Nigeria

Country Operational Plan (COP) 2017

Strategic Direction Summary

June 07, 2017

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1.0 Goal Statement

Since Fiscal Year (FY) 2016, PEPFAR Nigeria has been working with the Government of Nigeria (GON) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) to accelerate progress toward HIV epidemic control in 32 high-burden local government areas (LGAs).

Our approach seeks to achieve, in these "scale-up LGAs," the ambitious Joint United Nations Program on HIV/AIDS' (UNAIDS) 90-90-90 goal of having 90 percent of people living with HIV (PLHIV) in these LGAs diagnosed, 90 percent of those diagnosed on antiretroviral therapy (ART), and 90 percent of those on ART virally suppressed. Reaching the 90-90-90 goal in the scale-up LGAs will provide proof of concept to encourage the GON to invest more in a similar manner.

PEPFAR Nigeria has also been supporting PLHIV currently on ART in 503 "sustained support LGAs." Beginning in FY 2018, PEPFAR Nigeria will introduce highly targeted case-finding approaches in 13 of these LGAs (categorized as "sustained support plus") that have the highest burden and share borders with the scale-up LGAs. PEPFAR Nigeria will also advance same-day with age-specific, gender-sensitive approaches as part of national "test and start" implementation to improve linkage to treatment in all LGAs. With such coverage, PEPFAR Nigeria will build on ambitious targets, enabling 40 percent of PLHIV in the country to receive ART by FY 2020.

Our goals, expressed in terms of PEPFAR's five action agendas, are to:

Impact:	Exceed 80 percent ART coverage in 12 of the 32 scale-up LGAs by the end of FY 2018.
Efficiency:	Increase the number of people currently receiving treatment from **700,262** in FY 2016, to **768,439** in FY 2017 and **949,594** by the end of FY 2018.
Sustainability:	Advance supported LGAs toward epidemic control status via a phased approach, using a combination of demand for services and modeled PLHIV estimates to measure progress.
Partnership:	Continue to collaborate with the GON, the Global Fund, Civil Society Organizations (CSOs), and private sector partners.
Human Rights:	Advocate for improving national laws and policies and serving the needs of PLHIV in health care settings in non-discriminatory ways.

Site volume and yield analyses conducted for our prevention of mother-to-child transmission (PMTCT) and HIV testing and counseling (HTC) programs indicated that 1,961 sites had identified 12 or fewer PLHIV over the past year. PEPFAR Nigeria will transition support of these sites to GON in FY 2018. Savings associated with transitioning support to higher-yield sites will support targeted approaches in testing and additional patients on treatment in scale-up and sustained support plus LGAs. PEPFAR will support Nigeria to conduct population-based HIV surveys at the national level and in selected states to generate better data for program planning.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

Nigeria is a lower-middle-income country (GNI: 2,820 per capita, Atlas method[1]) with a current population estimate of 195,300,343 (population demographics: 49 percent female and 51 percent male[2]).

Currently, Nigeria's epidemic is generalized with national average HIV prevalence rates among pregnant women attending antenatal clinics (ANC) estimated to be around 3.0 percent[3] (compared with 4.1 percent in 2010). ANC prevalence rates in sentinel sites range from 15.4 percent in Benue state[4] and 10.8 percent in Akwa Ibom to 0.9 percent in Zamfara State. HIV prevalence among key populations (KP) is much higher than the national average (19.4 percent in brothel-based female sex workers (BBFSW), 8.6 percent in non-brothel-based FSW (NBBFSW) and 22.9 percent among men who have sex with men (MSM)[5]. HIV prevalence rates among sex workers and other identified vulnerable groups have been declining since 2007, but increasing among MSM within the same period (see table below). Less than half of the female sex-workers (FSW) surveyed had comprehensive knowledge about HIV compared to 65 percent of MSM and 51 percent average for all survey participants.

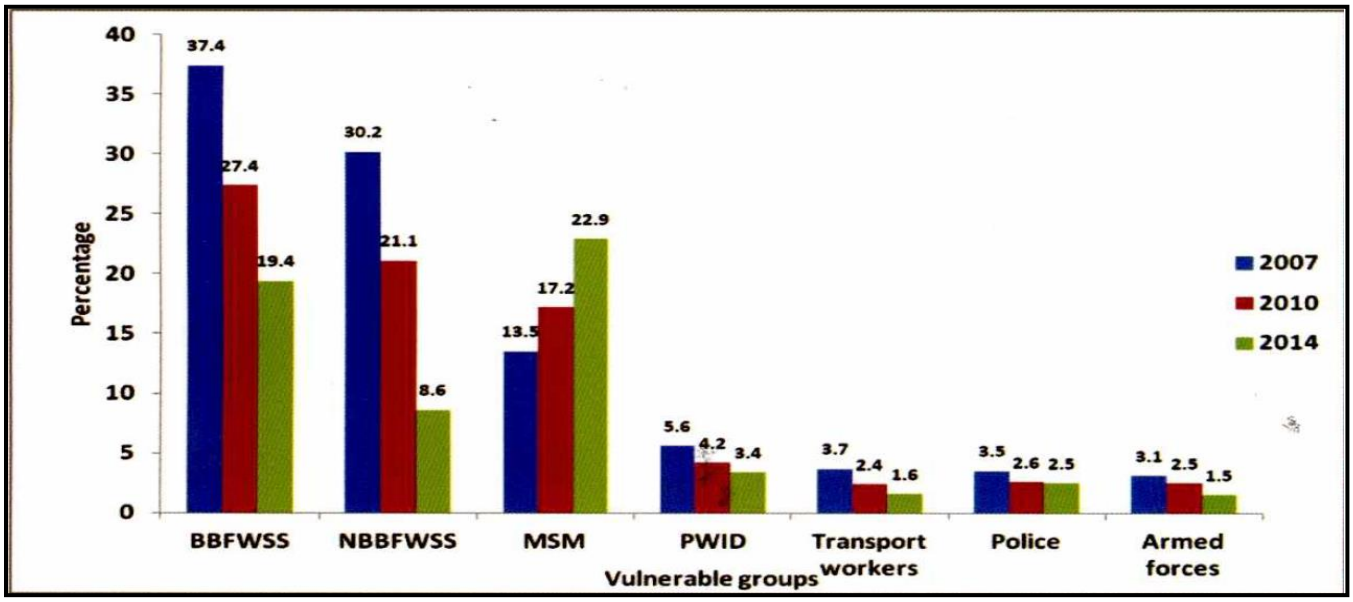


Figure – 2.1.1a – HIV prevalence rates among vulnerable groups in Nigeria (2007-2014)[6]

[1] World Bank, 2015 data http://data.worldbank.org/indicator/NY.GNP.PCAP.CD
[2] US Census population data, 2018
[3] 2014 National HIV Sero-prevalance Sentinel Survey among pregnant women attending Antenatal clinics in Nigeria
[4] 2014 National HIV Sero-prevalance Sentinel Survey among pregnant women attending Antenatal clinics in Nigeria
[5] Integrated Biological and Behavioral Surveillance Survey (IBBSS) 2014
[6] Integrated Biological and Behavioral Surveillance Survey (IBBSS) 2014

In total, about 3,460,000 people are currently estimated to be living with HIV in Nigeria, which has the second highest burden of people living with HIV (PLHIV) in the world. About 880,668 PLHIV are currently receiving treatment and there has been a slow decline[7] in the estimated incidence of HIV in Nigeria, with the number of new infections decreasing from an estimated 316,733 in 2003 to 239,155, a decade later in 2013[8]. Detailed demographic and epidemiological data are presented in Table 2.1.1. Coverage rates for prevention of mother-to-child transmission (PMTCT), anti-retroviral therapy (ART), viral load and early infant diagnosis (EID) remain unacceptably low and the country accounts for about one-third of new HIV infections in children (about 60,000 annually) due to high mother-to-child transmission rates. Only 12 percent of children living with HIV are receiving anti-retroviral drugs (ARVs).[9] Due to the high number of AIDS-related deaths, 174,253 in 2014 (down from 210,031 in 2013[10]) per year, the population of orphans and vulnerable children (OVC) is estimated at over 1,736,782.

PEPFAR Nigeria will finalize AIDS indicator surveys begun in COP14 in two states (Akwa-Ibom and Kaduna) as well as an additional survey in Nasarawa state begun in FY17. In COP17, PEPFAR Nigeria will collaborate with the Government of Nigeria (GON) and other stakeholders to conduct a similar survey nationwide to generate national and state estimates of HIV prevalence, incidence, and viral suppression.

Concerns have been raised about KP estimates from the national size estimation reports because implementing partners have been able to reach considerably more clients than have been estimated in previous years. PEPFAR targets are therefore based on an adjusted size estimation using program data. Additionally, PEPFAR will support a population size estimation exercise in COP2017[11].

Table 2.1.1 below provides a summary of demographic and epidemiological data while Table 2.1.2 provides programmatic data on the clinical cascade.

Figure 2.1.3 compares the trend of individuals currently receiving ART from 2005 to 2016 at national level and PEPFAR's contributions. As of September 30, 2016, PEPFAR contributed 700,262 patients currently on ART while the number of PLHIV currently receiving ART in Nigeria is 880,668. Between 2013 and 2014 a total of 107,600 patients on ART were transitioned to the GON.

[7] UNAIDS Global Progress Report 2015
[8] Nigeria GARPR 2015
[9] UNAIDS Global Progress Report 2015
[10] Nigeria GARPR 2015

Table 2.1.1 Host Country Government Results															
	Total		**<15**				**15-24**				**25+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	195,300,343	100	40,301,608	21	42,246,321	22	18,887,415	10	19,716,096	10	36,550,008	19	37,598,895	19	US Census population data, 2018
HIV Prevalence (%)		3.1													UNAIDS 2015 REPORT
AIDS Deaths (per year)	180,000														UNAIDS 2015 REPORT
# PLHIV	3,460,000		153,400		106,600		1,900,000(15+)		1,300,000 (15+)						UNAIDS 2015 REPORT
Incidence Rate (Yr)															
New Infections (Yr)	227,518														Nigeria GAPRP report (2015)
Annual births	31,828														
% of Pregnant Women with at least one ANC visit		64													NDHS 2013
Pregnant women needing ARVs	190.000														IATT- Nigeria Report (2013)
Orphans (maternal, paternal, double)	1,800,000														UNAIDS 2015 REPORT
Notified TB cases (Yr)	90,584														WHO, TB report 2015
% of TB cases that are HIV infected	14,846	17%													WHO, TB report 2015
% of Males Circumcised															
Estimated Population Size of MSM*	597,036														*Based on calibrated MSM size estimate applying 1.25% on 15 -49 years old Male Population

Table 2.1.1 Host Country Government Results															
	Total		**<15**				**15-24**				**25+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
MSM HIV Prevalence		22.9													IBBSS 2014
Estimated Population Size of FSW	256,282														Mapping and Characterization of Key Populations, 2015
Brothel Based FSW HIV Prevalence		19.4													IBBSS 2014
Non Brothel Based FSW HIV Prevalence		8.6													IBBSS 2014
Estimated Population Size of PWID	7,415														Mapping and Characterization of Key Populations, 2015
PWID HIV Prevalence		3.4													IBBSS 2014
Estimated Size of Priority Populations (specify)															
Estimated Size of Priority Populations Prevalence (specify)															
	* During the COP Review, civil society representatives requested use a percentage of 1.25% of men aged 15-49 as the adjusted size estimate of MSM.														

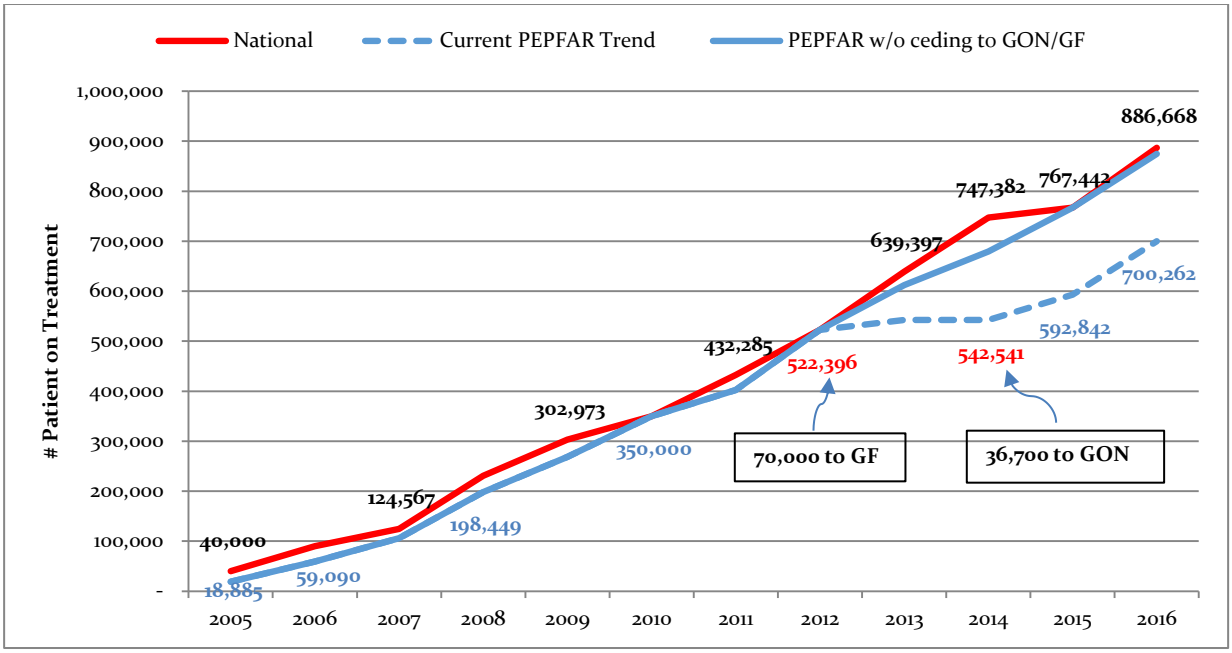
Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression

	Epidemiologic Data				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year **		
	Total Population Size Estimate (#)	**HIV Prevalence (%)**	**Estimated Total PLHIV (#)**	**PLHIV diagnosed (#)**	**On ART (#)**	**ART Coverage (%)**	**Viral Suppression (%)**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population	195,300,343	3.1%	3,460,000	1,819,250	880,668	25.5%	81%*	12,686,119	241,761	146,356
Population less than 15 years	79,615,259		307,192		40,237	13.1%		1,260,622	12,293	8,671
15-24 year olds	36,243,817							3,122,744	33,239	15,672
25+ year olds	75,891,957							6,829,391	161,973	107,078
MSM	597,036	22.9%								
FSW	256,282	19.4% (BBFSW) 8.6% (NBBFSW)								
PWID	7,415	3.4								
Priority Pop (specify)										

*- Derived from PEPFAR APR 16 Viral Suppression data

**- PEPFAR only data

Figure 2.1.3 National and PEPFAR Trend for Individuals currently on Treatment



2.2 Investment Profile

Low oil prices and ongoing security concerns have produced a widening fiscal gap and slowed economic growth in Nigeria. The GON outlined the principles of a Nigeria Economic Recovery and Growth Plan in early 2017 but it is unclear when Nigeria will be able to overcome an inadequate supply of foreign exchange, and electricity and fuel shortages. The GON is grappling with sub-Saharan Africa's worst-performing currency in 2016 and inflation has risen past 17 percent. While the most recent source of spending data, the National AIDS Spending Assessment (2014), indicated a total spending on HIV of US $632.4 million, domestic government funding accounted for only 27 percent of the total (up from 17.7 percent in 2011 and 21.3 percent in 2012). The majority of domestic public spending on HIV covers human resources and administrative expenses. Approximately 90 percent of Nigerian healthcare workers' salaries are funded by the GON. However, with the economic decline it has been increasingly difficult for state and local governments to pay healthcare workers.

Nigeria's substantial economic challenges are translating into a continued reliance on international donors to finance the HIV response at a level that will be insufficient to take the entire nation to epidemic control by 2020. With a tightening budget, the Federal Ministry of Health (FMOH), under the leadership of Minister of Health Dr. Isaac Adewole, began a primary healthcare center (PHC) revitalization effort in January 2017. The initial aim of the Honorable Minister was to revitalize 110 PHCs and the FMOH plans to expand the revitalization to 10,000 PHCs in subsequent years. Each PHC will provide a basic package of care, including PMTCT and a range of other basic services. The FMOH continues to promote rolling out state-based health insurance schemes to further finance a basic package of health services that includes routine

testing for HIV in antenatal settings, but states have been slow to implement insurance programs at scale. The Director General of the National Agency for the Control of AIDS (NACA), Dr. Sani Aliyu, is reshaping NACA's mandate away from service delivery implementation to focus on establishing accurate HIV prevalence estimates, improving PMTCT service uptake and increasing state-level resourcing of the HIV/AIDS response. The climate for spending on health is not favorable; however, the federal leadership is committed to tackling HIV as a component of universal healthcare with a common vision and closer coordination.

The Global Fund and PEPFAR continue to engage to ensure standardization, alignment and complementarity of programs in Nigeria. Global Fund Geneva and the Office of the Global AIDS Coordinator (OGAC) are also seeking greater alignment, transparency and accountability in the management of limited resources available to the country for HIV-related investments. Procurement data from October 2015 through September 2016 shows that about US$ **154,772,980.59** million was spent to procure HIV commodities for the National program. Overall PEPFAR and the Global Fund contributed 67 percent and 32 percent of the HIV commodity investments respectively.

Tables 2.2.1 and 2.2.2 below contain additional details of the HIV investments in the country.

Table 1.2.1 Investment Profile By Program Areas (NASA 2014)

AIDS Spending Categories	Government of Nigeria %	Private Sector %	PEPFAR %	Global Fund %	Other %	Total Expenditure
Prevention	17%	7%	65%	9%	1%	**$ 162,030,633**
Care and Treatment	13%	1%	86%	1%	0%	**$ 190,766,855**
Orphans & Vulnerable Children (OVC)	4%	0%	76%	20%	0%	**$ 22,085,841**
Program Management & Administration	18%	1%	60%	20%	0%	**$ 86,160,519**
Human Resources	83%	0%	13%	3%	0%	**$ 121,527,696**
Social Protection and Social Services	0%	0%	98%	2%	0%	**$ 11,278,205**
Enabling Environment	1%	1%	98%	0%	0%	**$ 32,564,082**
HIV-Related Research	2%	0%	97%	2%	0%	**$ 5,964,768**
Total	**27%**	**2%**	**64%**	**7%**	**0%**	**$ 632,378,599**

Table 1.2.2 Procurement Profile for Key Commodities (Oct 2015-September 2016)

Commodity Category	Total Expenditure	PEPFAR	Global Fund	Government of Nigeria (Sure-P and others)
ARVs	$ 112,265,530.25	$ 66,206,884.47	$ 45,216,540.04	$ 842,105.74
Rapid test kits	$ 19,036,354.21	$ 17,018,346.05	$ 2,018,008.16	
Opportunistic infection drugs	$ 3,476,409.79	$ 3,224,409.79		$ 252,000.00
Lab reagents – CD4	$ 11,766,705.14	$ 10,046,700.71	$ 1,508,808.00	$ 211,196.43
Lab reagents – Viral load	$ 6,061,231.16	$ 5,472,623.61	$ 539,190.35	$ 49,417.20
EID kits	$ 2,058,894.44	$ 2,058,894.44		
Other commodities	$ 107,855.60	$ 107,855.60		
Total	**$ 154,772,980.59**	**$ 104,135,714.67**	**$ 49,282,546.55**	**$ 1,354,719.37**

For the allocation period 2017-2019, Nigeria has been allocated US$660,686,133 for HIV, TB, Malaria and building Resilient and Sustainable Systems for Health (RSSH). The split as agreed by the country is US$77,288,613.30 RSSH; US$215,881,287.01 HIV; US$ 92,241,428.34 TB and US$ 275,274,804.35 Malaria. Nigeria has opportunities to access additional funding of up to US$42 million for HIV based on some conditions including submission of updated HIV disease burden and prevalence estimates. Nigeria will submit a joint TB/HIV application in May 2017 and has begun the application process. PEPFAR is fully engaged in the process and will continue to provide Technical Assistance as required to ensure a quality proposal is submitted to the Global Fund in May.

Renewed efforts to increase GON engagement and ownership have been made with the new administration. The USG team has prioritized critical investments like ARV and RTK procurement in discussions with GON counterparts, over less tangible program-related activities. The new administration has communicated a willingness to commit increasing budgetary resources to HIV, despite economic challenges. The Federal Ministry of Health (FMOH) granted permission for PEPFAR to pilot "test and start" in the selected scale-up LGAs while it revised the national guidelines to include the WHO "test and start" policy. This has now been done; however, PEPFAR resources alone are insufficient to meet the needs for a nation-wide roll-out of the "test and start", hence the urgent need for domestic investments in ARVs and other commodities.

