at-risk-populations (MARPS) staffed by a full multidisciplinary mobile team will bring user friendly ART treatment services to these marginalized populations.
ACTIONPLUS will build treatment and treatment support capacity of doctors, nurses, ancillary workers and volunteer cadres utilizing three tiers of in-service training: Basic HIV Training, Supplemental Program Area Training, and Advanced Training where content is both didactic and experiential (including mentorship and preceptor activities). Additionally, Assessment Guided Training addresses gaps identified through quality of care assessments. All trainings utilize and build on GON curriculum; utilize a network of Nigerian expert trainers and consultants to step-down and sustain local capacity.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	2,553,795	0

Narrative:

In FY 13, ACTION Plus-Up aims to provide comprehensive care, support and lab monitoring to 8,241 HIV infected children; 1,593 of these children will be started and maintained on ART.

Provider Initiated Testing and Counselling (PITC) will be expanded to PHCs, TB DOTS centres, OVC service points and family planning services. Lab staff will however provide oversight and quality assurance for PITC.

Early Infant Diagnosis (EID) is an important entry point for Pediatric ART. EID services will be strengthened by increasing oversight at the site and regional level, to ensure that all positive children are tracked and enrolled into care within 2 weeks of result delivery.

At PHCs, positive children may be formally referred to the hub site for more comprehensive ART care. Health care for HIV infected children will be integrated at all sites, and include access to free lab monitoring, TB diagnostics and appropriate formulation drugs via GON-sponsored DOTS programs, provision of cotrimoxazole prophylaxis, diagnosis and treatment of malaria and treatment of common OIs. The home-based care (HBC) team will address the need for palliative care, tracking of LTFU clients, and

in-home adherence counselling for parents. A coordinated approach to linkage will be operationalized at site and program levels including linkages between PMTCT and pediatric ART, OVC services, pediatric care and support, and nutrition. Linkages will be forged with child protection committees in the OVC program to create community awareness for paediatric testing and be used to mobilize families and the community to access available services and support the program. To improve adherence to ARVs among children and promote retention in care, ACTION Plus-Up will provide targeted adherence mentorship for pediatric providers to build their capacity in adherence counselling skills. Mentorship will cover child development, pediatric counselling, diagnosis disclosure, grief and loss and adherence to medications, employing the use of a national paediatric disclosure and counselling tool developed by IHVN. In collaboration with USG and Federal Ministry of Health, we will continue to build the capacity of sites and states to collect, analyse and use EID and pediatric HIV data to evaluate program performance. We will continue to provide regular on site and electronic correspondence with program and site data-collecting staff to ensure generation of quality and timely data from all sites.

Implementing Mechanism Details

Mechanism ID: 16940	**Mechanism Name: Strengthening Partnerships, Results and Innovations in Nutrition Globally (SPRING)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: John Snow Inc (JSI)	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,000,000	
Funding Source	**Funding Amount**
GHP-State	1,000,000

Sub Partner Name(s)

Helen Keller International		

Overview Narrative

SPRING works to address nutrition issues, such as anemia and stunting while working across sectors—including health, agriculture, and economic growth—SPRING's nutrition experts facilitate country-led, evidence-based nutrition and food security programs. SPRING will provide 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. Building off the previous technical assistance, SPRING will provide targeted training that meets the previously identified technical capacity needs. SPRING will develop a toolkit that enables USAID/PEPFAR implementing partners to make their own decisions and design programs with their own resources. SPRING will also support information and knowledge sharing among SPRING, USAID/PEPFAR, its partners, other donors and the GON. SPRING will also look into the possibility of developing or supporting an online platform to provide tools and e-learning materials to partners.

The SPRING project was initially funded at $600,000 for two states and additional funding is requested to expand Nutrition activities (NAC) to an additional two States to improve nutritional practices, improved access to quality services and for preventing stunting and anemia.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	500,000
Gender: Gender Equality	300,000
Human Resources for Health	200,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**16940**
Mechanism Name:	**Strengthening Partnerships, Results and Innovations in Nutrition Globally (SPRING)**
Prime Partner Name:	**John Snow Inc (JSI)**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	1,000,000	0

Narrative:

SPRING will provide 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. Building off the previous technical assistance, SPRING will provide targeted training that meets the previously identified technical capacity needs. SPRING will develop a toolkit that enables USAID/PEPFAR implementing partners to make their own decisions and design programs with their own resources. SPRING will also support information and knowledge sharing among SPRING, USAID/PEPFAR, its partners, other donors and the GON. SPRING will also look into the possibility of developing or supporting an online platform to provide tools and e-learning materials to partners.

USG Management and Operations

Assessment of Current and Future Staffing.

Redacted

Interagency M&O Strategy Narrative.

Redacted

USG Office Space and Housing Renovation.

Redacted

Agency Information - Costs of Doing Business

U.S. Agency for International Development

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
Computers/IT Services		392,859		392,859
ICASS		508,110		508,110
Management Meetings/Professional Developement		926,015		926,015
Non-ICASS Administrative Costs		607,232		607,232
Staff Program Travel		588,621		588,621
USG Staff Salaries and Benefits		1,374,163		1,374,163
Total	**0**	**4,397,000**	**0**	**4,397,000**

U.S. Agency for International Development Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services		GHP-State		392,859
ICASS		GHP-State		508,110
Management Meetings/Professional Developement		GHP-State		926,015
Non-ICASS Administrative Costs		GHP-State		607,232

U.S. Department of Defense

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
Computers/IT Services		243,400		243,400
ICASS		920,000		920,000
Institutional Contractors		1,410,000		1,410,000
Management Meetings/Professional Developement		90,000		90,000
Non-ICASS Administrative Costs		896,600		896,600
Staff Program Travel		290,000		290,000
USG Staff Salaries and Benefits		1,150,000		1,150,000
Total	**0**	**5,000,000**	**0**	**5,000,000**

U.S. Department of Defense Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services	Including phones w/internet access	GHP-State		243,400
ICASS		GHP-State		920,000
Management Meetings/Professional Developement		GHP-State		90,000
Non-ICASS Administrative Costs		GHP-State		896,600

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention

Agency Cost of	GAP	GHP-State	GHP-USAID	Cost of Doing

Doing Business				Business Category Total
Capital Security Cost Sharing		1,000,000		1,000,000
Computers/IT Services		1,308,026		1,308,026
ICASS		3,000,000		3,000,000
Management Meetings/Professional Developement		200,000		200,000
Non-ICASS Administrative Costs		4,861,717		4,861,717
Staff Program Travel		886,666		886,666
USG Staff Salaries and Benefits	2,868,591	875,000		3,743,591
Total	**2,868,591**	**12,131,409**	**0**	**15,000,000**

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		1,000,000
Computers/IT Services		GHP-State		1,308,026
ICASS		GHP-State		3,000,000
Management Meetings/Professional Developement		GHP-State		200,000
Non-ICASS Administrative Costs		GHP-State		4,861,717

U.S. Department of State

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total

ICASS		118,000		118,000
Staff Program Travel		15,000		15,000
USG Staff Salaries and Benefits		170,000		170,000
Total	**0**	**303,000**	**0**	**303,000**

U.S. Department of State Other Costs Details

Category	Item	Funding Source	Description	Amount
ICASS	ICASS	GHP-State	Support services & equipment	118,000