

Approved



Nigeria

Country Operational Plan

FY 2014

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

1. Epidemiology of the HIV Epidemic

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's land area is 1.33 times larger than the State of Texas, just over 923,768 km² versus 696,200 km² respectively. Many of Nigeria's States have large populations such as Lagos and Kaduna, which are 17.5 million and 6 million respectively and larger than many other African countries alone. The country has 3.5 million HIV-positive individuals and ranks third among the countries with the highest HIV/AIDS burden in the world, next only to India and South Africa. Adding to this burden are the estimated 2.23 million children orphaned by HIV/AIDS. The national HIV seroprevalence rate for HIV is 4.1%. 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 spread across all parts of the country, affects all population groups and spares no geographical area. Generalized prevalence among 15-49 year olds is about 3.4 percent, but significantly higher rates exist among key populations, including commercial sex workers (27.4 to 21.1 percent), injection drug users (54.2 percent) and men who have sex with men (17.2 percent). Heterosexual transmission accounts for up to 95 percent of HIV infections. Women account for close to 60 percent of all adults living with HIV.

HIV prevalence varies widely across states as well as rural and urban areas. Lower HIV prevalence occurs in particular geographic regions and within certain segments of the population. The variability in prevalence by states was demonstrated in a 2012 National HIV/AIDS and Reproductive Health Survey (NARHS-Plus), with prevalence ranging from a low of 0.2 percent in Ekiti State to a maximum of 15.2 percent in Rivers state. The NARHS Plus survey recorded nine states and the FCT at seroprevalence of at least five percent and a seroprevalence level of seven percent or higher in four states and the FCT. 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. A data set known as the Epidemiological Projection Package (EPP) utilizes UNAIDS supported Spectrum Data software, is being used to target PEPFAR resources for COP 14 and 15.



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.

2. Status of the National Response

The HIV/AIDS response in Nigeria remains highly dependent on external funds: Out of US \$561.4 million invested in HIV/AIDS in 2012, only 27.7% is attributed to the Government of Nigeria (GON). In 2013 President Goodluck Jonathan unveiled the President's Comprehensive Response Plan for HIV/AIDS (PCRP) in July to address this situation. Expected 2014 funding for the PCRP from the GON is \$40 million. This is a far from what is needed and leaves an enormous gap of over \$807.5 million in 2014 alone.

After the United States Government (USG), The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFTAM) is the largest donor contributing to the national response. In March 2014, the GFTAM Board allocated US\$ 1,137.4 million for HIV, tuberculosis, malaria and health systems strengthening. Of this amount US\$ 447,385,351 is earmarked for HIV/AIDS. This includes all existing funds available from the GFTAM as of January 1, 2014 and is expected to cover the 2014-2016 period. Access to new funding is contingent on compliance with the GFTAM's counterpart financing policy that requires the demonstration of:

1. Minimum threshold government contribution to disease programs supported by the GFTAM (20 percent for Nigeria);
2. Increasing government contribution over time to the (a) disease programs supported by the GFTAM, and (b) health sector; and
3. Reliable disease and health expenditure data to measure and monitor compliance with the requirements of government spending.

While these requirements will encourage the GON to better resource its response, the GON will still fall far short of its commitments under the Partnership Framework Implementation Plan on HIV/AIDS 2010-2015 (PFIP) and its own PCRP. Despite the large investments by the USG and the GFTAM, coverage rates for key services remain low. The national treatment coverage rates for prevention of mother-to-child transmission of HIV (PMTCT) is 17% and 33% for HIV treatment.

II. PEPFAR Focus in 2014



The USG programmatic approach for COP14 will focus on maintaining the service delivery undertaken during COP 12 and 13, with expansion of service delivery in some states. While the USG remains committed to implementing the Global Health Initiative (GHI) Strategy and the PFIP, it recognizes that the priorities of both the USG and the GON partnership need to change for maintaining current patients on therapy and more country ownership. The GHI and PFIP strategies include: Improved human resources for health; greater focus on women and children; delivery of highest-impact service interventions, particularly at the primary health care (PHC) level; and strengthened leadership, management, governance, and accountability for program ownership and sustainability. The USG will continue to focus on these areas being cognizant of the priorities identified by the GON in the PCRPs and the limitations of the USG contribution to the national response.