In FY 17, PEPFAR resource envelope shrunk substantially. Despite the reduction in funding, PEPFAR continued to make significant contributions to the national HIV program by supporting the strategic scale-up of the number of PLHV reached with treatment, PMTCT and related services. PEPFAR will streamline broad health systems investments while continuing to improve linkages with other United States Government, Global Fund, and World Bank investments. PEPFAR will continue to work with all stakeholders to focus investments that prioritize epidemiologic impact.

Table 1.2.3 documents non-PEPFAR United States Government funding for HIV and other health programs.

Table 1.2.3 USG Non-PEPFAR Funded Investments and Integration

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID TB	$13,500,000	$12,700,000	4	$4,400,000	Support the National TB Control Program to halve prevalence and mortality in 2015
USAID Malaria	$74,470,000	-	-	-	Halve malaria burden compared to 2010 levels under the PMI
USAID Maternal and Child Health	$46,000,000	-	-	-	End preventable child and maternal deaths
USAID Family Planning and Reproductive Health	$32,500,000	-	-	-	To improve access to and use of quality and voluntary Family Planning services including long-acting and permanent methods to reduce unwanted pregnancies

Table 1.2.3 USG Non-PEPFAR Funded Investments and Integration					
Funding Source	**Total USG Non-PEPFAR Resources**	**Non-PEPFAR Resources Co-Funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
USAID WASH	$9,227,000	-	-	-	Water supply and Sanitation
USAID NUT	$2,500,000	-	-	-	Reduce under-nutrition among women and children
CDC GHS/Ebola	$10,776,758	$3,000,000	1	$2,500.00	1. To detect threats early including characterizing and transparently reporting emerging biological threats early through real-time bio-surveillance. 2. To respond rapidly and effectively to biological threats of international concern. 3. To improve malaria intervention coverage and reduce malaria burden using National Stop Transmission of Polio Program (NSTOP) officers and malaria focal persons at Local Government Areas.
CDC-GID	$18,490,260		-	-	Support for polio eradication and strengthening Nigeria's routine immunization system through the National Stop Transmission of Polio (NSTOP) program.
DOD Ebola vaccine	$253,039	$253,040	1		Ebola vaccine development
DOD WRP-N AFRICOS	$85,117	$85,117	1		African cohort study: longitudinal follow up of PLHIV
DOD WRP-N Trust study	$604,982	$604,982	1		Reduce HIV/STI incidence and risk behaviors among MSM
DOD WRP-N PMI	$530,000	$530,000	1		Halve malaria-associated mortality
Total	**$208,937,156**	**$17,173,139**			

Table 1.2.4 PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP						
Funding Source	**Total PEPFAR Non-COP Ressources**	**Total Non-PEPFAR Resources**	**Total Non-COP Co-funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
Other PEPFAR Central Initiatives - CDC / TB/HIV - USAID (HOP) Other Public Private Partnership	$89,605		$6,575,000	0		TB: Developing a multi-country Model for implementing TB screening for HCW's in HIV care setting.
Sustainable Finance Initiative*	TBD	TBD	TBD	TBD	TBD	To increase domestic financing for HIV.
Total						

* Central Initiatives pending: activities under the Sustainable Finance Initiative are under development in 2016.

2.3. National Sustainability Profile

The 2016 Sustainability Index and Dashboard, which was developed in consultation with local civil society groups and other stakeholders, continues to inform the prioritization of PEPFAR system support investments in Nigeria.

PEPFAR has invested in State AIDS Indicator Surveys in Kaduna, Akwa Ibom, and Nasarawa States to address the identified lack of updated and credible epidemiologic data to inform the National HIV/AIDS response strategies in these state; these surveys will provide data to inform program planning in FY 2018. In addition, PEPFAR, in partnership with GON and Global Fund, will support a national AIDS Indicator Survey. These investments will help to re-define geographic and population priorities for the national response. Similarly, on-going investments in the National Health Management Information System (HMIS) for the country, including the development of a Master Facility List for the National DHIS 2.0 reporting platform and the support for the National Data Repository, is helping to improve the capacity to ensure that high quality service delivery data is available at all levels for program tracking and decision making.

Ongoing improvements in laboratory systems have helped to improve access to Viral load testing services across the country and the integration of new facilities into the laboratory network will not only help to improve the efficient use of available infrastructure and equipment but ultimately form the framework for a robust disease surveillance system under the leadership of the Nigeria Centre for Disease Control (NCDC).

Logistics Management Coordination Units in all the State Ministries of Health are helping to ensure that State Governments are now able to track the commodity stock levels in all health facilities and increasingly offers opportunities for integration of commodity supply chain systems across vertical disease programs and other Government health priorities. The Integrated Supply Chain project benefits greatly from the deployment of private-sector last mile delivery agents who have the capacity to apply modern technological tools to track stock movement from warehouses to health facilities and other service delivery points.

The new National Health Act and its provision for a Basic Health Care Provision Fund which is expected to be funded mainly through an annual budgetary grant from the Federal Government equivalent to at least one percent of the Consolidated Revenue Fund may offer too little to make any meaningful improvement to domestic funding for HIV and AIDS. The potential for direct funding from State Government is currently being explored through the PEPFAR HQ-funded Sustainable Financing Initiative currently working in Lagos and Rivers State. The near-term outcome of support targeted to help State Ministries of Health advocate and apply for increased budgetary provisions for health service delivery will inform plans for scale-up of this support to other states. The evolution of State Health Insurance schemes in these two states will also help to achieve these results.

Additional details about PEPFAR system support priorities for COP17 are provided in section 6 of this document and on Table 6 (Appendix C).

2.4 Alignment of PEPFAR investments geographically to disease burden

The 32 LGAs targeted for scale-up in COP17 remain those selected in FY 15. The scale-up LGAs are located in seven states: Akwa Ibom, Benue, Cross River, Lagos, Nassarawa, Rivers, and the FCT. Figure 2.4.1a (below) illustrates the alignment of PEPFAR investments with the HIV burden across all 36 states and FCT (see Figure 2.4.2b) and ART coverage (see Figure 2.4.2c). PEPFAR expenditures have declined or leveled off across the sustained-support areas. Investments in the states with the scale-up LGAs have largely grown. Benue, Lagos and the FCT received the largest investments ($50.9 million, $37.1 million and $31.5 million respectively). Spending in Kaduna and Plateau (classified as sustained support) were high at $20.7 million and 9.7 million respectively. In Kaduna, the high expenditure is a reflection of its previous status as a priority state during COP14 and current expenditure to support AIDS indicator study. The total expenditure for Plateau is two (2) percent of the total which is consistent with investment in other sustained support states.

Figure 2.4.2a- Estimated PLHIV in Nigeria's 774 LGAs

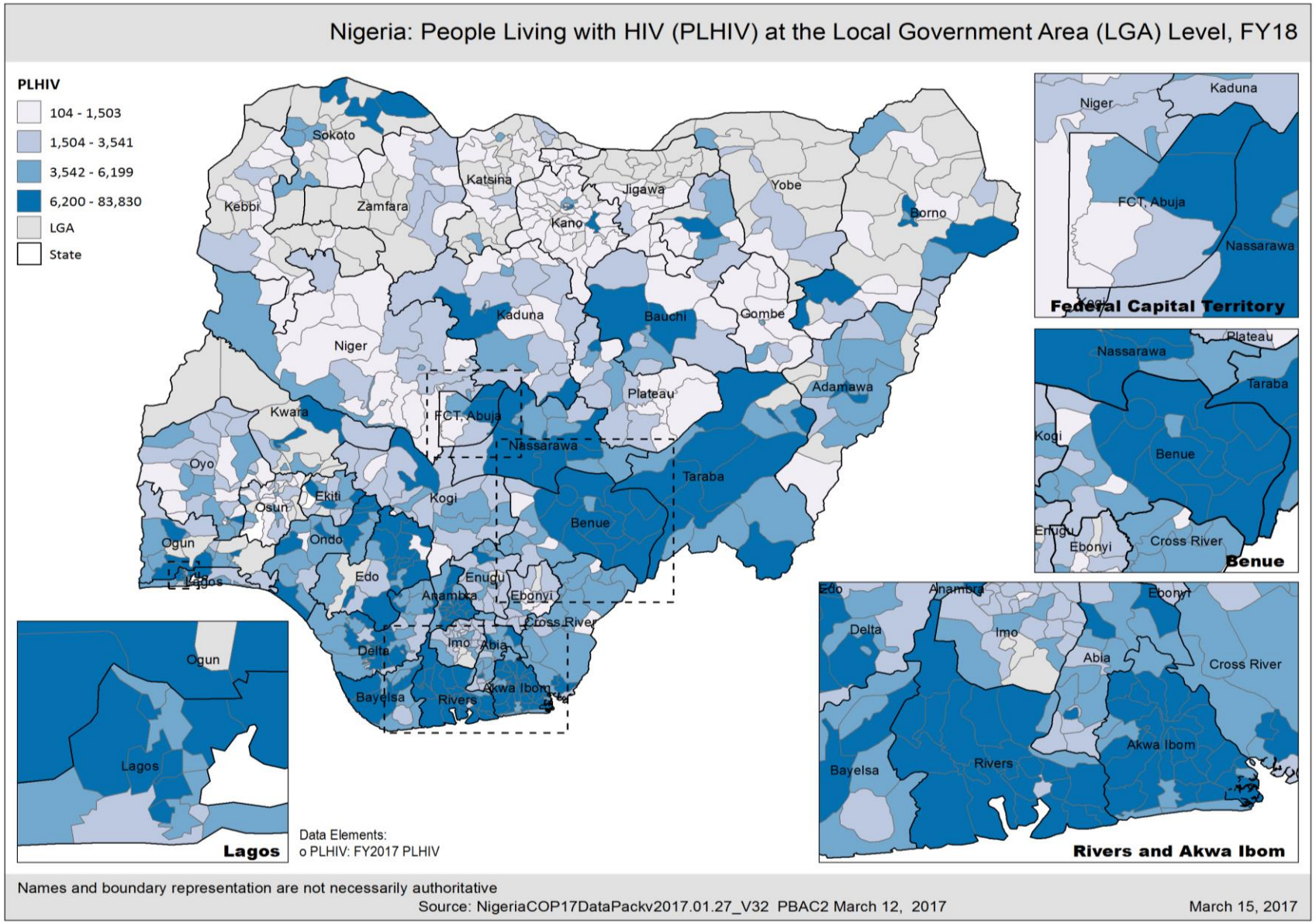


Figure 2.4.2b -ART Coverage in Nigeria's 774 LGAs

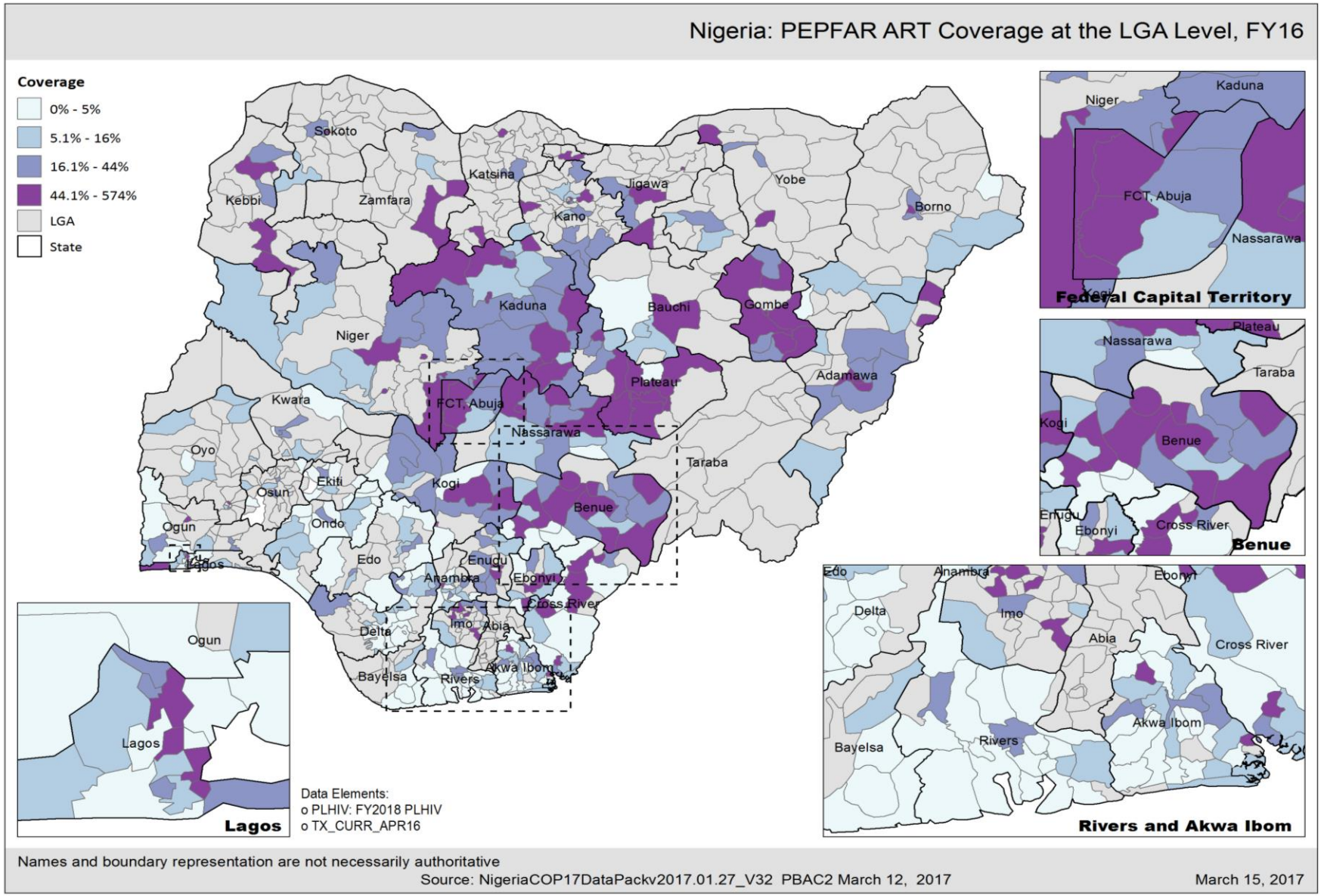
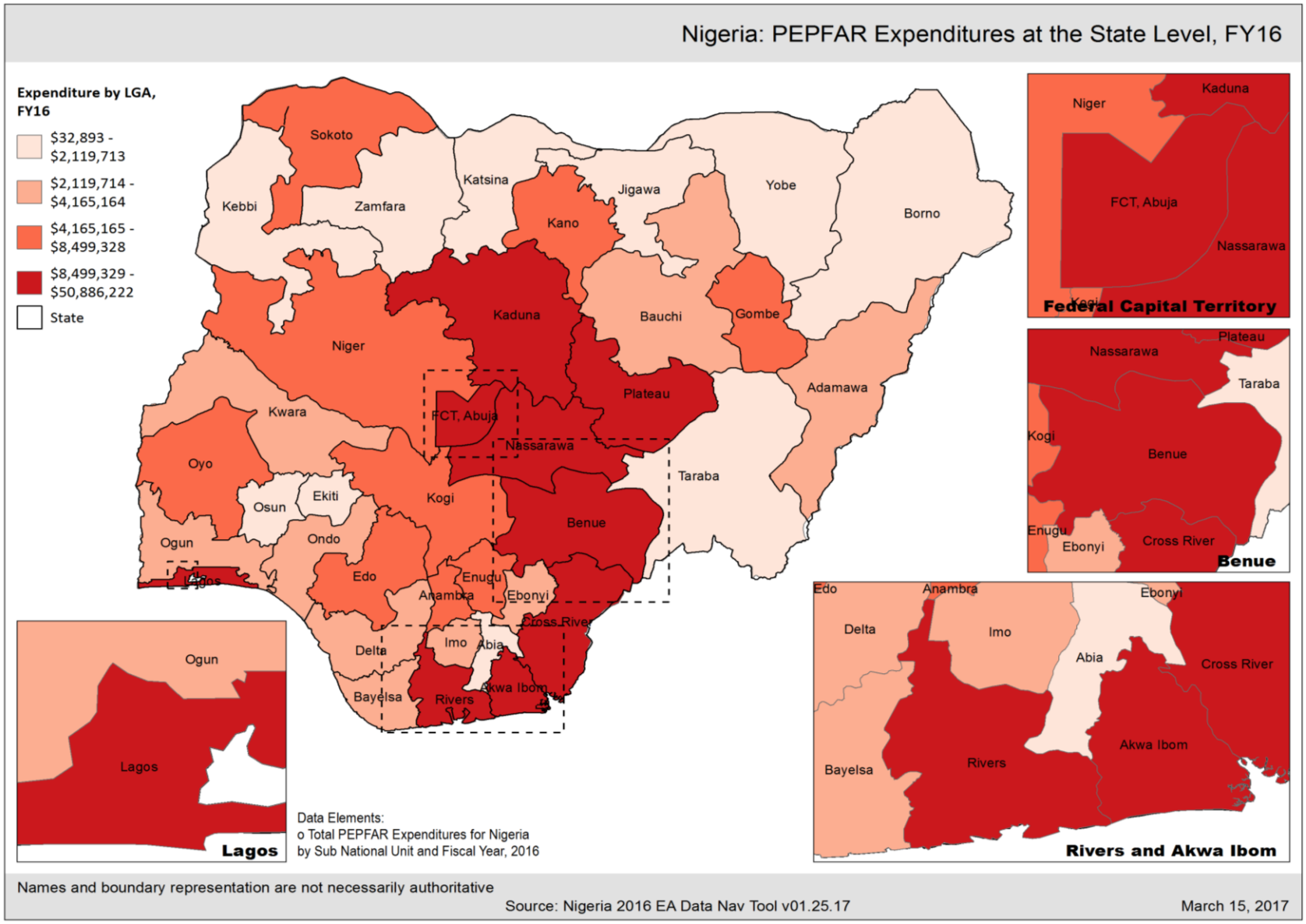


Figure 2.4.2c. -ART Expenditures in Nigeria's 774 LGAs



2.5 Stakeholder Engagement

A new stakeholder matrix was disseminated before the launch of the COP17 planning process to collect contact details of civil society organizations (CSOs) for the development of a ListServe. This will expand the coverage of PEPFAR Nigeria communications with local CSOs outside of the Federal Capital Territory. Currently about 500 CSOs have registered and are receiving periodic updates on the COP17 development process by email. The PEPFAR coordination office also introduced the new email address AbujaPEPFAR@state.gov to direct stakeholder feedback on the COP17 plans and on-going activities throughout the year. The PEPFAR page on the Mission's website was also updated with relevant documents for stakeholders to access, review and provide feedback.

The COP17 launch meeting, held on the 3rd of February, served not only as an opportunity to introduce the COP17 planning priorities but also provided a platform to discuss year-long stakeholder engagement plans with CSOs. The focus was on quarterly POART review meetings and joint field monitoring activities. The PEPFAR country team expressed the desire to have CSO leads serve as co-conveners of stakeholder engagement processes and to integrate CSO engagement plans and visions into the PEPFAR plan. Ways to ensure that the COP17 plans are well disseminated at sub-national levels was discussed and it was agreed that HIV/AIDS focal persons in public institutions at state and local Government levels should be added to the ListServe. The PEPFAR country team must clarify the supportive role of the Lead Implementing Partners and other PEPFAR-funded organizations to the State Ministries of Health and State AIDS Control Agencies.

In preparation for the GF Health Systems Strengthening grant application, the PEPFAR team has also worked with the NACA, the FMOH and other partners to review on-going investments in the National Health Management Information System. This effort has led to the development of an Investment Matrix to identify gaps in the systems for potential future investments. The progress of the ongoing PEPFAR-supported effort to update the National Master Facility List has been hailed as crucial step towards the operationalization of a single National District Health Information Systems for collation and storage of routine health program data. This effort is also supporting the State and Federal Governments to implement the protocol for on-going facility registration which has also been suggested as a way to ensure improved coverage of HIV and AIDS services in the large population of private-for-profit hospitals and clinics which provide health services to more than 40% of Nigerians. The PEPFAR team has also worked with GON and Global Fund to arrange for joint investment in a National AIDS Indicator survey.

The team has also supported the development and launch of the 2016 National Guidelines for HIV Prevention Treatment and Care which supports nationwide "test and treat", multi-month drug scripting, assisted partner notification for HIV testing and many more of the new strategies that have been prioritized in the COP17 improve program efficiency and effectiveness.

CSO stakeholders once again flagged the on-going challenge with user fees in PEPFAR-supported health facilities due to the insistence by clinicians that PLHIV accessing services in the facilities must first undergo Blood Chemistry and Hematology laboratory investigations, which are no

longer funded by PEPFAR, before they can commence ART or pick-up drug re-fills. This situation creates concerns for ART drug adherence and for the National Policy to "test and treat" all PLHIV according to the current WHO Guidelines. The CSOs have promised to continue following up with Government and other major stakeholders to mitigate these issues and it has been suggested that the National Health Insurance Scheme may offer opportunities in this regard.

3.0 Geographic and Population Prioritization

PEPFAR resources are insufficient to achieve epidemic control on a broad scale due to the underfunded domestic response and large unmet need for HIV treatment. To achieve the greatest epidemiological impact with the resources available, and to demonstrate to in-country and international stakeholders that achieving epidemic control in areas of high burden is feasible, PEPFAR investments have remain focused on scaling up services in 32 high HIV burden, high HIV prevalence LGAs; in these 32 scale-up LGAs, PEPFAR has focused on scaling-up ART, reducing community viral load, and significantly reducing transmission. In addition, PEPFAR has committed to ensuring that PLHIV currently on treatment as well as PLHIV newly identified at PEPFAR supported facilities continue to receive HIV treatment services in all LGAs. PEPFAR's strategy will not only save lives and improve health; it will also avert new infections and demonstrate to the GON that with sufficient funding for the same core services, the GON could avoid the escalating cost of a larger HIV epidemic.

Even though, two of the 32 scale up LGAs, namely Ikeja and Mushin, achieved treatment coverage of greater than 81 percent at the end of the first quarter of FY17, neither qualified to be classified as having attained saturation based on the new definition. Hence PEPFAR Nigeria will optimize performance towards saturation in the 32 high-burden, high prevalence scale-up LGAs by the end of FY 19. Table 3.1 shows the total number of PLHIV and number of patients currently on ART as of September 30, 2016 by LGA categorization. PEPFAR Nigeria will continue to maintain its commitment to support PLHIV currently on treatment across the rest of the country. As in previous years, PLHIV requiring HIV services in the sustained LGAs will not be turned away from PEPFAR-supported sites. Thus, passive enrollment in the non-scale up areas will potentially add an additional 124,109 net new patients on treatment in COP17.

In COP17, an additional 13 LGAs were selected, based on burden and contiguity to scale-up LGAs, for further treatment expansion using the following approach and considerations:

- In each of the 6+ 1 priority states (Akwa Ibom, Benue, Cross River, Lagos, Nassarawa, Rivers, and the FCT), LGAs were ranked based on burden in descending order excluding the scale up LGAs
- The sustained LGAs in each state were classified into quartiles for HIV burden
- LGAs in the top quartile (75%) and contiguous to the scale up LGAs were selected
- Excluded were LGAs supported by Global Fund.

These 13 LGAs have been designated as sustained plus LGAs. In COP17, PEPFAR Nigeria will continue its plans to scale up in the 32 LGAs which were selected in COP15; however, the 15-29

age group will be targeted for HIV prevention, care and treatment services. PEPFAR will continue to prioritize specific populations including: select military populations and communities with sizeable key populations that are in close proximity to the scale-up LGAs. PEPFAR is prioritizing key populations because members of these groups are disproportionately affected by HIV. KPs include female sex workers, men who have sex with men, and people who inject drugs. In FY18, PEPFAR Nigeria will increase its focus on children, adolescent girls and young women.

PEPFAR will continue to scale-up PMTCT, HIV testing services (HTS), care and treatment, community mobilization, and community-based services in the scale-up LGAs. PEPFAR will also scale-up enrollment of OVC within the prioritized LGAs and gradually reduce its footprint in sustained LGAs.

Table 3.1 Current Status of ART saturation

Prioritization Area	Total PLHIV/% of all PLHIV for COP17	# Current on ART (FY16)	# of SNU COP16 (FY17)	# of SNU COP17 (FY18)
Attained				
Scale-up Saturation	103,273	57,029	12	12
Scale-up Aggressive	371,939	113,107	17	20
Sustained-Plus	155,993	68,598	-	13
Sustained	2,129,650	461,528	496	462
Central Support				
Total	**2,620,455**	**700,262**	**528**	**507**

4.0 Program Activities for Epidemic Control in Priority Locations and Populations

4.1 Targets for priority locations and populations

Table 4.1.1 shows the plans for FY18 in terms of HIV counselling and testing, newly identified positive and newly initiated on treatment by testing stream in the scale-up LGAs. The testing yield among the tuberculosis (TB) patients and KPs is 19 and nine (9) percent respectively in FY18.

Table 4.1.1: FY 18 Target for Testing and TX_NEW by testing streams in the Scale up LGAs.

Table 4.1.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts

Entry Streams for ART Enrollment*	Tested for HIV (APR FY18) HTS TST	Newly Identified Positive (APR FY18) HTS TST POS	Newly initiated on ART (APR FY 18) *TX_NEW*
Adults			
TB Patients **	10,781	1,605	1,445
Pregnant Women	472,602	8,725	8,351
VMMC clients	-	-	-
Key populations	240,058	19,549	17,594
Priority Populations	-	-	-
Other Testing	2,071,268	48,314	42,591
Previously diagnosed and/or in care	-	-	-
Total Adults	**2,794,709**	**78,193**	**69,981**

Table 4.1.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts			
Entry Streams for ART Enrollment*	**Tested for HIV (APR FY18) HTS TST**	**Newly Identified Positive (APR FY18) HTS TST POS**	**Newly initiated on ART (APR FY 18) *TX_NEW***
Pediatrics (<15)			
HIV Exposed Infants	15,633	483	460
Other pediatric testing	503,016	5,017	4,937
Previously diagnosed and/or in care	-	-	-
Total Pediatrics	**518,649**	**5,500**	**5,397**
TOTAL	**3,313,358**	**83,693**	**75,378**

***Military Included**
**** Used average positivity yield across scale-up LGAs to determine positives, and 90% linkage**
*****Includes EID positives**

Table 4.1.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts – Not Applicable/Not Shown

Table 4.1.3: Target Populations for Prevention Interventions to Facilitate Epidemic Control

Table 4.1.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control*			
Target Populations	**Population Size Estimate** (scale-up SNUs)	**Coverage Goal (in FY17)**	**FY18 Target**
FSW	153,982	80%	123,186
MSM	77,567	30%	23,270
PWID	5,141	80%	4,113
TOTAL	**236,690**	**64%**	**150,569**

***Military Included**

* Tier 1 are scale up LGAs, Tier 2 are LGAs that share boundaries with Tier 1, and Tier 3 are LGAs that do not share boundaries with scale up LGAs. All LGAs are within the seven priority states. There will be no KP programing outside of the seven priority states.
**Based on technical guidance to reach more MSM due to the high program positivity rate and high/rising IBBSS prevalence, the denominator for MSMs is lower than the target. The additional targets represent about a 20 percent reduction from FSW targets.

4.2 Key population prevention

KPs in Nigeria continue to have exceptionally high positivity rates for HIV. They include FSWs, MSM and persons who inject drugs (PWID). Based on a trend analysis of the Integrated Biological and Behavioral Surveillance Survey, Nigeria is experiencing a gradual decline in HIV prevalence rate among FSW, from a previous 2010 estimate of about 27 percent to a 2014 estimate of about 19 percent. PWID have had a prevalence estimate comparable to that of the general population with a decline from 4.2 percent in 2010 to 3.4 percent in 2014. Conversely, MSM had a rising prevalence from 17 percent in 2010 to about 23 percent in 2014. This corresponds with a significantly lower condom use among MSM as compared to FSW and may be a reflection of the hostile socio-political and cultural environment for MSM currently existing in Nigeria.

PEPFAR Nigeria's KP strategy for COP17 is focused on achieving the UNAIDS 90-90-90 among key populations. Overall, the KP portfolio will seek to intensify case finding through strategically targeted testing including self-testing options, same day, same site commencement of ART for positive KPs and an intensively focused adherence/support program with viral load testing to ensure community viral suppression. The use of evidence-informed prevention-based peer-led networks will form the fulcrum for the 90-90-90 service delivery.

4.2.1 First 90: In FY18, the KP portfolio will intensify case finding of HIV positive KPs. Program level prevalence data has been in the range of ten percent, which is about the same as the country KP average, but significantly below known in-country survey estimates. This was due to factors such as cohort testing, dilution from testing outside of KPs, and absence of risk-profile based testing approaches. In FY18, PEPFAR will significantly improve testing yield. Testing services will actively seek out KPs who are likely to be positive by using a risk profile based approach that will rely on behavioral and biological markers for HIV positivity. This will include testing all KPs presenting with sexually transmitted infections (STIs), low condom use, high risk sex, and KPs with sero-discordant partners. Partner notification services will be cascaded around every positive KP diagnosed. Further, all sources of dilution including clients of sex workers and all other individuals/groups that do not fall within the strict definition of KPs will not be tested in FY18. Intensified Proficiency Testing will improve the quality of testing while also ensuring that true positives are identified. Overall, more testing will be done in priority LGAs than in sustained support.

4.2.2 Second 90: The PEPFAR Nigeria KP portfolio will continue implementation of the One-Stop-Shop (OSS) strategy. The OSS is a community clinic for KPs that creates a safe space for the delivery of a complete cascade of KP focused prevention, treatment, care and support services. It also acts as a hub for community based ART delivery using peer-led networks and community outreach workers. "Stable KPs" will have ARVs delivered directly to them using peer networks in a way that guarantees confidentiality and non-discrimination as a differentiated care model. Stable KPs are defined as those who are clinically stable, have shown significant level of drug adherence and demonstrated actual viral suppression or progress towards it. At the community level, more innovative and KP centered models will be used for the distribution of ARVs. One of such is the use of "Sexy Kits". These are small packs that include condoms and lubricants and possible ARV medications for the HIV positive KPs. For the full implementation of treatment as a prevention strategy, "test and start" will be rolled out in all the one stop shops for all HIV positive clients immediately after diagnosis irrespective of CD4 count or viral load and also adequate provision of ARVs will be ensured for pre-exposure prophylaxis among high risk and discordant pairs.

4.2.3 Third 90: Activities that will strengthen retention in care among KPs will be supported in a robust manner. Client engagement protocols will be set up where KPs are actively engaged by virtual peer facilitators as a strategy to assure linkage to ART, retention on ART, and adherence to ART. Viral load testing will be conducted within three to six months after ART initiation in line with current programming standards. OSSs will be linked to hub facilities for improved access to necessary investigations as may be required by clients including GeneXpert technology for TB diagnosis. The OSS will be linked into the integrated sample transfer network. This will reduce

turnaround times for receiving test results that have been proven to positively influence treatment outcomes including adherence. The peer mechanism will be used to intensify adherence and also address the different levels of stigma and discrimination. Positive health dignity prevention (PHDP) will be deployed within and outside the OSS depending on the preferences of the clients. These will in turn improve the ARV uptake of positive KPs and so increase the likelihood of individual viral suppression and reduce the occurrence of drug resistance.

4.2.4 Sexual Transmission Prevention: Eligible KPs will continue to benefit from traditional prevention interventions using the Minimum Prevention Package of Interventions in line with the National Prevention Plan of the GON. This service package includes peer education/interpersonal communication, condom programming (including male, female and lubricants), STI management, HIV testing and counseling, community level system strengthening, and structural level interventions. These interventions constitute a suite of mutually reinforcing prevention interventions that reduce the risk of new infections among KPs. Beyond the provision of information to KPs, the peer education sessions will serve to also deliver treatment, care and support services.

4.2.5 Community Approach: The KP program will work very closely with the OVC program. Children of FSWs that are positive or highly vulnerable will be able to access OVC services that will be offered by OVC implementing partners. This collaboration will ensure that services, across the OVC and KP programs, are leveraged by all populations that require the services. In like manner, the KP program will offer technical assistance to the OVC program to ensure that adolescents and young adults in the OVC program receive qualitative prevention services that are tailored to the specific needs of beneficiaries.

4.2.6 Geographic Targeting: The fundamental rule for KP geographic targeting is provision of KP focused services at scale within priority LGAs, and targeting of hotspots outside of priority LGAs but within the seven states of Benue, Nasarawa, FCT, Rivers, Cross Rivers, Akwa Ibom, and Lagos. In FY18, the KP program will continue to work in the priority LGAs using a tiering system. Tier One LGAs are scale-up LGAs including the Sustained plus LGAs. Tier Two LGAs are LGAs that share boundaries with scale-up LGAs and sustained plus LGAs, while Tier Three LGAs are those that do not share boundaries with scale up and sustained plus LGAs. Tier Three LGAs will have partner notification services operating therein. Emphasis will be placed on reaching KPs within Tier One and Two LGAs while linking to OSS with same day same site initiation of ART. The OVC program will be cascaded around the KP program in scale up and sustained plus LGAs (Tier 1) only.

4.2.7 Programming Environment: The Same Sex Marriage Prohibition law and continuous harassment from overzealous law enforcement agents continue to impede the uptake of HIV services among KPs. The Legal Environmental Assessment report and other rights violation reports clearly show the need to address these gaps in improving KP access to services. In FY18, PEPFAR Nigeria will continue its engagement with key rights and law enforcement agencies with the aim of reducing unnecessary and illegal violations that impede access to critical HIV services.

4.3 Voluntary medical male circumcision (VMMC)

This is not applicable in Nigeria, as the rate of male circumcision is greater than 90[12] percent.

4.4 Preventing Mother-To-Child Transmission (PMTCT)

PEPFAR supports comprehensive PMTCT services, contributing towards epidemic control, in 32 scale-up LGAs by providing the following: routine provider-initiated testing and counseling (PITC) during antenatal care, labor & delivery on an opt out basis; ARVs in labor and delivery; cotrimoxazole; EID; PMTCT Option B+; and postpartum family planning (without FP commodity procurement). In order to increase uptake of services in the 32 scale-up LGAs and given the low first ANC attendance rate in Nigeria (64%), community engagement is critically needed to mitigate harmful traditional beliefs and cultural practices and stigma and discrimination that hinder access and contribute to under-utilization of services.

Mother-to-mother support groups foster continuous home-based care for mother-infant pairs, and mobile outreach services assure access for hard-to-reach populations. Common problems identified through the Site Improvement through Monitoring System (SIMS) include prolonged EID turn-around-times and poor client flow. Concerns are being addressed through stakeholder meetings, strengthening demand generation, improved national pooled procurement, and last-mile delivery and reporting. PEPFAR is adequately represented on the national PMTCT task team to address these challenges and improve service delivery activities. Lead implementing partners provide complementary technical assistance at sub-national levels.

In the scale-up LGAs, the PMTCT program will collaborate with the laboratory and the care and treatment technical working groups (TWGs) to ensure every HIV-positive pregnant woman enrolled on PMTCT receives at least one viral load estimation prior to delivery to determine whether the resultant HIV exposed infant (HEI) is high risk and thus eligible for enhanced ARV prophylaxis. The program will also employ improved innovative linkage strategies to ensure all HIV-infected infants identified are linked to treatment. Partner performance will be monitored through regular SIMS visits, routine monthly and quarterly program data reviews and monthly review meetings. These will be followed-up to ensure remedial actions are taken by partners.

In COP17, the program will expand the enhanced (real time) option B+ monitoring initiated in FY16 within 126 facilities to include all facilities supported for PMTCT in the 32 scale-up LGAs. The congregational PMTCT (Baby Shower) strategy currently used in selected communities will be scaled up with necessary adaptations. In addition, the program will pilot the implementation of enhanced ARV prophylaxis for high-risk HIV-exposed infants in selected tertiary health facilities in line with the recent WHO recommendation as adopted in Nigeria's national guideline. In COP17, the program will also restore routine testing in ANC settings, in a dramatically reduced

[12](UNAIDS, 2007) – 'Male circumcision: global trends and determinants of prevalence, safety and acceptability' - http://www.malecircumcision.org/media/documents/MC_Global_Trends_Determinants.pdf

number of PMTCT sites (those that were not discontinued due to low volumes of positives tested).

PMTCT Efficiency Analysis

PEPFAR supported PMTCT at 4,113 sites at the end of FY 16 (sites that reported results for PMTCT in our annual progress report (APR) 16). The PEPFAR site yield analysis showed 1,921 sites to be low-yield sites (each reported less than four (4) HIV positive individuals or less than 12 HIV positive individuals in the case of combined HTS and PMTCT sites in FY16). PEPFAR will transition support (RTKs, oversight, and monitoring visits) of these sites to GON within FY17, and they will not be assigned FY18 PEPFAR targets. These 1,921 sites accounted for four (4) percent of the HIV-positive pregnant women seen in that year (having 1,917 out of a total reported of 46,840). The sites were distributed as follows; 1,835 combined HTS and PMTCT sites in sustained support LGAs, 45 stand-alone PMTCT sites in sustained support LGAs, and 41 stand-alone PMTCT sites in scale up LGAs. None of these are treatment sites. After transitioning these sites to GON, the program will have only 2,189 PMTCT sites which constitute 53 percent of the total number PMTCT sites but which contributed 96 percent of the positives reported in FY16. Figure 4.4.1 below illustrates the site volume analysis.

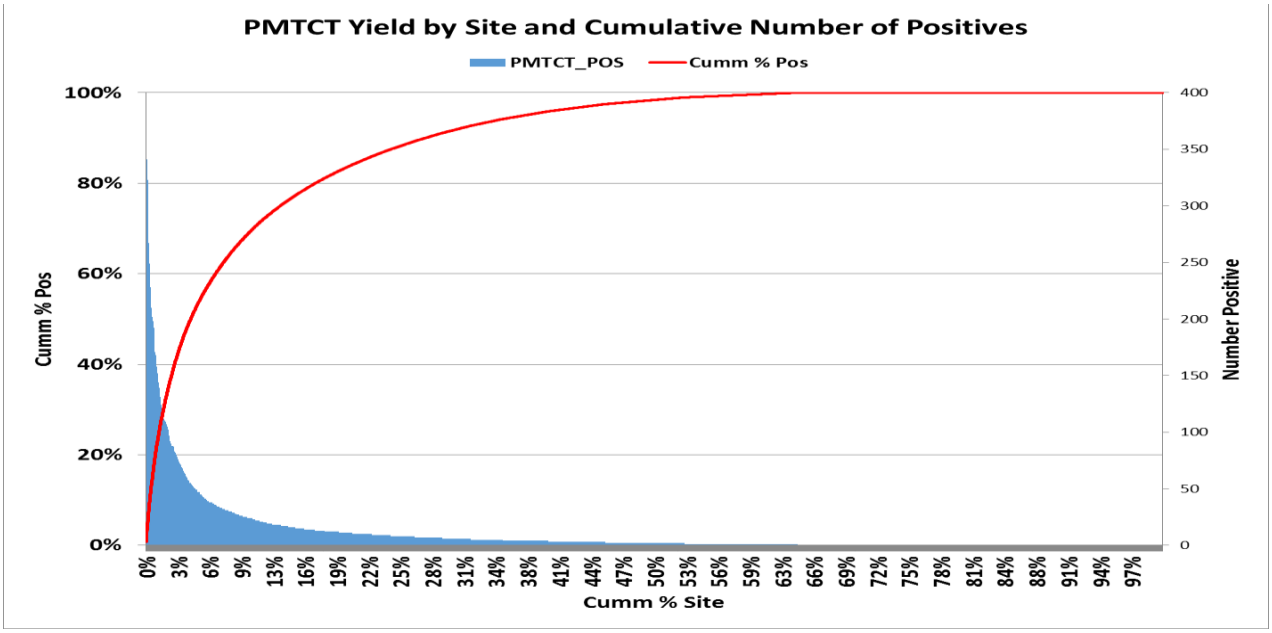


Figure 4.4.1 PMTCT Site Yield Analysis for FY 2016

4.5 HIV Testing Services (HTS)

PEPFAR provides site monitoring and mentoring for HTS and supports a service package that includes procurement of HTS commodities, rapid testing, and linkages to treatment and care of identified HIV positives. The program will continue to strategically support the treatment program to test and identify HIV positive individuals within specific age and sex bands in the 32 scale-up LGAs to fill identified treatment gaps by refocusing HTS activities in these specific locations, optimizing high yield/high volume streams and strategies(including index partner testing and social network testing). Thus, community engagement in these priority LGAs is

important because communities serve as advocates and mobilizers for HTS and trained volunteers often provide critical HTS in priority locations, particularly among KPs. In addition, service integration within prevention, care and treatment, and broader primary health care are critical for hard-to-reach populations. For these activities, advocacy for resource mobilization is targeted to ensure GON commitment for ongoing service provider training and capacity building.