The US Mission health team is coordinated through the Department of State and is implemented by three agencies including 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 COP14, DoD WRP-N will continue to strengthen their partnership with the Nigerian Ministry of Defense's liaison team, the Emergency Plan Implementation Committee (NMOD – EPIC) to continue to promote country ownership and sustainability. USAID and CDC will continue to work with implementing partners (IPs) in close collaboration with the GON at all levels across the full array of HIV/AIDS service delivery areas to develop maintenance and transition strategies of PEPFAR services. Particular attention will be paid to the work of the comprehensive care and treatment lead IPs and their capacity building efforts with State governments.

The USG will maintain its current level of service delivery in PMTCT and treatment services. Strategic scale up of services will occur in two focus states and six additional states. COP14 will focus on maintaining service levels in all but the two focus and six strategic scale-up states. In the "maintenance states," the USG will discontinue demand creation activities, outreach, and community-based programs designed to identify positive people and will discontinue expansion into new service sites. While pipeline resources were available to the program in previous years, current budget realities do not allow for additional spending beyond the new resources available to the country, totaling \$458,614,281.

As requested in the FY 2014 PEPFAR Planned Country Allocation memo dated October 18, 2013, the USG has developed a cost per target for each key program area which was used to develop state-level targets and budgets. Implementing mechanism budgets and targets also used this data to create their work plans and budgets. Considering the need to maintain our current client load on treatment, limited scale-up is planned. The proposed scale-up is highly concentrated to ensure impact. The USG is proposing to increase funding for the TB/HIV program, increase pooled procurement of drugs and



laboratory supplies to create greater efficiencies, work closely with the lead IPs to ensure the newly created State Management Teams are successful, and more fully roll out the DHIS, in compliance with the allocation memo.

III. Progress and Future

1. PF/PFIP Monitoring

In 2009, NACA led an intensive 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. On August 25, 2010, the USG and the GON signed the Partnership Framework (PF) on HIV/AIDS for 2010-2015. The PF is 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.

Former U.S. Ambassador to Nigeria Terence P. McCulley and Nigerian Secretary to the Government of the Federation (SGF) Senator Anyim Pius Anyim signed the PFIP on HIV/AIDS 2010-2015 on December 1, 2011 -- World AIDS Day 2011. The PFIP was designed to shift 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. 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. The USG will continue to support decentralization as a means of realizing the PEPFAR and GHI goal of health services integration in support of broader health systems strengthening while continuing 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 such as maternal and child health, family planning and malaria control. The PFIP envisioned a "straight lining" of the USG contribution to the National Response, while GON contributions expanded through



2015. The USG contribution has been “straight lined” as envisioned. In 2012 and 2013, the USG continued to scale up services beyond what was planned in the PFIP to compensate for the shortfall of GON resources. Continued large-scale expansion of the program is not possible given the need to ensure that all patients placed on treatment can continue to receive treatment going forward. The GON continues to fall short in meeting funding commitments as experienced under the PF and now under the PCR. The USG will continue to press GON counterparts to fulfill such commitments.

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. President Jonathan recommitted to achieving universal access in 2013 with the launch of the PCR at the African Union Special Summit on AIDS, TB, and Malaria (locally called the Abuja+12 meeting). Although an impressive commitment, the challenge remains putting that pledge into action. More than 70% of funding for HIV/AIDS comes from development partners. This situation is not sustainable, particularly at a time of global economic crisis. While leadership at the national-level has improved significantly over the last five years, several factors prevent attainment of universal access to HIV prevention, treatment, and care. Organizational and technical capacity among government offices and staff remains low at the state and LGA levels. Insufficient staff, staff turnover, poorly defined and over-lapping job descriptions and insufficient resources to carry out key functions (e.g., coordination, planning, monitoring, and reporting) remain 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.

COP14 activities reflect the objectives outlined in the NSF2 and the Nigeria’s National Strategic Health Development Plan (NSHDP) and support greater country ownership and sustainability. COP14 activities align with the commitments agreed upon by the USG, GON, and other PFIP stakeholders. 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 GFTAM to



ensure complementarity and avoid duplication. The USG currently serves as the Chair of the Development Partners Group for HIV. Implementation of USG decentralization efforts has been accomplished through joint planning and analysis in close collaboration with the National Primary Health Care Development Agency (NPHCDA) as well as the GFTAM under the interim funding arrangement. Appropriate sites are identified to eliminate overlap and duplication of effort.