In COP17, the program will continue to implement and optimize approaches that improve yield and case-finding, including but not limited to testing sex partners of index patients, testing within high-risk social networks, multiple testing points/streams within facilities (TB clinic, inpatient wards, pediatric clinic, maternal child health (MCH) clinic, STI clinic, under-five clinic, malnutrition clinic, immunization clinic, ANC clinic, and outpatient department), recency testing, targeted HIV self-testing, and targeted mobile testing outreach. The choice of which testing modalities/streams to scale-up will be determined by LGA-specific analysis of yield by testing stream/modality (scaling up high yield modalities/streams) and availability of room for such scale-up in the particular testing stream/modality as well as treatment gap disaggregated by age and sex. In addition, services will be targeted at underserved sub-populations (age and sex bands) such as men and adolescent and young persons aged 10 – 24 years using evening/weekend clinics, assisted partner notification, assisted self-testing and other approaches.

The GON recently approved a policy to roll out test and start in all locations (both scale-up and sustained LGAs) and is in the process of reviewing the National HTS guidelines to capture this and emerging testing strategies like partner notification services, social network testing, self-testing, and recency testing thus expanding the scope of strategies that PEPFAR can employ. SIMS visit findings and the roll out of test and start nationwide call for refocusing of the program to improve the quality of testing through the Rapid Testing Quality Improvement Initiative and implementation of WHO's retesting of PLHIV at ART initiation.

HTS Efficiency Analysis

PEPFAR supported HTS at 4,064 sites at the end of FY16 (sites that reported results for HTS in APR16). The site yield analysis showed 1,875 sites to be low-yield sites (each reported less than four (4) HIV positive individuals or less than 12 HIV positive individuals in the case of combined HTS and PMTCT sites in FY16). PEPFAR will withdraw support (RTKs, oversight, and monitoring visits) to these sites within FY17 and they will not be assigned FY18 targets. These 1,875 sites accounted for two (2) percent of the HIV-positive individuals seen in that year (having 4,937 out of a total reported of 584,663). The sites were distributed as follows; 1,835 combined HTS and PMTCT sites in sustained support LGAs and 40 stand-alone HTS sites in sustained support LGAs. None of these are treatment sites. After transitioning support out of these sites, the program will have only the 2,189 PMTCT sites which constitute 54 percent of total HTS sites but contributed 98 percent of the positives reported in FY16. Figure 4.5.1 below illustrates the site volume analysis.

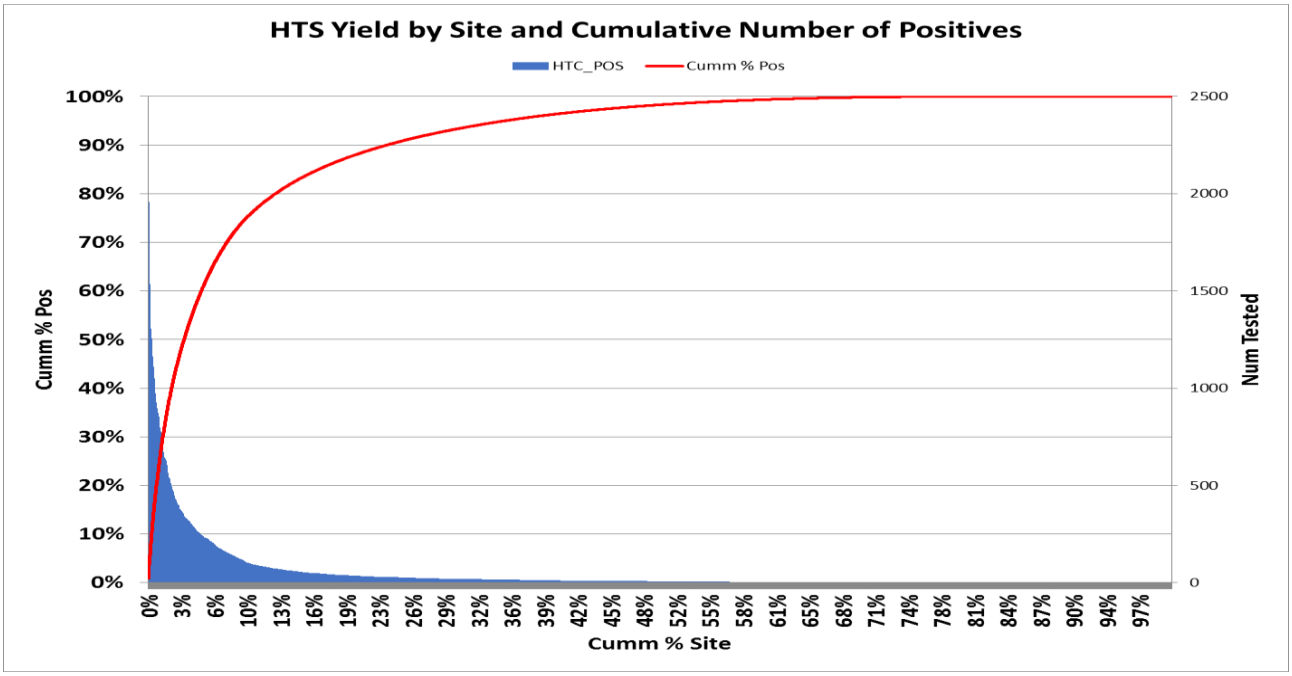


Figure 4.5.1 HTS Site Yield Analysis for FY 2016

Combined Result of HTS & PMTCT Efficiency Analyses

As a result of both PMTCT and HTS efficiency analyses that were conducted a total of 4,153 sites that reported HTS results in all settings including PMTCT, 1,961 low-yield sites will not be supported in FY18. Following withdrawal of PEPFAR support from these low-yield sites, 46 sustained support LGAs will be without PEPFAR support for HTS. PEPFAR supported Care and Treatment services are not currently offered in these LGAs. PEPFAR will continue to support KP and OVC services.

4.6 Facility and community-based care and support

Nigeria's National Guidelines for HIV Prevention, Treatment and Care (2016) defines a comprehensive package of care and support interventions that should be available to PLHIV in the continuum of care. These include: medical; supportive; socio-economic; and psychosocial services e.g. cotrimoxazole (CTX) prophylaxis, screening for TB, provision of Positive Health, Dignity and Prevention (PHDP) services, EID, nutritional assessment and counseling, nutritional support for malnourished children, PLHIV support group activities, defaulter tracking, and linkage and referral services based on need at the health facility. In the community, it is estimated that 20 percent of PLHIV on ARVs will receive the following services: PHDP services; psychosocial support through activities of PLHIV support groups, defaulter tracking, linkages and referrals to complementary services e.g. legal support and economic empowerment.

PEPFAR Nigeria will continue to support: TB screening; cotrimoxazole prophylaxis; and PHDP services that aim to reduce morbidity and mortality, optimize retention in care, improve quality of life, and prevent ongoing HIV transmission. HIV exposed infants will be identified and enrolled in care and followed up longitudinally until they are no longer at risk of infection through breastfeeding and their final HIV status is confirmed. Exposed infants will benefit from

pre-exposure prophylaxis, cotrimoxazole preventive therapy, growth monitoring, nutrition assessment and counseling of their care givers, EID, and immediate commencement on ART of those found to be HIV infected.

In the scale up LGAs, there will be increased enrolment of new cases of adult, adolescent and children infected with HIV while measures will be put in place to ensure that those already on treatment maintain good adherence to their medication and are retained in care. Referral to OVC services in the community will be strengthened for infected and affected children and their caregivers. A minimum package of care will be provided to clients enrolled to help improve their adherence to treatment and retention in care.

The National Treatment Guidelines (2016) defines differentiated care as the delivery of a minimum package of HIV/AIDS treatment care and support services according to the diversity of the care needs of people living with HIV. In FY 18, PEPFAR will continue to support innovative models of differentiated care commenced in FY 17 for the different categories of people living with HIV based on service needs. The different PLHIV categories include:

1. Newly diagnosed patients who are clinically well at presentation will be rapidly assessed to determine willingness to initiate ART same day and thereby receive adherence counseling as well as ongoing adherence support to continue treatment.
2. Patients who present with advanced disease will receive fast-track ART initiation, opportunistic infection screening and management.
3. Patients who have been stable on ART will require fewer clinic visits. Stable patients are those who have received ART for at least one year and have no adverse drug reactions that require regular monitoring; have no current illnesses or pregnancy; are not currently breastfeeding; and have good understanding of lifelong adherence and evidence of treatment success (two consecutive viral load measurements below 1000 copies/mm3). Stable patients will receive multi-month scripting (three (3) month drug refills) and biannual doctors' visits.
4. Patients who have been unstable on ART. Unstable patients are those with evidence of treatment failure (clinical, immunological or virological failure), and/or poorly adhering to medication. Unstable patients will receive close monitoring for identification and treatment of opportunistic infection, viral load and adherence monitoring.

PEPFAR will continue to support differentiated care models for the different categories of PLHIV listed above at both facility and community settings to improve efficiency and quality of care. PEPFAR Nigeria will work with the GON to streamline the provision of HIV care services at PHCs in a more efficient manner. In addition, informal settings in scale-up LGAs such as patent medicine vendors (PMVs) and other community structures will be engaged to support refills of ART for stable patients on treatment. Community volunteers, primarily PLHIV, will be supported to play active roles in peer adherence counseling, defaulter tracking and coordination of community support groups to improve retention in care for adults, adolescents and pediatric clients. The network of PLHIV in the community will continue to be supported, so PLHIV can share common concerns and participate in decision-making to address issues common to them

such as stigma and discrimination. They will be involved in the delivery of differentiated care for patients within their community.

4.7 TB/HIV

The PEPFAR program will continue to prioritize TB/HIV activities to combat the dual infection of HIV and TB. This support will: focus on key interventions to maintain high rates of HIV testing among all TB cases; ensure universal ART for all PLHIV: ensure timely TB diagnosis and treatment completion; scale up TB Preventive Therapy (TPT); and, sustain joint TB/HIV programming and monitoring. These core TB/HIV interventions are key evidence-based approaches to achieving the UNAIDS 90-90-90 goals. The PEPFAR TB/HIV program will continue to work with the government and other key stakeholders in this regard.

In FY18 and FY19, PEPFAR will continue to focus on scale-up LGAs with high HIV burden to provide HTS for both presumptive TB and TB patients. In COP17, PEPFAR Nigeria will continue to support GeneXpert diagnosis for improved TB yield in the scale up LGAs.

There will also be a coordinated GeneXpert network for improved TB case detection among PLHIV. Support will be provided for sputum transport logistics for GeneXpert tests and functionality of all supported GeneXperts will be ensured through integrated equipment maintenance and warranty renewal. Programming for TPT will be prioritized as well as TB infection prevention and control. The PEPFAR care and treatment program will continue to scale up TPT and support the GON to: review the TB/HIV guidelines; develop systems and monitoring and evaluation tools; strengthen INH logistics management systems; as well as monitor partner performance.

Efforts will be intensified to ensure contact tracing for all HIV positive patients diagnosed with TB, especially pulmonary TB cases. This will improve TB case detection among HIV patients and their households and will contribute to increased HTS uptake. The program will also intensify TB case finding among KPs, children, and pregnant women attending ANC in all scale up LGAs.

To further strengthen referral services between TB and HIV service points, PEPFAR will continue to support TB/HIV referral coordinators and volunteers in the scale up LGAs. Preliminary results from the evaluation of this intervention show increased performance across all indicators of the TBHIV cascade with a commendable increase in the uptake of both ART and TB treatment services. This intervention will continue to: ensure that priority attention is given to TB/HIV co-infected patients across service delivery points; facilitate timely diagnostic evaluation for TB among PLHIV through sputum referral for GeneXpert diagnosis; provide prompt treatment initiation for confirmed TB/HIV cases; and ensure follow up and documentation of treatment outcomes.

Priorities for commodity procurement will include provision of Gene Xpert cartridges and INH through a coordinated logistics system to avoid stock outs and wastage among implementing partners. Future efforts will focus on mentoring, supportive supervision and capacity building of care providers.

4.8 Adult treatment

Test and start commenced in Nigeria in FY16 but was limited to the 32 scale up LGAs based on Ministerial approval received prior to adoption and revision of the guidelines. The National Treatment Guidelines was revised in 2016 to reflect the 2015 WHO care and treatment recommendations, including "test and start". Consequently, PEPFAR Nigeria will continue to implement "test and start" in scale up LGAs and in the sustained response areas which began rolling it out in 2017.

PEPFAR will support treatment through differentiated models of care and treatment for stable and unstable HIV infected patients. Stable patients are those who have received ART for at least one year and have no adverse drug reactions that require regular monitoring; have no current illnesses or pregnancy; are not currently breastfeeding; and, have good understanding of lifelong adherence and evidence of treatment success (two consecutive viral load measurements below 1000 copies/mm^3). Stable patients will receive multi-month scripting (three (3) month drug refills) and biannual doctors' visits. Whereas patients classified as unstable are those who do not meet the criteria outlined above e.g. poorly adhering to medication, treatment failure (clinical, immunological or virological failure) and they will require frequent clinic visits for clinical consultation, laboratory investigations, adherence support and drug refills.

The newly supported models of care will improve treatment outcomes and create efficiencies within the PEPFAR budget. The treatment service delivery package includes: provision of ARVs; facility/community-based adherence monitoring; retention activities; and viral load assay to monitor treatment efficacy. The full service package for scale up LGAs is specified below.

Service Package	
Clinical evaluation and assessment	✔
Assessment and management of TB and other OIs	✔
Provision of PHDP services	✔
Provision of ARVS and Cotrimoxazole	✔
Routine HIV testing for TB clients at existing TB/DOTS POS	✔
ART Monitoring using Viral Load	✔
Baseline CD4 for newly diagnosed HIV positive patients to inform further testing for OIs	✔
Facility & Community Retention & Medication Adherence Support	✔
Provision of EID services	✔
Referrals and linkages – social services, FP/RH	✔
PITC in multiple POS including ANC	✔
Active Case Finding & Enrolment – Community ART	✔
HIV testing among OVCs and linkage to ART services	✔
Community outreach and demand creation activities	✔

Efficiencies will continue to be gained through the pooled procurement of key commodities within the integrated national logistics system. The logistics system will be modified to

accommodate the new multi-month dispensing of ARVs. Community activities will be strategically targeted at adherence reinforcement, retention, and viral load suppression. Demand creation activities in the scale-up LGAs will sensitize communities on services that are available. Community support groups are to be strengthened and will continue to play an active role in improving medication adherence, drug distribution, and retention on treatment. PEPFAR will continue to support various community ART service delivery models as a means of increasing ART uptake, decongesting health facilities, improving access to hard to reach locations and making services more convenient in the scale-up LGAs. Community treatment locations in the scale up LGAs will include PHCs, KP OSS, and mobile clinic services and outreach.

In FY18, increased effort will be directed at ensuring that more men are accessing HIV treatment services. Strategies for achieving this will include:

- Advocacy to key community and opinion leaders on the need for men to access HIV services;
- Engagement of male role models as champions to promote increased uptake of HIV services by men;
- Support for females in care to encourage their male partners to seek HIV services;
- Support for CBOs with skills and resources to provide community based care and treatment services for men and MSM; and
- Utilization of men living positively to promote access to HIV services among men.

PEPFAR Nigeria will also support innovative approaches that will improve care and treatment service across the clinical cascade:

- Flexible clinic hours – including evening and weekend hours
- Use of peer navigators to ease flow of clients across the cascade of care
- Use of PLHIV volunteers as lay counsellors and referral escort
- Same day ART initiation including express lane services for newly diagnosed PLHIV.

PEPFAR Nigeria will pilot virtual clinical mentoring using an information, communications technology (ICT) platform to build the capacity of healthcare workers in secondary health facility to improve quality of care and patient outcomes. The pilot involves setting up hubs at tertiary health facilities with highly skilled medical professionals that will serve as resources persons with several peripheral sites (secondary health facilities) as spokes connecting virtually to the hub. This will be a cost–efficient way of providing capacity building and mentoring compared to the traditional method of building capacity which entails pulling health care workers from their sites and creating service gaps.

4.9 Pediatric Treatment

Pediatric Treatment services are critical to achieving the UNAIDS 90-90-90 goals in scale up LGAs and are retained as core activities. The service delivery package includes: early identification of HIV infected children under 15 years of age and timely initiation on treatment; screening for TB and other opportunistic infections; provision of TB Preventive Therapy for eligible children; adherence support; optimization of ARVs; activities to improve retention of children in care and treatment such as co-scheduling appointments for parent-child pairs, making health facilities

friendly for children and adolescents; and longitudinal tracking. Following the adoption of "test and start", the national policy document was reviewed and finalized. The National guidelines were printed and disseminated in the second quarter of FY17. This will enhance timely initiation of children on ART by removing the potential delays associated with use of CD4 count in determining eligibility for ART.

The introduction of lopinavir/ritonavir pellets at the end of FY16 will result in availability of a more efficacious ARV regimen and in more appropriate formulations for children less than five (5) years old thereby resulting in better viral suppression rates in this age group. Review of the FY16 pediatric clinical cascade in the 32 scale up LGAs revealed suboptimal performance in case identification despite a significantly higher number of children tested for HIV. Linkage to treatment was also poor. Also noted was that most of the pediatric ART enrolment were from high volume ART sites located in sustained support LGAs with potential to enroll more children.

Following a three month pilot of intensified pediatric case finding which ended in the second quarter of FY17, lessons learned are being implemented across health facilities in the scale up LGAs to improve testing efficiency by focusing efforts on the three (3) streams with the highest volume of positives. These include family index cases, in-patient, and out-patient departments. It should be noted that while testing in TB clinics had high positivity rate, the number of HIV positive children identified from this stream was quite low. In COP17, intensified pediatric case finding strategies will be expanded to high volume pediatric ART sites within the six (6) priority states and the Federal Capital Territory in order to optimize pediatric ART enrolment. Communities in the scale-up LGAs will be sensitized and engaged to increase demand for pediatric HIV services, promote adherence and retention on treatment using existing structures within the community. These include ward development committees, lay counselors and focal persons to champion HIV services for children and adolescents who will play a vital role in defaulter tracking and promoting adherence. Children on treatment will be prioritized for routine viral load monitoring and efforts will be made to ensure timely utilization of the results to inform management of children not achieving viral suppression.

The program will expand high yield pediatric HIV testing initiatives in the communities targeting OVC children missing school and or who are malnourished. There will be increased effort to improve follow-up of mother-infant pairs through strengthened community linkages and longitudinal cohort tracking especially for HIV exposed infants.

EID coverage is low in Nigeria due to: poor identification of HIV exposed infants; poor linkage to EID services; long turnaround time from receipt of sample to issuance of results to facilities; and inadequate human resources. In FY18, additional measures to address these challenges are to: intensify screening of mother-infant pair across all service points to determine exposure status; strengthen continuous quality improvement (CQI); strengthen the use of longitudinal registers to track mother-infant pairs; train and retrain clinical staff on dried blood spot (DBS) collection, transport and tracking; develop integrated sample referral transport and results return systems; and sustain advocacy to government to employ and/or deploy more laboratory scientists to the polymerase chain reaction (PCR) laboratories.

4.10 OVC

The OVC program will continue to scale up services in priority areas and realign to conform to the geographic focus of the Nigeria program. The service delivery package will be consistent with harmonized services and case management packages as outlined in the standard operating procedures for case management in OVC programing in Nigeria. Children will receive need-based and age-appropriate interventions including: support to access healthcare; HIV testing and counselling; linkages to treatment and adherence support for HIV positive children; nutrition assessments and counselling; caregiver and community capacity-building for parenting; early childhood development activities; child protection services; and household economic strengthening. Adolescents, especially girls with significant socio-economic vulnerabilities which can predispose them to HIV infection, will be targeted with interventions addressing school dropout, abuse, exploitation and HIV transmission.

In FY 18, the program will improve access to health, education, protection, economic and psychosocial support services for children who are living with HIV, children affected by HIV and children who are vulnerable due to other causes within the scale-up LGAs. Community-based OVC programs, using a case management approach, will provide household based services that will ensure family stability and increase household economic status of beneficiaries. Case managers will use the standardized case management approach which outlines the package of interventions as well as the roles and responsibilities of service providers and refer beneficiaries to other services where needed and when not available on site. Table 4.1.4 outlines targets for OVC and linkages to HIV testing, treatment and care. Prevention messaging will target adolescent OVC, especially girls, with age and context appropriate messaging including linkages to adolescent-friendly reproductive health services. There will be a strong focus across the program on strategies to empower households and communities for better parenting and sustainable care and support to OVC. Strong referral systems will be put in place to deliver services within the household and community, as a means of providing seamless facility and community services to HIV positive individuals within the community where they reside.

During SIMS visits, the transition of girls to secondary school was identified as an area of weakness along with community-facility linkages (and vice-versa) for OVC service delivery. In FY18, PEPFAR will build the capacity of local partners to identify and address issues related to the transition of girls to secondary schools and mitigate harmful community practices that increase adolescent vulnerability to HIV/AIDS while integrating gender considerations into all existing and new activities. Local partners will also strengthen facility-community linkage systems for improved OVC service delivery and scale-up of routine HIV testing of children of adult patients. Children identified as positive will be linked to health facilities for care and treatment, especially in scale-up LGAs.

Significant community-based organizational capacity has been built to serve OVC; however, gaps remain in the area of resource mobilization for OVC care and ongoing training for volunteer community para-social workers. The coordination and supervisory capacity of the Ministry of Women's Affairs and Social Development is low, especially at the state and LGA levels. PEPFAR Nigeria will continue to build capacity of these groups, including advocacy for workforce development and prevention of and response to violence against children. Implementing partners

will also work with community-based organizations to strengthen case management as the gateway to service provision.

Table 4.1.4 Targets for OVC and Linkages to HIV Services

SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY18Target) OVC_SERV	Target # of Active Beneficiaries Receiving Support from PEPFAR OVC Programs whose HIV Status is Known in Program Files (FY18 Target) OVC*
ak Ikot Ekpene	9,803	24,898	23,653
ak Okobo	6,330	14,987	14,238
ak Oron	6,097	24,108	22,903
ak Uruan	7,147	16,084	15,280
ak Uyo	18,043	45,496	43,221
be Buruku	18,434	24,571	23,342
be Gwer West	11,265	15,356	14,588
be Katsina-Ala	21,161	30,856	29,313
be Konshisha	19,811	11,781	11,192
be Logo	15,987	26,174	24,865
be Tarka	6,498	13,958	13,260
be Ushongo	16,931	10,723	10,187
cr Calabar Municipal	8,655	15,289	14,525
cr Calabar South	8,321	16,881	16,037
fc Abuja Municipal Area Council	123,543	93,541	88,864
fc Bwari	41,690	33,170	31,512
la Agege	33,418	12,854	12,211
la Ajeromi-Ifelodun	83,267	16,564	15,736
la Alimosho	199,933	19,408	18,438
la Apapa	24,103	8,574	8,145
la Ifako-Ijaiye	30,128	15,383	14,614
la Ikeja	21,464	28,285	26,871
la Mushin	36,481	20,570	19,542
la Surulere	53,697	8,952	8,504
na Doma	12,199	11,404	10,834
na Karu	19,580	24,088	22,884
na Lafia	25,546	48,484	46,060
na Nasarawa	15,183	15,071	14,317
na Obi	12,669	22,736	21,599
ri Eleme	17,205	13,590	12,911
ri Obio/Akpor	29,017	22,267	21,154
ri Port-Harcourt	24,488	38,973	37,024
TOTAL	**978,094**	**745,076**	**707,824**

4.11: Addressing COP17 Technical Considerations

PEPFAR is implementing an integrated package of innovative, evidence-based interventions to address the key technical issues of 1) increasing focus on prevention and care services for PLHIV

under 30 years old; 2) increasing testing yield and improving testing modalities; 3) improving linkage and retention in treatment and viral suppression; and 4) supporting a sustainable and replicable quality service delivery model.

Scaling up prevention and care services among persons under 30 years of age is a focus of the PEPFAR program in Nigeria. PEPFAR will leverage its investments in OVC and key populations prevention/treatment to improve prevention and care services among young and adolescent girls/boys. In addition, PEPFAR will prioritize these populations for receipt of the novel methods to improve HIV case-finding, linkage to treatment, and retention in treatment (see below).

To increase testing yield and improve testing modalities in the 32 scale-up LGAs, PEPFAR will continue to utilize multiple testing streams, emphasizing the maintenance of high testing coverage in TB treatment facilities as well as the increased testing in outpatient department (OPD) facilities where the bulk of PLHIV are identified. In addition, PEPFAR will make access to testing more convenient by implementing evening/weekend hours testing at PEPFAR-supported facilities, providing focused community based testing to key populations and partners of newly diagnosed PLHIV, and supplying HIV self-testing kits to PLHIV for use by their sexual partners as part of an assisted partner notification program. In addition, PEPFAR will implement risk stratification tools to identify children at higher risk for HIV infection to prioritize these children for HIV testing as well as HIV recency testing to identify newly diagnosed PLHIV who are recently infected (and more likely to transmit infection) with the goal of prioritizing sexual partners of these patients for partner notification and HIV testing; as well as sero-conversion monitoring. It is envisioned that these modalities would increase testing yield and contribute to the goal of achieving 90-90-90 in the scale-up LGAs.

While PEPFAR will not be supporting community testing services in the 13 sustained-plus LGAs, PEPFAR will support the use of recency testing, self-testing, and assisted partner notification in PEPFAR-supported facilities to increase testing yield and improve case-finding.

Ensuring linkage and retention has been a longstanding challenge in Nigeria. While PEPFAR has improved linkage to treatment in the 32 scale-up LGAs, linkage rates in the sustained support LGAs continue to be poor. Therefore, PEPFAR will apply best practices and lessons learned from the scale-up LGAs to improve linkage in the sustained support LGAs. To further improve linkages, PEPFAR will continue to expand same day ART initiation; implement patient centered differentiated models of care; and encourage three-month medication scripting and community-based medication refills. Understanding that certain populations require particular focus in improving linkage and retention, PEPFAR-supported facilities will expand evening/weekend hours to target adult men and will leverage investments in OVC and other program areas to improve linkage and retention among young, adolescent women and men.

Finally, the PEPFAR model of service delivery in the sustained-plus LGAs, which incorporates methods to strengthen case finding, linkage and retention within a conservative resource envelope, is meant to serve as an example of a sustainable model for the GON to support and expand moving forward.

4.12 Commodities

Stock-outs have been a rare occasion within Nigeria despite the move towards pooled procurement with the Global Fund across multiple health commodities. However, the two (2) products that were a struggle during FY16 were viral load reagents and to a lesser degree, HIV rapid test kits (RTKs). In September 2016 the PEPFAR program experienced nearly a month of insufficient viral load reagents – largely due to the rapidly increased demand for viral load compounded by the transition to a new procurement contractor. In FY16, the PEPFAR program experienced a shortage of funding for HIV rapid tests but did not stock out of RTKs. The RTK funding shortage was due to the overachievement of HIV testing targets. The shortage would have resulted in depletion of all RTK supplies but PEPFAR stepped in to ensure partners reduced census-style testing and other forms of community testing with relatively low HIV sero-positivity. In FY18 the close monitoring of the RTKs budget will continue as the PEPFAR team focuses on the scale-up of more efficient forms of testing. For scale-up and sustained plus LGAs, PEPFAR will procure products for self-testing and recency testing.

4.13 Collaboration, Integration and Monitoring

During FY16 implementation, PEPFAR Nigeria identified the following key challenges across the clinical cascade namely: low yield from HIV testing efforts; suboptimal linkage; suboptimal retention; and low viral load coverage in the 32 scale up LGAs. In the scale up LGAs, despite the tremendous efforts put in HIV testing in FY16, the yield ranges from 0.26% to 3.7%. It became obvious to all stakeholders that the HIV epidemic data in Nigeria is flawed; hence the need to conduct a population based study to improve state-wide HIV prevalence and burden estimates. To address this gap, PEPFAR Nigeria, working with GON and other stakeholders, will commence this survey in COP17. PEPFAR Nigeria will continue to sustain the gains that show progressive improvement in linkage rates achieved in FY16 in the 32 scale up LGAs. In COP17, every identified HIV positive individual will be linked to treatment using the following approaches – same-day ART initiation, flexible clinic hours for men and use of volunteers to escort HIV positive clients for ART initiation. To address the low viral load coverage, the PCR laboratory capacity will be optimized using extended hours of operation, provision of additional human resources and regular monitoring and supervision of the laboratories.

PEPFAR Nigeria will continue to improve its partner performance management through bi-weekly and monthly engagement to review data and provide timely feedback to guide implementation in line with COP17 directions. In addition, PEPFAR Nigeria technical staff will continue to engage partners during quarterly TWG meetings to review program performance, explore challenges, and share lessons learned and best practices.

PEPFAR Nigeria will continue to improve efficiency in service delivery by adopting strategies that improve testing yields like index partner testing, self-testing, and differentiated care models that improve treatment outcome and create efficiencies.

In COP17, PEPFAR Nigeria will continue to strengthen collaboration with GF, and other key stakeholders in the implementation of HIV/AIDS program in Nigeria through improved

coordination meetings, joint planning and streamlining of service packages and geographical prioritization to prevent duplication of efforts and improve efficiencies.

5.0 Program Activities in Sustained Support Locations and Populations

5.1 Targets for attained and sustained locations and populations

None of the 32 LGAs selected for scale-up to saturation has reached the attained status for saturation based on the age and sex requirements per the new definition. None will have achieved greater than 81 percent ART coverage.

5.2 Targets for sustained support locations and populations

Table 5.1.2 shows FY17 and 18 expected achievements for HIV counseling and testing at PMTCT and HTS service delivery points as well as patients currently on ART and OVC served in the sustained LGAs.

Table 5.1.2 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Support LGAs

Sustained Support Volume by Group	Expected result APR 17	Expected result APR 18
HIV testing in PMTCT sites - PMTCT_STAT	1,217,627	1,991,393
HTS (only sustained ART sites in FY 17) - HTC_TST/HTS_POS	1,843,699	4,706,230
Current on ART - TX_CURR	550,844	674,953
OVC - OVC_SERV	400,398	516,565

5.2 Key and Priority Population Prevention

Key Populations in Nigeria continue to have exceptionally high positivity rates for HIV. They include female sex workers, men who have sex with men (MSM) and persons who inject drugs (PWID). Based on a trend analysis of the Integrated Biological and Behavioral Surveillance Survey, Nigeria is experiencing a gradual decline in HIV prevalence rate among female sex workers (FSW), from a previous 2010 estimate of about 27 to a 2014 estimate of about 19. People who inject drugs have had a prevalence estimate comparable to the general population with a decline from 4.2 percent in 2010 to 3.4 percent in 2014. Conversely, MSM had a rising prevalence from 17 percent in 2010 to about 23 percent in 2014. This corresponds with a significantly lower condom use among MSM as compared to FSW and may be a reflection of the hostile socio-political and cultural environment (For MSMs) currently existing in Nigeria.

PEPFAR Nigeria's Key Population (KP) strategy for COP 17 is fundamentally focused on achieving the UNAIDS 90-90-90 goals among key populations. Overall, the KP portfolio will seek to intensify case finding through strategically targeted testing including self-testing options, same day same site commencement of ART for positive KPs and an intensively focused adherence/support program with viral load testing to ensure community viral suppression. The use of evidence-informed prevention-based peer-led networks will form the fulcrum for the 90-90-90 service delivery.

5.2.1 First 90: In FY 18, the KP portfolio will intensify case finding of positive KPs. Program level prevalence data has been in the range of ten percent, which is about the same as the country KP average, but variations within the different KPs are significantly below known in-country survey estimates. This was due to factors such as cohort testing, dilution from testing outside of KPs, and absence of risk-profile based testing approaches. In FY 18, we will significantly improve testing yield. Testing services will actively seek out KPs who are likely to be positive by using a risk profile based approach that will rely on behavioral and biological markers for HIV positivity. This will include testing all KPs presenting with STIs, low condom use, high risk sex, and KPs with sero-discordant partners. Partner notification services will be cascaded around every positive KP diagnosed. Further, all sources of dilution including clients of sex workers and all other individuals/groups that do not fall within the strict definition of KPs will not be tested in FY 18. Intensified Proficiency Testing will improve the quality of testing while also ensuring that true positives are identified. Overall, less testing will be done in sustained LGAs than in priority support.

5.2.2 Second 90: The PEPFAR Nigeria KP portfolio will continue implementation of the One Stop Shop strategy. The One Stop Shop is more of a community clinic for KPs that creates a safe space for the delivery of a complete cascade of KP focused prevention, treatment, care and support services. It also acts as a hub for community based ART delivery using peer-led networks and community outreach workers. "Stable KPs" will have ARVs delivered directly to them using peer networks in a way that guarantees confidentiality and non-discrimination as a differentiated care model. Stable KPs are defined as those who are clinically stable, have shown significant level of drug adherence and demonstrated actual viral suppression or progress towards it. At the community level, more innovative and KP centered models will be used for the distribution of ARVs. One of such is the use of "Sexy Kits". These are small packs that include condoms and lubricants and possible ARV medications for the HIV positive KPs. For the full implementation of treatment as a prevention strategy, "Test and start" will be rolled out in all the one stop shops for all HIV positive clients immediately after diagnosis irrespective of CD4 count or viral load and also adequate provision of ARVs will be ensured for pre-exposure prophylaxis among high risk and discordant pairs. In the sustained support LGAs, all positive KPs identified will be linked to ART in OSS situated in priority LGAs. OSS in sustained support LGAs will only be activated if the volume and distance to the nearest OSS is obviously a hindrance to a 90% linkage rate.

5.2.3 Third 90: Activities that will strengthen retention in care among key population will be supported in a robust manner. Client engagement protocols will be set up where; KPs are actively engaged by virtual peer facilitators as a strategy to assure linkage to ART, retention on ART and adherence to ART. Viral load will be conducted within three to six months after ART initiation in line with current programming standards. One-Stop-Shops will be linked to hub facilities for improved access to necessary investigations as may be required by clients including GeneXpert. The OSS will be linked into the integrated sample transfer network. This will create a short turnaround time that has been proven to positively influence treatment outcomes including adherence. The peer mechanism will be used to intensify adherence and also address the different levels of stigma and discrimination. Positive health dignity prevention (PHDP) will be deployed

within and outside the OSS depending on the preferences of the cohorts. These will in turn improve the ARV uptake behavior of positive KPs and so increase the likelihood of individual viral suppression and reduce the occurrence of drug resistance.

5.2.4 Sexual Transmission Prevention: Eligible KPs will continue to benefit from traditional prevention interventions using the Minimum Prevention Package of Interventions in line with the National Prevention Plan of the Government of Nigeria. This service package include peer education/interpersonal communication, condom programming (including male, female and lubricants), STI management, HIV testing and counseling, community level system strengthening, and structural level interventions. These interventions constitute a suite of mutually reinforcing prevention interventions that reduce the risk of new infections among KPs. Beyond the provision of information to KPs, the peer education sessions will serve to also deliver treatment, care and support services.

5.2.5 Community Approach: The KP program will work very closely with the Orphans and Vulnerable Children (OVC) program. Children of female sex workers (FSW) that are positive or highly vulnerable will be able to access OVC services that will be offered by OVC implementing partners. This collaboration will ensure that, services across OVC and KP programs are leveraged by all populations that require the services. In like manner the KP program will offer technical assistance to the OVC program to ensure that, adolescent and young adults in the OVC program receive qualitative prevention services that are tailored to the specific needs of the OVC. This collaboration will only be in LGAs that support the OVC program.

5.2.6 Geographic Targeting: The fundamental rule for KP geographic targeting is provision of KP focused services at scale within priority LGAs, and targeting of hotspots outside of priority LGAs but within the seven states of Benue, Nasarawa, FCT, Rivers, Cross Rivers, Akwa Ibom, and Lagos. In FY 18, the KP program will continue to work in the priority LGAs using a tiered system. Tier One LGAs are scale-up LGAs including the Sustained plus LGAs, Tier Two LGAs are LGAs that share boundaries with scale-up LGAs and sustained plus LGAs, and Tier Three LGAs are LGAs that do not share boundaries with scale up and sustained plus LGAs. Tier Three LGAs will have partner notification services operating there. Emphasis will be placed on reaching KPs within Tier One and two LGAs while linking to OSS with same day same site initiation of ART. The OVC program will be cascaded around the KP program in scale up and sustained plus LGAs (Tier 1) only.

5.2.7 Programming Environment: The Same Sex Marriage Prohibition law and continuous harassment from overzealous law enforcement agents continue to impede the uptake of HIV services among KPs. The Legal Environmental Assessment report and other rights violation reports clearly show the need to address these gaps in improving KP access to services. In FY 18, PEPFAR Nigeria will continue its engagement with key rights and law enforcement agencies with the aim of reducing unnecessary and illegal violations that impede access to critical HIV services.

5.3 Voluntary medical male circumcision (VMMC) - Not Applicable

5.4 Preventing Mother-To-Child Transmission (PMTCT)

The GON recently approved the implementation of test and start (including PMTCT option B+) in the entire country. Therefore, PEPFAR will roll out Option B+ across the sustained support LGAs in FY17 and beyond. However, PEPFAR will not support community demand creation activities in these LGAs and routine testing (PITC Opt-out) will be provided to pregnant women in ANC settings. Testing targets are set at 41 percent of the annual pregnant women population of each of the LGAs based on historical trend (program data) that suggest this to be the proportion that access ANC services in PEPFAR-supported facilities within these LGAs. Following status determination, every HIV-positive pregnant and breast-feeding woman identified will be enrolled on life-long ART (same-day initiation) regardless of CD4 count and every HIV-positive pregnant woman enrolled on PMTCT will receive at least one viral load estimate prior to delivery to determine whether the resultant HEI is high risk and eligible for enhanced ARV prophylaxis. The program will employ innovative strategies to ensure all HIV-infected infants identified are linked to treatment.

The expected volume of patients needing the minimum package of services in the sustained LGAs has been calculated by LGA and summarized in Table 5.1.2. For FY18, the expected number of pregnant women to be tested at PMTCT sites was derived based on the assumption that these sites would provide routine counseling and testing in antenatal clinic settings. It is estimated that 41 percent of pregnant women in these LGAs will seek care in PEPFAR-supported facilities and be tested under these conditions.

PEPFAR support will be withdrawn from low yield sites with combined HTS and PMTCT absolute volume of fewer than 12 positives identified in FY16 and new clients that present at those sites will be referred to the nearest supported facility for such services.

5.5 HIV Testing Services (HTS)

The GON recently approved a policy to roll out test and start nationwide, beginning from the first quarter of 2017, and is in the process of reviewing national HTS guidelines to capture this and emerging testing strategies like partner notification services, social network testing, self-testing and recency testing thus expanding the scope of strategies PEPFAR can employ. Therefore, PEPFAR will adopt the test and start strategy in all the sustained support LGAs without changing its strategic pivot of limiting testing in those locations to within facilities only, and based on clinical symptomatology or client request.

In COP17, with additional resources tied to performance, 13 sustained support LGAs were selected by PEPFAR, based on burden and proximity to scale-up LGAs, for further treatment expansion. In these newly selected 13 LGAs, tagged “Sustained Plus LGAs”, while initial testing will be limited to facilities and based on clinical symptoms/signs or client request, assisted partner notification, self-testing and recency testing strategies will be employed to further optimize case-finding from the initial set of index patients. However, outside the 32 scale up and the 13 sustained plus LGAs, all HTS activities will remain facility-based and not include routine provider-initiated testing and counseling (PITC) but will be based on clinical symptomatology or when requested by the client.

SIMS visit findings and the roll out of test and start nationwide call for refocusing of the program to improve the quality of testing through the Rapid Testing Quality Improvement Initiative and implementation of WHO's retesting of PLHIV at ART initiation in the sustained support LGAs as well. In addition, PEPFAR will employ current best practices and lessons learned from improving linkage success rates in the scale up LGAs to also improve linkage success in sustained support LGAs and the assure the quality of services provided in all PEPFAR supported service delivery points.

5.6 Facility and community-based care and support

Nigeria's National Guidelines for HIV Prevention, Treatment and Care (2016) defines a comprehensive package of care and support interventions that should be available to PLHIV in the continuum of care. These include medical, supportive, socio-economic and psychosocial services e.g. cotrimoxazole (CTX) prophylaxis, screening for tuberculosis, provision of PHDP services, EID, nutritional assessment and counseling, nutritional support for malnourished children, PLHIV support group activities, defaulter tracking, and linkage and referral services based on need at the health facility. In the community, it is estimated that 20 percent of PLHIV on ARVs will receive the following services: PHDP services; psychosocial support through activities of PLHIV support groups; defaulter tracking; and linkages and referrals to complementary services such as legal support and economic empowerment.