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 through COP 14. 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 hired a multilateral advisor whose portfolio includes focus on joint USG/GFTAM/National Agency for the Control of AIDS (NACA) planning and implementation. Additionally, the USG has decentralized service delivery allowing for a more manageable program at the local level. The USG will continue to provide targeted capacity building and direct engagement of state and local governments to leverage 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 is preventing overlap of activities, improving standards of care, and improving coordination, advocacy, and capacity building efforts as well as increased coverage through targeted saturation of LGAs. As a critical component of the PFIP, rationalization is improving the accountability of USG-supported IPs and ultimately creating a more manageable program for the GON. Further, the process is facilitating IPs to attain commitments from GON at the state and local levels.

3. Trajectory in FY 2015

PFIP projections show donor resources for 2015 as remaining flat while those of the GON are expected to grow. Early reports from the Ministry of Finance indicate that the Federal Government contribution to HIV/AIDS will be in the range of \$40 million for CY 2015. However, this does not capture State and LGA financial contributions, which are expected to grow. The USG is seeking more accurate data on GON resources expended on HIV and AIDS in Nigeria. Once gathered, stakeholders at all levels will use this data to improve resource allocation for HIV and AIDS programming.

The USG will maintain the number of women receiving PMTCT and the number of people on treatment across all states and increase the numbers in selected states by continuing to improve the efficiency and effectiveness of its programs. PEPFAR will improve efficiencies by implementing policies designed to make these interventions more cost effective and sustainable.

The USG team will continue to work closely with the GFTAM and UNAIDS to ensure proper coordination of programs that work synergistically together. In COP13, 54 treatment sites were handed over to NACA for follow up with GFTAM support. This is one such method employed to create a strengthened and unified treatment program. The USG will look for opportunities during COP14 and 15 to transition other aspects of the program to the GON. The USG will work with UNAIDS using the investment case for Nigeria as a way to highlight the importance of funding the National Response at an appropriate level.

IV. Program Overview

1. PMTCT

The USG PMTCT portfolio has increased engagement with state and local governments through a Lead IP approach to build technical capacity of states and local governments in planning. The lead IP streamlines communication with the GON by providing one point of contact at the state level. Furthermore, USG has supported partners to maintain PMTCT activities at primary health care and secondary facilities. Integration of PMTCT services with maternal and neonatal child health service



outlets and increasing private sector engagement remain important areas of focus for the program. As PMTCT services have been extended to over 3800 sites in COP13, COP14 will focus on maintenance of current service levels and quality improvement with an eye towards sustainability and transition.

In 2013, about 17% of HIV-positive pregnant women received anti-retroviral therapy (ART) to reduce the risk of mother-to-child transmission (MCT). 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 selected for scale-up. 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 regimen will serve to streamline PMTCT services and improve adherence rates. Option B+ will be piloted in two focus states.

The USG will continue efforts to maintain coverage of PMTCT services to pregnant women in FY 2014 in the two “focus” and six “strategic” scale-up states. Support in the remaining states is expected to remain static while ensuring no woman presenting for services is turned away. The USG will dialogue with other stakeholders, particularly the United Nations Children’s Fund (UNICEF) and the GON, to implement this limited 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 will maintain its provision of PMTCT services using the “hub and spoke” model to improve PMTCT service delivery.

2. Treatment - Maintenance and Limited 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 goals and strategies of the National Strategic Framework (NSF) and the PFIP. USG will use funds to purchase approved or tentatively approved FDA ARVs in their generic formulation, to maximize the amount of drugs available for distribution and use. Harmonization, quality of service, reduced target costs and cost leveraging remain mainstays of the treatment program. Standardized services and health care worker training is provided across all implementing partners. Pediatric treatment services also remain a priority in FY 2014. The USG will continue its efforts to leverage GON, GFTAM, and other development partners for ARV procurement.

The USG will use a ‘Test to Treat’ strategy focusing on identifying positive persons eligible for treatment based on a CD4 count of 500 or less. We will also encourage partners to use a modified provider-initiated approach (PITC) for all targeted patients accessing health facilities. PEPFAR will diagnose HIV-exposed children less than 18 months of age for HIV infection and start them on ARVs and provide them with co-trimoxazole prophylaxis. Priority areas in the provision of care and support



services will include scaling-up pediatric care and support services, early identification of HIV-infected children using PITC, integration into maternal and new-born child health (MNCH), and scaling-up PMTCT in selected states.