PEPFAR Nigeria will continue to support TB Screening, cotrimoxazole prophylaxis, and PHDP services that aim to reduce morbidity and mortality, optimize retention in care, improve quality of life, and prevent ongoing HIV transmission. HIV exposed infants will be identified and enrolled in care, followed up longitudinally until they are no longer at risk of infection through breastfeeding and their final HIV status is confirmed. Exposed infants will benefit from ARV prophylaxis, cotrimoxazole preventive therapy, growth monitoring, nutrition assessment and counseling of their care givers, EID, and linkage of HIV infected infants to ART services. Referral to OVC services in the community will be strengthened. PEPFAR Nigeria will continue to support clients already enrolled in its care and support services in all sustained plus and sustained support LGAs. Referral to OVC services in the community will be strengthened for infected and affected children and their caregivers. In all sustained plus and sustained support LGAs, a minimum package of care will be provided to clients enrolled to help improve their adherence to treatment and retention in care.

PEPFAR Nigeria will continue to support GON efforts to decentralize care services to PHCs in order to increase access to services for PLHIV. In addition, the program will extend services to informal settings such as patent medicine vendors (PMVs) and other community settings. Community volunteers, primarily PLHIV, will be supported to play active roles in peer adherence counseling, defaulter tracking and coordination of community support groups to improve retention in care for adults, adolescents and pediatric clients. Support groups will continue to be supported, so PLHIV can share common concerns and participate in decision-making to address issues common to PLHIV such as stigma and discrimination. These groups will now be used to help deliver differentiated care for patients within their community.

5.7 TB/HIV

The PEPFAR program will continue to prioritize TB/HIV activities to combat the dual infection of HIV and TB. This support will: focus on key interventions to maintain high rates of HIV testing among all TB cases; ensure universal ART for all PLHIV; ensure timely TB diagnosis and treatment completion; scale up TPT; and sustain joint TB/HIV programming and monitoring. These core TB/HIV interventions are key evidence-based approaches to achieving the UNAIDS 90-90-90 goals. The PEPFAR TB/HIV program will continue to work with the government and other key stakeholders in this regard.

In FY18 and FY19, PEPFAR will continue to focus on providing HTS to only registered TB patients in all sustained plus and sustained support LGAs. In COP 17, PEPFAR Nigeria will continue to support GeneXpert diagnosis, for improved TB yield in all sustained plus and sustained support LGAs.

Support will be provided for sputum transport logistics for GeneXpert tests and functionality of all supported GeneXperts will be ensured through integrated equipment maintenance and warranty renewal. Programming for TPT will be prioritized as well as TB infection prevention and control. The PEPFAR care and treatment program will continue to: scale up TPT; support the GON to review TB/HIV guidelines; develop systems and monitoring and evaluation tools; strengthen the INH logistics management systems; and monitor partner performance.

Efforts will be intensified to ensure contact tracing for all HIV positive patients diagnosed with TB, especially pulmonary TB cases. This will improve TB case detection among HIV patients and their households and will contribute to increased HTS uptake.

Priorities for commodity procurement will include provision of GeneXpert cartridges and INH through a coordinated logistics system, to avoid stock outs and wastage among implementing partners. Future efforts will focus on mentoring, supportive supervision and capacity building of care providers.

5.8 Adult treatment

The National Treatment Guidelines was revised in 2016 to reflect the 2015 WHO care and treatment recommendations, including “test and start”. Consequently, PEPFAR Nigeria will continue to implement “test and start” in the sustained response areas which began rolling it out in 2017.

PEPFAR will support treatment through differentiated models of care and treatment for stable and unstable HIV infected patients. Stable patients will receive multi-month scripting (three (3) month drug refills) and biannual doctors’ visits, whereas unstable patients will require frequent clinic visits for consultation, laboratory investigations, adherence support and drug refills. The newly supported models of care will improve treatment outcomes and create efficiencies within the PEPFAR budget. Using lessons learned on improved linkages in the scale-up LGAs, PEPFAR Nigeria will work with implementing partners to close the linkage gap in all sustained plus and sustained support LGAs with key interventions, as well as institute measures to strengthen and improve linkages in COP17 by ensuring that every positive client identified is immediately linked to treatment.

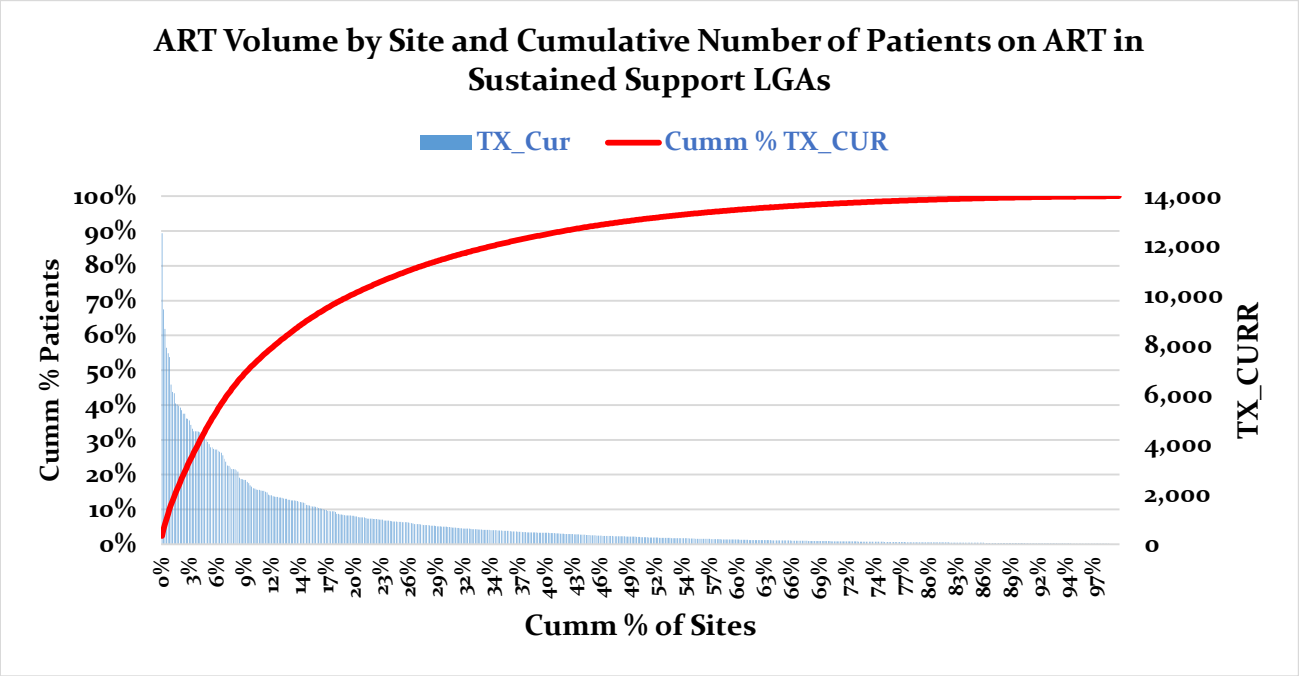
The treatment service delivery package includes: provision of ARVs; facility/community-based adherence monitoring; retention activities; and viral load assay to monitor treatment efficacy. The full service package for both sustained plus and sustained LGAs is specified below.

Service Package	
Clinical evaluation and assessment	✔
Assessment and management of TB and other OIs	✔
Provision of PHDP services	✔
Provision of ARVS and Cotrimoxazole	✔
Routine HIV testing for TB clients at existing TB/DOTS POS	✔
ART Monitoring using Viral Load	✔
Baseline CD4 for newly diagnosed HIV positive patients to inform further testing for OIs	✔
Facility & Community Retention & Medication Adherence Support	✔
Provision of EID services	✔
Referrals and linkages – social services, FP/RH	✔

ART Site Efficiency Analysis

In 2016, eighty percent of ART patients were seen in 28 percent (175) of PEPFAR supported ART sites in sustained plus and sustained support LGAs (Figure 5.8.1) whereas the remaining 20 percent of ART patients were see in the remaining 72 percent of sites (455). The patients being seen at the remaining 72 percent of the sites ranges between 0-766 of which nine (9) sites have less than 20 patients receiving ART (total number of patients in the nine (9) sites is 71). PEPFAR Nigeria will work with implementation partners and the GON to transfer the 71 patients in the nine (9) sites located in the sustained support LGAs to proximal high volume sites based on patient preference.

Figure 5.8.1 - ART site volume analysis



5.9 Pediatric Treatment

Pediatric Treatment services will be maintained in the sustained support LGAs and service delivery package includes: early identification of HIV infected children under 15 years of age and timely initiation on treatment; screening for TB and other opportunistic infections; provision of TB Preventive Therapy for eligible children; adherence support; optimization of ARVs; activities to improve retention of children in care and treatment such as co-scheduling appointments for parent-child pairs, making health facilities friendly for children and adolescents; and longitudinal tracking. The adoption of the "test and start" strategy Nation-wide provides opportunity for timely initiation of children on ART by removing the potential delays associated with use of CD4 count in determining eligibility for ART. The introduction of lopinavir/ritonavir pellets towards end of FY16 will result in availability of a more efficacious ARV regimen and in appropriate formulations for children under five (5) years old thereby resulting in better viral suppression rates in this age group. Review of the FY16 performance revealed that most of the pediatric ART enrolment were from high volume ART sites located in sustained support LGAs and that these sites still have potential to enroll more children on ART. Based on the lesson learned from the intensified pediatric case finding in selected sites in scale up LGAs in FY17, some high volume pediatric ART sites in sustained support LGAs located in the six (6) priority states and the FCT will be targeted to expand this initiative in COP17. Children on treatment will be prioritized for routine viral load monitoring and efforts will be made to ensure timely utilization of the results to inform the management of children not achieving viral suppression.

EID coverage is low in Nigeria due to poor identification of HIV exposed infants, poor linkage to EID services, long turnaround time from receipt of sample to issuance of results to facilities and inadequate human resources. In FY18, additional measures to address these challenges are to:

intensify screening of mother-infant pair across all service points to determine exposure status; strengthen CQI; strengthen the use of longitudinal registers to track mother-infant pairs; train and retrain clinical staff on DBS collection, transport and tracking; develop integrated sample referral transport and results return systems; and sustain advocacy to government to employ and/or deploy more laboratory scientists to the PCR laboratories.

5.10 OVC

In the Sustained plus LGAs, the OVC program will continue the scale up of services to conform to the geographic focus of the Nigeria program. The service delivery package will be consistent with the harmonized services and case management packages as outlined in the standard operating procedures for case management in OVC programing in Nigeria. Children will receive need-based and age-appropriate interventions including: support to access healthcare; HIV testing and counselling; linkages to treatment and adherence support for HIV positive children; nutrition assessments and counselling; caregiver and community capacity-building for parenting, early childhood development, child protection and household economic strengthening. Adolescents, especially girls with significant socio-economic vulnerabilities which can predispose them to HIV infection, will be targeted with interventions addressing school dropout, abuse, exploitation and HIV transmission.

In FY18, the program will improve access to health, education, protection, economic and psychosocial support services for children who are living with HIV, children affected by HIV and children who are vulnerable due to other causes within the sustained plus LGAs. Community-based OVC programs, using a case management approach, will provide household based services that will ensure family stability and increase household economic status of beneficiaries. Case managers will use the standardized case management approach which outlines the package of interventions as well as the roles and responsibilities of service providers and refer beneficiaries to other services where needed and when not available on site. Table 5.1.3 outlines the targets for OVC and linkages to HIV testing, treatment and care. Prevention messaging will target adolescent OVC, especially girls, with age and context appropriate messaging including linkages to adolescent-friendly reproductive health services. There will be a strong focus across the program on strategies to empower households and communities for better parenting and sustainable care and support to OVC. Strong facility-community referrals will be used to deliver services within the household and community, as a means of providing seamless facility and community services to HIV positive children within the community in which they reside.

In LGAs receiving sustained support, partners will focus on intensive household economic strengthening interventions. Households will be graduated out of the program in phases as household income rises. Partners will work with CSOs, and government ministries, departments and agencies (MDAs) in sustained support LGAs to seek alternative sources of support for OVC and their households still requiring support once transitioned out of PEPFAR OVC programs. In COP16, PEPFAR supported sustainability planning and monitoring of OVC service delivery partners for the transition of beneficiaries to other GON investments.

During SIMS visits, transition of girls to secondary school was identified as an area of weakness along with community-facility linkages (and vice-versa) for OVC service delivery. In FY18,

PEPFAR will build the capacity of local partners to identify and address issues related to the transition of girls to secondary schools and mitigate harmful community practices that increase adolescent vulnerability to HIV/AIDS while integrating gender considerations into all existing and new activities. Local partners will also strengthen facility-community linkage systems for improved OVC service delivery and scale-up of routine HIV testing of children of adult patients. Children identified as positive will be linked to health facilities for care and treatment, especially in scale-up LGAs.

Table 5.1.3 Targets for OVC and Linkages to HIV Services in Sustained Plus LGAs

SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY18Target) OVC_SERV	Target # of Active Beneficiaries Receiving Support from PEPFAR OVC Programs whose HIV Status is Known in Program Files (FY18 Target) OVC*
ak Essien Udim	11,929	2,447	2,325
ak Etinan	12,488	5,472	5,198
ak Ibesikpo Asutan	10,049	771	732
be Gboko	28,516	33,068	31,415
be Makurdi	20,292	52,914	50,268
be Ukum	16,362	36,559	34,731
cr Akamkpa	8,193	2,899	2,754
cr Akpabuyo	28,024	1,835	1,743
cr Odukpani	12,608	649	617
fc Gwagwalada	22,659	17,003	16,153
la Kosofe	47,249	4,653	4,420
na Nasarawa Eggon	16,106	9,980	9,481
ri Okrika	13,400	251	238
TOTAL	247,875	168,501	160,075

5.11Establishing service packages to meet targets in sustained districts

Outside the scale-up LGAs, enrolled patients will be maintained in care and treatment services. PEPFAR Nigeria will discontinue support for HTS and PMTCT sites reporting less than 12 positive individuals in the past year. In the sustained plus and sustained support LGAs, passive enrollment of patients into care and treatment services will continue for patients who request services or are in need of testing based on provider-screened symptomatology or the presence of opportunistic infections (OIs.) In addition, sustained plus LGAs will benefit from improved case finding through assisted partner notification, self-testing, and recency testing.

Patients enrolled in the program will be provided a minimum package of services. This package includes cotrimoxazole provision, periodic clinical assessments/monitoring, screening for OIs including TB, routine HIV testing at TB/DOTS centers and routine laboratory monitoring, including viral load monitoring. Baseline CD_4 count will be conducted to determine OI need but will not be a criterion for ART initiation. Selected community activities targeted at improving medication adherence and retention in care and treatment will be conducted. No patient will be denied treatment; therefore, persons requesting HIV testing or presenting with an OI will be

provided testing and treatment as needed. There will be no demand generation for testing and no active scale-up of care, treatment, HTS or PMTCT services in these areas. OVC currently served with core interventions in the sustained plus and sustained support LGAs, primarily household economic strengthening, capacity building of caregivers, and linkages to care and treatment, will continue to be supported through the end of FY18. Following improvement in household income levels, households in the program in these LGAs will be graduated out of the program in phases.

With one exception, HTS will be restricted to passive testing and linkage to care in PMTCT and ART sites as well as routine testing at TB DOTS centers. The exception will be HTS for key and military populations. KPs will be reached through targeted testing in the sustained plus and sustained support LGAs located in the six (6) plus one priority states.

The expected volume of patients needing the minimum package of services in the sustained LGAs has been calculated by LGA and summarized in Table 5.1.2. In FY18, the expected number tested at PMTCT sites was derived based on the assumption that these sites would continue to provide counseling and testing in ANC settings only at the client's request as well as when clinical symptomatology warrants. It is estimated that 30 percent of pregnant women in these LGAs will seek care in PEPFAR-supported facilities and be tested under these conditions. There will be no routine testing of women attending ANC in sustained plus and sustained support LGAs. Expected volumes for current on ART in the sustained plus and sustained support LGAs were derived using current program data and account for: (1) test and start strategy; (2) estimated loss to follow up; and (3) the anticipated decline in HTS services in these LGAs. PEPFAR Nigeria is estimating a seven (7) percent increase in sustained support LGAs and ten (10) percent in sustained plus LGAs in net new on treatment associated with passive enrollment as well as an increase inflow of testing resources from a few states and other donor supported sites. The GON occasionally conducts demand generation activities independent of PEPFAR; those patients may seek treatment at PEPFAR-supported facilities.

Finally, the number of OVC receiving the minimum package of services outlined above will decline gradually and the number of OVC households that will be graduated and no longer supported by PEPFAR will decline.

5.12Commodities

Stock-outs have been a rare occasion within Nigeria for HIV commodities and this holds true in both the scale-up and sustained locations. Spending on HIV rapid tests will continue to be monitored closely and while the focus on testing in the scale-up areas remains finding the number of positives to advance coverage levels – in the sustained areas the PEPFAR program will focus attention on program efficiencies that ensure patients are linked to care. In FY18, PEPFAR will no longer support the supply of PEPFAR-procured RTKs to health facilities that have been unable to identify more than one HIV positive patient a month (calculated as the average during FY16) in sustained support LGAs. The discontinuation is expected to save the US Government $1.5 million in RTK procurement and will allow implementing partners to focus on sites that are finding larger numbers of HIV positive patients that must be linked to treatment.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

The United States Government streamlined systems investments during COP16 planning and PEPFAR will continue to concentrate on the same key programmatic gaps in COP17. COP16 activities defined as most critical to addressing priority programmatic gaps and priority policies have made steady progress. COP17 benchmarks have been defined to further advance each of the activities to close major program gaps.

6.1 Critical Systems Investments for Achieving Key Programmatic Gaps

To maximize the efficient use of resources and achieve the targets within the time frame, the PEPFAR Nigeria team further optimized investments against gaps identified in the COP16 with some realignment of barriers within each gap:

Gap 1: Lower than expected number of HIV positive persons identified in the scale-up LGAs (1st 90) continues as a major gap and the progress and updates are as follows:

- **Barrier 1 - Existing data, including national and sub-national surveys and statistics, may not reflect accurate population estimates, sero-prevalence and HIV burden.** The lack of sero-prevalence data at a national and sub-national level continues to be a barrier. Steady progress has been made on the state level AIDS Indicator Surveys (AIS). New activities under the first barrier include expanding the state level AIS to a national survey; updating key population size estimates; and a characterizing adolescent HIV risk and burden.

- **Barrier 2 - Current approaches for testing are low yield:** Lab, HMIS and DHIS related activities have been moved into COP17 Table 6.3 because the activities address multiple gaps and barriers. The activities that remain include finalizing the evaluation of partner notification service testing which will conclude in early in FY18. New activities under this barrier include: piloting of recency testing, self-testing and implementation research on barriers to testing eligible children living with PLHIV.

- **Barrier 3 - Attitudes and cultural practices limit access and uptake of HIV testing services.** In COP17, this barrier will be addressed by service delivery partners who will continue to collate best practices to removing barriers to testing.

Gap 2: Recognizes too few of the identified PLHIV in the scale-up LGAs are enrolled and retained on treatment (2nd 90), which continues to be a gap. The progress and updates are as follows:

- **Barrier 1 - Insufficient scale of community ART - 95% of ART initiation is occurring in health facilities.** COP16 implementation strategies have increased the proportion of patients enrolled through community ART. Work with community health workers is moving forward and an update of the ART curriculum will be completed by the end of FY17. Evaluations of differentiated care models (community ART and multi-month scripting) have been designed and will also be completed in FY17.

- **Barrier 2 - Limited task-sharing among qualified cadre members in the 32 scale-up local government areas:** In COP16, service delivery partners were asked to help advance task-sharing among qualified healthcare workers in the 32 scale up LGAs and will largely be complete by COP17.

- **Barrier 3 - Strategies used for linkages and retention to services have not been optimized.** In FY17 PEPFAR will work to simplify and streamline procedures for newly diagnosed HIV patients, design a staggered appointment system and evaluate retention through differentiated care. Two (2) new activities will be to pilot specialized measures to improve adolescent retention.
- **Barrier 4 – Facility based patient fees for services negatively affect linkage and retention.** COP16 activities addressing this barrier are moving ahead and will improve access to HIV services in private health facilities and increase state-level resourcing for HIV services.

- **Barrier 5** – Data systems are insufficient to accurately identify and track linkage and retention of HIV positive individuals to services. Several activities are underway that will improve the national program's ability to track HIV service delivery and this work will be expanded in COP17, to improve tracking of new indicators related to viral load through the National Data Repository and real-time tracking of PMTCT services at additional health facilities.

Gap 3: Reflects the low uptake of viral load services for treatment monitoring in the scale-up LGAs (3rd 90), which continues to be a gap. The progress and updates are as follows:

- **Barrier 1 -A national strategic plan for scale-up of viral load access does not exist.** COP16 activities have moved ahead and already a draft PCR lab network has been designed, an integrated sample transport system is in the early phases of planning and the training on the use of DBS has been completed. Two (2) new activities in COP17 will further address this barrier, through a viral load surveillance system that provides a better depiction of overall viral suppression rates and monitoring of drug resistance.

- **Barrier 2 -There is low demand for viral load monitoring by service providers:** A sensitization of healthcare providers on the need for viral load monitoring of HIV patients is ongoing and will be completed in FY17.

- **Barrier 3 -There are poor transport systems and referral networks for viral load.** As noted above, activities have moved forward to scale-up viral load through not only a referral network but an integrated sample transport network.

- **Barrier 4 -There is inefficient use of resources available for PCR labs.** Many of the activities previously captured under this barrier which are underway in FY17 have now been moved to Section 6.3 of COP17 but will continue to be supported. New activities under this

barrier include evaluating the determinants of virologic outcomes and optimizing the existing labs to potentially consolidate equipment and ensure it is used efficiently.

6.2 Critical Systems Investments for Achieving Priority Policies

Test and start and new and efficient service delivery models continue to be the policy priorities. Nigeria has adopted the latest WHO guidelines to advance the national treatment guidelines to include test and start with support from PEPFAR. Differentiated care models commenced in COP16 are being deployed and evaluated and in COP17 an emphasis will be placed on same-day initiation.

6.3 Proposed system investments outside of programmatic gaps and priority policies.

All other systems investments listed in Table 6.3 address multiple barriers and gaps and have been deemed crucial to maintaining the program.

7.0 USG Management, Operations and Staffing Plan to Achieve Stated Goals

The PEPFAR Nigeria team conducted an analysis and assessment of programmatic alignment of staff and the ability to successfully implement the PEPFAR business model. Through the OU assessment of interagency business processes as well as interagency partner management and technical leadership, gaps were identified in technical leadership/management, strategic information, testing, and care and treatment. To meet these needs, the OU is repurposing seven positions and adding five new positions:

Technical leadership and management

Due to the breadth of the Walter Reed Program Nigeria (WRP-N), it is necessary to add a deputy for programs. This position will serve as deputy and senior technical advisor to the country director. S/he shares oversight responsibilities for the design, development and implementation of PEPFAR related technical program activities and has direct responsibility for day-to-day coordination of WRP-N's technical and administrative management activities that implement or support PEPFAR. Duties and responsibilities include program design, planning, monitoring and evaluation, supervision of technical staff and oversight of cooperative agreements. The position works closely with the country director to ensure that all program activities contribute to measurable results that are in accordance with WRP-N regulations, PEPFAR strategic objectives, international ethical guidelines and standards for public health care.

USAID will repurpose a Health Advisor (U.S. Personal Services Contractor) position to a Tuberculosis and Resource Mobilization Group Leader (Foreign Service Officer) position. The incumbent will oversee the design and implementation of site/system-level activities to improve the diagnosis, treatment, and notification of HIV/tuberculosis co-infections as part of USAID's overall support for tuberculosis control. In addition, the incumbent will lead efforts for the entire PEPFAR program to increase Nigeria's own political and financial commitments in advancing and sustaining the country's HIV response.

Strategic Information

PEPFAR is highly dependent on data for decision making. Robust data reviews inform and validate geographic prioritization and target setting; such data analyses are also used to conduct periodic detailed reviews of program execution to ensure alignment of implementation with the COP plans. The most up to date epidemiologic and programmatic data is used to determine if additional pivots are required. In light of the continually increasing demands for data, the OU will repurpose two positions and requests three new positions for strategic information.

CDC will reprogram an ASPPH fellow position to an LE surveillance position as well as an LE biomedical prevention position to Health Management Information Systems (HMIS). The surveillance position will facilitate analysis of the level of HIV infection in the population and trends in HIV infection levels for purposes of decision-making. Duties and responsibilities focus on working with USG partners to develop, implement and strengthen survey and disease activities funded through PEPFAR that accomplish the desired outcomes; the position is responsible for providing technical expertise and assistance to the Ministry of Health (MOH) and other partners in the design, implementation and strengthening of routine disease surveillance systems and the conduct of large, complex surveys designed to measure HIV prevalence and other indicators of importance to evaluating the impact of HIV control programs. The HMIS position is responsible for strengthening information systems within the context of the in-country HIV/AIDS programs supported through PEPFAR; provides technical leadership for reporting systems and works at a program management level to collaborate with the Ministry of Health and other HIV/AIDS partners in the development and strengthening of data, information systems and software that will improve data flow from the sub-national to the national level of the host country; provides the USG team, Ministry of Health, and other implementing partners technical recommendations and expertise in the design, development, improvement, and maintenance of information systems that strengthen health service effectiveness and efficiency.

WRP-N plans to add two new LE monitoring and evaluation positions to develop and lead M&E activities within WRP-N and support the Nigerian Ministry of Defense. The position holders will develop and implement strategies and systems that will ensure effective monitoring and evaluation of all program and HIV/AIDS related activities; use appropriate technologies to integrate data collection, processing, and reporting, in a manner that enhances the use of the information for improving patient and program outcomes. At a technical level, the incumbent will ensure appropriate, high quality implementation of these systems and evaluate program results on a regular basis. The incumbent also works with WRP-N partners at both implementer and national levels to quantify progress towards targets set for PEPFAR and the national HIV response. S/he will support all interagency PEPFAR Nigeria monitoring and evaluation activities, improving PEPFAR Nigeria program's data quality through capacity building for USG partners, data quality assessments (DQA), and periodic feedback to improve program performance.

USAID will add a Strategic Information Advisor (Foreign Service National) position to focus on two areas of work that will benefit the entire PEPFAR program. First, the incumbent will develop and implement new practices to collect, manage, analyze, and use expenditure data throughout the year to identify and address outliers and improve efficiencies in supporting service delivery. Second, the incumbent will lead efforts to collaborate with the NACA and Federal Ministry of

Women's Affairs and Social Development to establish a management information system for social services targeting orphans and vulnerable children. The incumbent will also contribute to data analyses for annual operational planning and quarterly consultations.

HIV Testing Services

Considering the challenges that the program faces in identifying HIV positive persons in the priority local government areas, it has become apparent that the country program needs to focus more resources on developing and implementing innovative HIV testing strategies that will yield the greatest number of positive persons and linking them to treatment. In response to the gaps in testing and linkage, CDC will repurpose one USDH position from a public health advisor (cooperative agreement management) to a behavioral scientist focusing on innovative approaches to improve HIV Testing Services (HTS) and linkage to care. In addition, with the adoption of nationwide test and start, a CDC LE position will be repurposed from PMTCT to HIV testing to ensure adequate focus on targeted testing. These positions will contribute to developing, implementing, monitoring and evaluating HIV testing and counseling programs; provide leadership in promoting the use of internationally recognized best practices in HTS provision across PEPFAR sponsored programs in Nigeria; ensure that project implementation addresses program strategic objectives; provide program and administrative management; coordinate and collaborate with other PEPFAR agencies; and ensure collaboration among PEPFAR partners involved in HTS and treatment programs.

Care and Treatment Services

Treatment is the priority program area for PEPFAR. To strengthen our programmatic focus on implementation of new strategies including test and start, differentiated models of care, and other innovative approaches to reach the treatment targets, USAID will repurpose two positions and add one new position.

USAID will repurpose a Foreign Service National position, from a Senior Laboratory Manager to a Clinical Laboratory Manager, for the benefit of the entire PEPFAR program. The incumbent will guide implementing partners in the recruitment, training, deployment, and supervision of laboratory staff. As part of such guidance, the incumbent will oversee the development and implementation of quality assurance/quality control procedures for point-of-care HIV rapid testing as well as the collection and processing of other specimens (for assays such as HIV recency, early infant diagnosis, and viral load). The incumbent will also guide the use of information systems, interpretation of laboratory results, and improvement of operating procedures.

Based on existing talent among Nigerian logisticians, USAID will repurpose a Commodities Advisor position, from a Resident-hire U.S. Personal Services Contractor to a Foreign Service National mechanism, which will benefit the entire PEPFAR program. The incumbent will oversee the implementation of selected components in the Procurement and Supply Management program. These include the pilots and gradual introduction of self-testing, HIV recency testing, and dolutegravir-based antiretroviral treatment regimens as well as commodities for the national and state AIDS Indicator Surveys.

USAID will add a Care and Treatment Program Manager (Foreign Service National) position that will benefit the entire PEPFAR program. The incumbent will manage one or more implementing mechanisms to improve HIV positivity yield as well as linkage to and retention on treatment in facility and community settings. The incumbent will identify, adapt, and scale-up promising innovations from applied research and/or "positive deviants" in programming to increase antiretroviral treatment coverage among certain age/sex sub-populations with relatively higher levels of unmet need.

APPENDIX A

SNU Prioritization

Table A.1

Scale-Up LGAs	COP15 Prioritization	APR16 Achievement	COP16 Prioritization	Expected Achievement by APR17	COP17 Prioritization	COP17 Target (APR18)
ak Ikot Ekpene	Scale-up Sat	61.30%	Scale-up Sat	74%	Scale-up Sat	86%
ak Okobo	Scale-up Agg	7.60%	Scale-up Agg	15%	Scale-up Agg	21%
ak Oron	Scale-up Sat	48.60%	Scale-up Sat	69%	Scale-up Sat	87%
ak Uruan	Scale-up Sat	21.90%	Scale-up Sat	36%	Scale-up Agg	49%
ak Uyo	Scale-up Sat	64.90%	Scale-up Sat	40%	Scale-up Sat	84%
be Buruku	Scale-up Agg	27.90%	Scale-up Agg	36%	Scale-up Agg	45%
be Gwer West	Scale-up Agg	20.70%	Scale-up Agg	30%	Scale-up Agg	38%
be Katsina-Ala	Scale-up Agg	71.70%	Scale-up Agg	49%	Scale-up Sat	115%
be Konshisha	Scale-up Sat	27.00%	Scale-up Sat	39%	Scale-up Agg	61%
be Logo	Scale-up Sat	39.60%	Scale-up Sat	59%	Scale-up Agg	77%
be Tarka	Scale-up Sat	65.70%	Scale-up Sat	83%	Scale-up Sat	100%
be Ushongo	Scale-up Agg	18.20%	Scale-up Agg	20%	Scale-up Agg	33%
cr Calabar Municipal	Scale-up Sat	66.30%	Scale-up Sat	82%	Scale-up Sat	95%
cr Calabar South	Scale-up Sat	43.80%	Scale-up Sat	67%	Scale-up Sat	89%
fc Abuja Municipal Area Council	Scale-up Sat	33.90%	Scale-up Sat	34%	Scale-up Agg	44%
fc Bwari	Scale-up Sat	43.60%	Scale-up Sat	53%	Scale-up Agg	69%
la Agege	Scale-up Sat	25.10%	Scale-up Sat	44%	Scale-up Agg	62%
la Ajeromi-Ifelodun	Scale-up Agg	23.80%	Scale-up Agg	30%	Scale-up Agg	36%
la Alimosho	Scale-up Agg	6.60%	Scale-up Agg	10%	Scale-up Agg	12%
la Apapa	Scale-up Sat	15.00%	Scale-up Sat	26%	Scale-up Agg	35%
la Ifako-Ijaiye	Scale-up Agg	25.40%	Scale-up Agg	34%	Scale-up Agg	43%
la Ikeja	Scale-up Agg	116.60%	Scale-up Agg	128%	Scale-up Sat	150%
la Mushin	Scale-up Agg	105.10%	Scale-up Agg	109%	Scale-up Sat	112%
la Surulere	Scale-up Agg	7.30%	Scale-up Agg	13%	Scale-up Agg	19%
na Doma	Scale-up Agg	38.60%	Scale-up Agg	48%	Scale-up Agg	63%
na Karu	Scale-up Agg	53.80%	Scale-up Agg	69%	Scale-up Sat	92%
na Lafia	Scale-up Agg	50.60%	Scale-up Agg	61%	Scale-up Agg	78%
na Nasarawa	Scale-up Agg	49.10%	Scale-up Agg	16%	Scale-up Sat	82%
na Obi	Scale-up Agg	59.40%	Scale-up Agg	16%	Scale-up Agg	75%
ri Eleme	Scale-up Agg	4.90%	Scale-up Agg	10%	Scale-up Agg	14%
ri Obio/Akpor	Scale-up Sat	27.90%	Scale-up Sat	39%	Scale-up Agg	49%
ri Port-Harcourt	Scale-up Agg	65.90%	Scale-up Agg	42%	Scale-up Sat	85%

APPENDIX A

Table A.2 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	**Total PLHIV**	**Expected Current on ART (APR FY 17)**	**Additional Patients Required for 80% ART Coverage**	**Target Current on ART (APR FY18) TX_CURR**	**Newly Initiated (APR FY 18) TX_NEW**	**ART Coverage (APR 18)**
Attained	-	-	-	-	-	-
Scale-Up Saturation	103,273	48,467	40,967	94,097	21,894	85%
Scale-Up Aggressive	414,684	169,128	172,901	180,544	53,484	49%
Sustained Plus	155,993	71,538	67,640	84,478	20,890	54%
Sustained	2,728,901	479,927	1,739,721	590,475	171,440	22%
Central Support	-	-	-	-	-	-
Commodities (if not included in previous categories)	-	-	-	-	-	-
Total	**3,402,851**	**769,060**	**2,021,229**	**949,594**	**267,708**	**28%**

B.1 Planned Spending in COP 2017

B.1.1 Total Funding Level				
Applied Pipeline	**New Funding**	**Total Spend**		
$ 131,869,754	**$ 251,744,527**	**$ 383,614,281**		
Table B.1.2 Resource Allocation by PEPFAR Budget Code				
PEPFAR Budget Code	**Budget Code Description**	**New Funding**	**Applied Pipeline**	**Total Amount Allocated**
MTCT	Mother to Child Transmission	$ 5,654,970	$ 10,139,155	$ 15,794,125
HVAB	Abstinence/Be Faithful Prevention	$ -	$ -	$ -
HVOP	Other Sexual Prevention	$ 2,525,957	$ 6,050,753	$ 8,576,710
IDUP	Injecting and Non-Injecting Drug Use	$ -	$ -	$ -
HMBL	Blood Safety	$ -	$ -	$ -
HMIN	Injection Safety	$ 275,000	$ -	$ 275,000
CIRC	Male Circumcision	$ -	$ -	$ -
HVCT	Counseling and Testing	$ 32,512,119	$ 4,172,336	$ 6,684,455
HBHC	Adult Care and Support	$ 15,626,004	$ 6,623,137	$ 22,249,141
PDCS	Pediatric Care and Support	$ 5,666,883	$ 256,782	$ 5,923,665
HKID	Orphans and Vulnerable Children	$ 30,579,344	$ 24,725,666	$ 55,305,010
HTXS	Adult Treatment	$ 26,163,581	$ 32,957,802	$ 59,121,383
HTXD	ARV Drugs	$ 82,489,065	$ 14,940,226	$ 97,429,291
PDTX	Pediatric Treatment	$ 2,740,499	$ 847,272	$ 3,587,771
HVTB	TB/HIV Care	$ 8,549,384	$ 1,690,595	$ 10,239,979
HLAB	Lab	$ 4,189,337	$ 4,662,485	$ 8,851,822
HVSI	Strategic Information	$ 13,152,111	$ 6,067,247	$ 19,219,359
OHSS	Health Systems Strengthening	$ 4,775,500	$ 2,000,000	$ 6,775,500
HVMS	Management and Operations	$ 16,844,772	$ 16,736,298	$ 33,581,070
TOTAL		**$ 251,744,527**	**$ 131,869,754**	**$ 383,614,281**
***Central Funding - $12,200,00**				

c. Section 6 Tables: Systems Investments

Table 6.1.1 Key Programmatic Gap #1: FIRST 90 – there is a lower than expected number of HIV positive persons identified in the thirty-two scale-up local government areas (LGA)										
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Year One (COP 16) Annual Benchmark**	**Status Update on Year One Annual benchmark**	**Year Two (COP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Proposed COP 2017**	**Budget Code(s)**	**Activity Budget Amount**	**Associated IM Mech. ID**	**Relevant SID Element and Score (if applicable)**
Barrier One: Existing data, including national and sub-national surveys and statistics, may not reflect accurate population estimates, sero-prevalence and HIV burden	**Outcome 1:** More realistic estimates through AIDS indicator surveys or expanded evaluations completed in the thirty-two scale-up local government areas (reports disseminated).	CDC AIDS Indicator Surveys (AIS)- Nassarawa State	State government engaged Pre-data collection activities on-going	Nasarawa State AIS completed and reports disseminated in FY18.	1. Study Protocol Developed and IRB Clearance obtained 2. Research assistants identified and trainined 3. Pilot conducted 4. Data collection concluded 5. Data Analysis& Report concluded 2. Technical report finalized and disseminated	Survey activities concluded and report written.	HVSI	$ 1,000,000.00	AFENET	Element 13: Epidemiological and Health Data - **SID Score: Yellow**
		USAID AIDS Indicator Surveys (AIS) New State	Will be reprogrammed to National AIS.				HVSI	~~$2,500,000~~	~~FHI360~~	
		CDC AIDS Indicator Surveys -Kaduna State AIS	Data collection on-going, will be completed in FY17	Activity will be completed in FY17.			HVSI	~~$500,000~~	~~AFENET~~	
		USAID AIDS Indicator Surveys - Akwa Ibom AIS	Data collection on-going, will be completed in FY17	Activity will be completed in FY17.			HVSI	~~$500,000~~	~~FHI360~~	
		CDC AIS in Priority SNUs (Benue State)	Will be reprogrammed to National AIS.				HVSI	~~$1,293,750~~	~~AFENET~~	
		USAID AIS in Priority SNUs	Will be reprogrammed to National AIS.				HVSI	~~$646,875~~	~~FHI360~~	
		New Activity	**New Activity**	Final study Protocols developed Protocol Clearance Obtained Data collection commemced in 2 of 6 regions/states - based on phased implentation Preliminary Regional reports available for 2 regions	# of regions where data collection has commenced # of regions with preliminary reports available	National AIDS Impact Surveys	HVSI	$ 11,014,806	CDC TBD 2	
		New Activity	**New Activity**	Surveys conducted and reports drafted.	Survey conducted (Y/N); reports drafted (Y/N)	KP size estimates for 7 states	HVOP	$ 400,000.00	UMB	Element 13: Epidemiological and Health Data - **SID Score: Yellow**
		New Activity	**New Activity**	Characterization conducted and reports drafted.	Characterization conducted (Y/N); reports drafted (Y/N)	Characterization of adolescent and young people aged 18 - 30 done, to determine HIV risk and burden, and also to inform on intervention scale.	HVOP	$ 250,000.00	UMB	Element 13: Epidemiological and Health Data - **SID Score: Yellow**