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

Partners will maintain 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 to scale-up 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.

The USG will continue to pool ARV procurements through the Partnership for Supply Chain Management System (SCMS) in COP14. 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 (LMIS) 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 COP14 is the expansion and enhancement of TB-HIV sites at the state and local levels. The USG will contribute medical equipment, testing commodities, and training to support treatment and testing sites. The USG will continue provider-initiated routine HIV testing in the TB Directly Observed Treatment Short-Course (TB DOTS) settings to maintain access to services for adults and children co-infected with HIV and TB. The USG also seeks 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 (combination prevention with age



appropriate messaging; Positive Health, Dignity and Prevention programs (PHDP); prevention of medical transmission (blood and injection safety); and HIV counseling and testing.

Only 25-percent of the adult population knows their HIV status. Ninety-percent of adults perceive themselves as having no or low risk of HIV infection. The USG Sexual Prevention strategic focus includes the following: 1) prioritizing the combination prevention approach (biomedical, behavioral, and structural) in line with the National Prevention Plan's Minimum Prevention Package Initiative; 2) focusing behavioral interventions on minimizing risk and increasing (biomedical) protection in focus populations; 3) and seeking behavioral interventions via mass media campaigns and community and social mobilization by partners. Prevention activities will be phased out of all non-focus states during 2014. HCT in focus states will be limited to clinical settings as a passive diagnostic tool. The USG will ensure that HCT is targeted and measured to ensure that testing does not out-pace availability of ART. In tier 1 & 2 states, community mobilization for HTC will continue.

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 COP14, the USG will continue supporting the 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.

The USG has integrated prevention activities into all care and treatment activities. Efforts to reduce new infections among high-risk and high-transmission communities will continue. In the focus states, the USG will employ multiple HCT strategies (provider initiated testing and counseling, mobile HCT and couples HCT) to enable target populations to know their HIV status as an entry into prevention, care, and treatment services.

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. These activities will be transitioned to the focus states during COP14, with a view of achieving state saturation. Nigeria has a mixed HIV epidemic; 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. This will be managed carefully in COP14, due to the signing of the Same Sex Marriage Act by President Jonathan in early 2014.

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 a sustainable and gender-sensitive multi-sectorial HIV/AIDS response. The USG will also work to strengthen coordination mechanisms at all levels. Planned activities include buttressing the lead IP strategy by developing an implementation framework and a monitoring plan ensuring expectations are clear and consistent across lead IPs. The USG will also strengthen civil society organizations at all levels by providing financial and technical support, management training, planning, and advocacy skills.

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

The USG will continue to 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.

5. Other Programs

The USG and GON will implement the established basic package of services for HIV-positive people and their families. We will promote care services for all HIV-positive patients identified in USG programs in COP14, including provision of basic care kits; management of opportunistic infection and sexually-transmitted infections; laboratory follow-up; nutritional, Positive Health, Dignity and Prevention (PHDP), psychosocial, and spiritual support; and referrals within the 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, and local governments, 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 continue household economic strengthening to empower families to respond to the needs of vulnerable children. Other strategies include promotion of community-initiated responses, child protection, outreach to early childhood development, HIV/Sexually transmitted infections (STIs) prevention, and social workforce strengthening.

Laboratory maintenance will be more controlled and sustainable. USG-supported laboratories will continue to focus on maintaining services through the implementation of 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.

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 NSP2), one national HIV/AIDS coordinating authority (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. COP14 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. Rollout of a unified DHIS will be prioritized.

V. GHI and Program Integration

USG programmatic directions are inter-related and support GHI principles. For example, the recent focus on improving PHCs is ensuring the down-referral of patients from overcrowded secondary and tertiary facilities and creating opportunities to start additional patients on ART. Further, better functioning PHCs have increased the availability of PMTCT services as women seek antenatal, family planning, and reproductive health services, pediatric vaccinations, and other services at this level. A core component of 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.

USAID will continue to 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

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federal and PHC levels.

Integration activities will continue with the President's Malaria Initiative (PMI) and in the area of family planning, focusing on two of the strategic scale-up states.

Time Frame: October 2014 to September 2015