Key Systems Barrier	Outcomes expected after 3 years of investment	Year One (COP 16) Annual Benchmark	Status Update on Year One Annual benchmark	Year Two (COP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Proposed COP 2017	Budget Code(s)	Activity Budget Amount	Associated IM Mech. ID	Relevant SID Element and Score (if applicable)
Barrier Two: Current approaches for testing are low yield	**Outcome 1:** improved efficiencies for testing	Program evaluation completed and findings and recommendations related to testing approaches shared.	• Initial stakeholder consultations with IPs, FMOH, USG HTS TWG; and conducted baseline assessment of PNS in Nigeria, including IP survey and data request • PNS working group with IPs, FMOH, and USG HTS TWG established • Piloted M&E tools and conducted additional training.	Based on the findings and recommendations from the evaluation, GON will be supported to develop a National PNS Strategy by December 2017. The evaluation will be conducted and evaluation report in FY18, after PNS has gone to scale in Nigeria.	• Draft concept note for evaluating PNS scale-up activities submitted to USG HTS TWG and USAID/W • Evaluation activities conducted • Hold final project evaluation meeting with IPs to review data and evaluation outcomes • Write final evaluation report • Present evaluation outcomes at final project wrap-up meeting with key stakeholders	Program evaluation done to determine best practices for testing with a particular focus on index patient testing and contact tracing. (Also addresses Prog. Gap 2: Barrier 3)	HVSI	$ 400,000.00	JHPIEGO MCSP	Element 6: Service Delivery **SID Score: Red**
	Outcome 2: PEPFAR supported labs have gained accreditation recognition for quality performance	Moved to Table 6.3					~~HLAB~~	~~$1,060,059~~	~~Various partners~~	Element 10: Laboratory (Emphasis on Lab Quality Monitoring, Viral Infrastructure and Capacity of Laboratory Workforce - **SID Score: Yellow**
							~~HLAB~~	~~$332,273~~	~~IHVN~~	
							~~HLAB~~	~~$241,425~~	~~IHVN, APIN,~~	
							~~HLAB~~	~~$318,775~~	~~APIN B~~	
							~~HLAB~~	~~$531,532~~	~~Various partners~~	
							~~HTXS~~	~~$312,897~~	~~Various partners~~	
							~~HLAB~~	~~$65,591~~	~~IHVN~~	
	Outcome 3: improved targeted testing among persons more likely to be infected	**New Activity**	**New Activity**	1. Results of Pilot of the use of incidence testing (using rapid incidence assay technique) used to inform HIV case finding methods in all Priority LGAs	Number of priority LGAs implementing standardized procedure for recency testing in target populations	Pilot the use of Recency Testing (using rapid incidence assay technique) to identify recent infections in target populations (ANC, KP, and ADYW) to prioritize them for partner/contact tracing, testing and linkage to treatment	HLAB	$ 250,135.00	CDC-TBD	Element 6: Service Delivery - **SID Score: Red**
		New Activity	**New Activity**	2. Results of Pilot of the use of Self-Testing in target populations (ANC, KP,ADYW) used to inform testing approaches in all priority LGAs	Number of priority LGAs implementing standardized procedures for self-testing in target populations	Pilot the use of Self-Testing in target populations (ANC, KP,ADYW) as a testing approach to reach sexual partners and spouses of index cases for testing and linkages to treatment as necessary.	HLAB	$ 200,314.00	EQUIP/ Kethimpilo	
		New Activity	**New Activity**	Study conducted and report released	Availability of report	Operations research into enhancers/barriers to testing eligible children of adult PLHIV in care and treatment	HVCT	$ 500,000.00	University of Maryland Baltimore	
		Moved to Table 6.3					~~HVSI~~	~~$1,500,000~~	~~MEASURE~~	Element 15: Performance Date –
		CDC support to GoN on DHIS dashboard and capacity building for data analytics and data use.	Beta version/Demo Dashboard developed and running Dec 2016.	Activity will be completed in FY17.			~~HVSI~~	~~$800,000~~	CDC TBD	
Barrier Three: Attitude and cultural practices (norms and community structures) limit access to and uptake up of HIV testing services by persons more likely to be infected	**Outcome 1:** Improved uptake of HIV testing services enabled by support from community gate keepers	No benchmarks were established beyond meeting testing targets.	Partners are on track to meet testing targets.	Partners to expand testing in under-served areas with high seropositivity, by addressing community gatekeepers.	Increased of seropositivity compared to APR16.	Addressed through service delivery partners (does not require a system investment)	N/A	$ -	N/A	Element 6: Service Delivery - SID Score: Red
TOTAL								**$13,291,431**		

Table 6.1.2 Key Programmatic Gap #2: SECOND 90 – too few identified PLHIV in the thirty-two scale-up local government areas (LGA) are enrolled and retained in HIV treatment										
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Year One (COP 16) Annual Benchmark**	**Status Update on Year One Annual benchmark**	**Year Two (COP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Proposed COP 2017**	**Budget Code(s)**	**Activity Budget Amount**	**Associated IM Mech. ID**	**Relevant SID Element and Score (if applicable)**
Barrier One: Insufficient scale of community ART - 95% of antiretroviral therapy (ART) initiation is occurring in health facilities	**Outcome 1:** Larger patient population served through community ART	**1:** Work with the Community Health Extension Workers Registration Board (CHEWRB) to review and update current integrated in-service training curriculum for CHEWs in line with the new WHO recommended guidelines– Quarter 1; **2:** Support CHEWs institutions in scale-up states (Benue, Nasarawa, Lagos, Akwa-Ibom, Cross-River, Rivers and FCT) to adopt and implement new/updated curriculum – Quarter 2; **3:** Facilitate the training of CHEWs in 7 scale-up states – Quarter 2-4;	• Update of CHEW training curricula to incorporate new policies of Test and Start and Differentiated Service Delivery Models (DSDM) – completed in Q1; • Support for the adoption of new curricula in CHEWs training institutions in SU LGAs - ongoing; • Pilot training – completed in Q2; • Training of Trainers – completed in Q2; • Training of CHEWs in 7 scale-up LGA states - Pending Q2 -Q4	Activity will be completed in FY17.			~~OHSS~~	~~$690,000~~	~~CCCRN~~	Element 7: Human Resource for Health – **SID Score: Yellow**
	Outcome 2: Identification and standardization of the most efficient models of community ART. Efficiency is defined by cost and ability to serve the greatest number of recipients with high quality service	**1:** Study Protocol Developed and IRB Clearance obtained by March 2017; **2:** Data collection completed by Sep 2017	Protocol developed FMOH team engaged Implementing teams constituted	Activity will be completed in FY17.			~~HVSI~~	~~$400,000~~	~~CDC TBD~~	Element 6: Service Delivery - **SID Score: Red**
Barrier Two: Limited task-sharing among qualified cadre members in the thirty-two scale-up local government areas	**Outcome 1:** Increased capacity of clinics to manage more patients with the same staff strength.	Dissemination, implementation and monitoring of the national task-sharing policy in the thirty-two scale-up local government areas	Comprehensive care and treatment partners are advancing task-shifting in the 32 LGAs; particularly at refill sites assisting with multi-month scripting.	Activity will be completed in FY17.						

Table 6.1.2 Key Programmatic Gap #2: SECOND 90 – too few identified PLHIV in the thirty-two scale-up local government areas (LGA) are enrolled and retained in HIV treatment										
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Year One (COP 16) Annual Benchmark**	**Status Update on Year One Annual benchmark**	**Year Two (COP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Proposed COP 2017**	**Budget Code(s)**	**Activity Budget Amount**	**Associated IM Mech. ID**	**Relevant SID Element and Score (if applicable)**
Barrier Three: **S**trategies used for linkages and retention to services have not been optimized	**Outcome 1:** Simplify and streamline the current standard operating procedures for newly diagnosed HIV positive patients	In-service Training program to support the development of Test and Start and New Models of Service Delivery curriculum and roll-out of training for Community Health Extension Workers (CHEWs) in prioritized LGAs. (same as above)	• Update of CHEW training curricula to incorporate new policies of Test and Start and Differentiated Service Delivery Models (DSDM) – completed in Q1; • Support for the adoption of new curricula in CHEWs training institutions in SU LGAs - ongoing; • Pilot training – completed in Q2; • Training of Trainers – completed in Q2; • Training of CHEWs in 7 scale-up LGA states - Pending Q2 -Q4	Activity will be completed in FY17.			OHSS	$ -	CCCRN	Element 7: Human Resource for Health – **SID Score: Yellow**
	Outcome 2: Reduced patient waiting times; Increased clinic through-put	Design and implement an improved staggered appointment system	Comprehensive care and treatment partners are advancing this at high volume sites.	Activity will be completed in FY17.				$ -	N/A	**Element 6: Service Delivery- SID Score: Red**
	Outcome 3: Increase in proportion of identified patients linked to care and treatment	Program evaluation of linkage and retention of patients through differentiated models of care shared.	· Developed and implemented a MMD protocols (in combination with community-based ART models, such as community pharmacies or PMV and CSGs) · Study SOP developed · Request for Ethical clearance completed	Activity will be completed in FY17.			HVSI	$ -	EQUIP (HOP funded)	
		New Activity	**New Activity**	1. Feasibility Study Completed 2. MHealth intervention launched 3. Evaluation completed	1. # of active participants on mHealth platform (through posts, comments and reactions to comments by type); 2. Proportion of participating youth self-reporting adherence to treatment on mHealth platform; 3. Proportion of participating youths that are still retained in clinical HIV services 12 months after enrolment.	A study to examine acceptance, demand and practicability of enrolling young PLHIV enrolled in treatment unto mHealth platforms designed to improve adherence.	HKID	$325,000	Youth Power Action/FHI360	
	Outcome 4: Improved yield from HIV testing streams among children and adolescents and improved linkage to treatment among children and adolescents	**New Activity**	**New Activity**		1. Number of children and adolescents newly diagnosed with HIV from all testing streams 2. Proportion of newly disgnosed HIV postive children and adolescents linked to antiretroviral treatment	Pilot intensified case finding in children and adolescents in selected high volume pediatric ART sites. Optimize enrolment of children and adolescent on ART in these sites, strengthen linkage and retention through QI collaboratives.	PDTX	$ 300,000.00	HRSA	

Table 6.1.2 Key Programmatic Gap #2: SECOND 90 – too few identified PLHIV in the thirty-two scale-up local government areas (LGA) are enrolled and retained in HIV treatment										
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Year One (COP 16) Annual Benchmark**	**Status Update on Year One Annual benchmark**	**Year Two (COP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Proposed COP 2017**	**Budget Code(s)**	**Activity Budget Amount**	**Associated IM Mech. ID**	**Relevant SID Element and Score (if applicable)**
Barrier Four: Facility-based patient fees for service negatively affect linkage and retention	**Outcome 1:** ~~*Successfully monitored patient fees for services*~~ Increased HIV/AIDS service coverage **(Revised Outcome to what is within the manageable interest of the PEPFAR program)**	Modified COP16 benchmark: Increased availability of privately funded HIV services in private for-profit and public health facilities	1. Lagos & Rivers states selected for SFI interventions 2. IP engaged to implement private sector component 3. Workplan for year 1 developed, reviewed and approved (November 11, 2016) 4. Assessment ongoing to identify potential health facilities & community pharmacies that will be engaged	Additional revenues generated by private health providers for HIV/AIDs prevention, care and treatment	1. Number of clients receiving ART services from Private Health Facilities 2. Number of Antiretroviral pick up visits to Community Pharmacies 3. Number of Public/Private Partnership contracts established with private laboratories 3. Percentage of private health facilities/Community Pharmacies/ Laboratories reporting health data into the Government of Nigeria database 4. Return on SFI investments	**Activity 1:** Private sector strengthening **Activity 2:** Leveraging the role of licensed pharmacists for test & start **Activity 3:** Support proliferation of public private partnerships		$ -	~~*N/A*~~ FHI360 - HOP Funding (request for support to more States)	
	Outcome 2: Modified outcome in COP17 - Increased domestic resource mobilization for HIV/AIDS programs	Advocacy plan developed to ensure inclusion of HIV/AIDS services (PMTCT & HTC) in health insurance benefit package	1. Lagos & Rivers states selected for SFI interventions 2. IP engaged to implement public sector component 3. Workplan for year 1 developed, reviewed and approved (January 13, 2017) 4. Kick off meeting with stakeholders planned for February 3, 2017	Health insurance benefit package expanded to include HIV/AIDS services (PMTCT & HTC)	1. Actuarial analysis of HIV care and treatment completed 2. Data available to inform the development advocacy plan for the expansion of benefit package 3. Number of HIV/AIDS services included in the State scheme benefit package (PMTCT and HCT)	**Activity 1:** Benefit package expansion **Activity 2:** Support to state health insurance core implementation team		$ -	Abt Associates/ HFG (HOP funded)	**Element 11: Domestic Resource Mobilization - SID Score: Red**

Table 6.1.2 Key Programmatic Gap #2: SECOND 90 – too few identified PLHIV in the thirty-two scale-up local government areas (LGA) are enrolled and retained in HIV treatment										
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Year One (COP 16) Annual Benchmark**	**Status Update on Year One Annual benchmark**	**Year Two (COP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Proposed COP 2017**	**Budget Code(s)**	**Activity Budget Amount**	**Associated IM Mech. ID**	**Relevant SID Element and Score (if applicable)**
Barrier Five: Data systems are insufficient to accurately identify and track linkage and retention of HIV positive individuals to services	**Outcome 1:** Improved linkage of identified patients to care and treatment services	Moved to Table 6.3					~~HVSI~~	~~$1,500,000~~	~~MEASURE~~	Element 15: Performance Date – Focus on Timeliness, Analysis and Quality of Service data - SID Score: Yellow
	Outcome: Enhanced demand for and use of data through the DHIS dashboard	CDC support to GoN on DHIS dashboard & capacity building for data analytics and data use.	Beta version/Demo Dashboard developed and running Dec 2016	Completed Activity			~~HVSI~~	~~$ -~~	~~UMB~~	
	Outcome 2: Improved accounting of private-sector services for patients receiving HIV services	Increased private sector resources available for HIV services	1. Lagos & Rivers states selected for SFI interventions 2. IP engaged to implement private sector component 3. Workplan for year 1 developed, reviewed and approved (November 11, 2016) 4. Health facilities & community pharmacies identified & engaged	1. Total market approach for HIV services developed 2. Private sector led procurement of ARVS established	1. Number of clients receiving ART services from Private Health Facilities 2. Number of Antiretroviral pick up visits to Community Pharmacies 3. Number of Public/Private Partnership contracts established with private laboratories 4. Percentage of private health facilities/Community Pharmacies/ Laboratories reporting health data into the Government of Nigeria database 5. Return on SFI investments	**Activity 1:** Private sector strengthening **Activity 2**: Leveraging the role of licensed pharmacists for test & start **Activity 3:** Support proliferation of public private partnerships	SFI	$ -	SIDHAS (HOP funded)	
	Outcome 3: Improved tracking of patients who are tested through PEPFAR services, but enrolled in services by another program	Integration of VL and PMTCT indicators into National Electronic Health Data Repository has commenced	About 65% and 75% of HIV treatment facilities in sustained and scale up LGA are on-board the national electronic helath data repository	VL and PMTCT indicators have been integrated into National Electronic Health Data Repository and reporting has commenced	Indicators have been integrated (Y/N)	Introduce VL and PMTCT indicators into National Electronic Health Data Repository for use Program Management	HVSI	$2,000,000	UMB	**SID Score: Yellow**
		Modified COP16 benchmark: 80% of clients on treatment in scale-up LGAs and 40% of clients on treatment in sustained LGAs are covered by NDR	1. 65% and 75% of HIV treatment facilities in sustained and scale up LGA are on-board the national electronic health data repository 2. Interactive dashboard developed to enable data analysis and visualization	100% of clients on treatment in scale-up LGAs and 60% of clients on treatment in sustained LGAs are covered by NDR	% of clients on treatment who are covered by NDR	Expand NDR to cover more treatment clients				
		Real time monitoring support deployed in 260 out of 2,781 HFs in the scale up LGAs.	New PMTCT Activity for COP - Previously Centrally-funded	Real time monitoring support deployed in 2,700 out of 2,781 HFs in the scale up LGAs.	# of HFs in scale-up LGAs where real time monitoring support is deployed	Scale-up PMTCT option B+ monitoring to cover more sites that are eligible for real time monitoring.	MTCT	$474,400	TBD	
COP17 total:								**$ 3,099,400**		

Table 6.1.3 Key Programmatic Gap #3: THIRD 90 - there is a low uptake of viral load services for treatment monitoring in the thirty-two scale-up local government areas (LGA)										
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Year One (COP16) Annual Benchmark**	**Status Update on Year One Annual benchmark**	**Year Two (COP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Proposed COP 2017 Activities**	**Budget Code**	**Activity Budget Amount**	**Associated IM Mech. ID**	**Relevant SID Element and Score (if applicable)**
Barrier One: A national strategic plan for scale-up of viral load access does not exist	**Outcome 1**: At least 95% of supported clincs and labs have functional integrated sample referral system **Outcome 2:** Viral load services provision are standardized, consistent and coordinated, and accessible at all levels of care	GON develops and adopts a national strategic plan for scale-up of viral load access	Completed	Activity will be completed in FY17.			HLAB	~~$ 87,250~~	~~FHI360, IHVN, APIN, MSH, CIHP~~	Element 10: Laboratory (Emphasis on Lab Quality Monitoring, Viral Infrastructure and Capacity of Laboratory Workforce - **SID Score: Yellow**
		A national strategic plan for viral load access is disseminated and implemented	Completed	Activity will be completed in FY17.						
		Integrated sample referral system is piloted in 32 priority LGAs	Sample transport network designed.	At least 50% of supported clincs and labs have functional integrated sample referral system	Proportion of supported treatment sites have lab samples picked up and taken to lab using an integrated model. Pilot of integrated sample shipment process in Lagos, Benue, Nassarawa, and Akwa Ibom. Completed by the end of quarter 2 of FY17	Integrated Sample Transfer for Viral Load, EID and TB samples from Hub sites to PCR and GeneXpert laboratories and return of results within defined turn-around-time	HLAB	$ 1,480,000	Global Health Supply Chain Program	
		45% of Labopratory Scientis and other Lab staff are skilled and proficient in viral load testing using plasma/DBS samples in PEPFAR supported PCR Labs	Training and mentoring of service providers is on-going.	At least 95% of laboratory scientists and other lab staff in 5100% of supported PCR Labs are skilled and proficient in Viral load testing using plasma/DBS	Proportion of Lab scientists in supported PCR labs who are proficient in Viral load testing using Plasma and DBS sample types	Training, mentorship, and Expansion of DBS for viral load testing; with Technical Assistance from ILB-Atlanta	HLAB	$ 85,000 $ 30,000 $ 47,812 $ 21,250 $ 15,938	CDC TBD CDC TBD FHI360 HJF USAID Comp TBD	
		New Activity	**New Activity**	100% (3) of the HIV Drug resistance monitoring labs are coordinated as part of a network to provide data	Proportion of Patients with VL>1000 copies/ml after EAC tested for Drug Resistance	Coordination of HDRM Labs & HIV Drug Resistance Testing for Patients with VL >1000 copies/ml after Enhanced	HLAB	$ 106,667 $ 40,000 $ 13,333	CDC TBD FHI360 USAID Comp TBD	
Barrier Two: There is low demand for viral load monitoring by service providers	**Outcome 1:** Viral load assay is routinely and efficiently used by providers for HIV treatment monitoring and tracking of viral load suppression	Survey - KAP Survey on the use of VL for monitoring treatment by clinicians and lab service providers as a precursor for increasing demand for Viral load testing in Priority LGAs	Protocol completed and submitted for IRB approval; implementation plan under development; and data collection anticipated in Q3 and report in Q4 of FY17.	Activity will be completed in FY17.			~~HLAB~~	~~$ 25,000~~	~~APIN~~	
	Outcome 2: 1 hub site established in each of the 6 PEPFAR-supported geopolitical regions	**New Activity**	**New Activity**	Set up 1 hub site with 8 satellite sites linked into hub Improved linkage within sites and increase VL uptake	Functional hub established # of sites linked into hub Clinical cascade data from participating sites	Fosters the development of peer networks and communities of practice that increase provider satisfaction Trains healthcare workers while they remain at their posts, reducing costs related to travel and limiting time away from seeing patients Offers the opportunity to address operational and program priorities, including laboratory support and supply chain management	HTXS	$ 37,500 $ 300,000 $ 50,000 $ 12,500	FHI360 CDC TBD HJF USAID Comp TBD	

Table 6.1.3 Key Programmatic Gap #3: THIRD 90 - there is a low uptake of viral load services for treatment monitoring in the thirty-two scale-up local government areas (LGA)										
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Year One (COP16) Annual Benchmark**	**Status Update on Year One Annual benchmark**	**Year Two (COP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Proposed COP 2017 Activities**	**Budget Code**	**Activity Budget Amount**	**Associated IM Mech. ID**	**Relevant SID Element and Score (if applicable)**
Barrier Three: There are poor transport systems and referral networks for viral load	**Outcome 1:** Laboratory services for Viral load, EID, and GeneXpert are being optimized	A mapping of PCR labs and health facilities is being used to inform sample referrals for Viral load, EID , and GeneXpert samples in an efficient manner	GIS mapping of PEPFAR supported Treatment/PMTCT sites, PCR sites and GeneXpert sites have been accomplished using Llamisoft software. The data is currently being updated.	Activity will be completed in FY17.			HLAB	$ -		Element 10: Laboratory (Emphasis on Lab Quality Monitoring, Viral Infrastructure and Capacity of Laboratory Workforce - **SID Score: Yellow**
	Outcome 2: A GON coordinated and led robust network of tiered laboratories is providing viral load assays and other related laboratory services, as well as support disease surveillance in a cost effective manner.	Moved to Table 6.3					~~HLAB~~	~~$ 350,000.00~~	~~APHL~~	
	Outcome 3: Viral load samples collected and referred for testing through the referral network are consistently meeting the standard requirement for sample quality	Viral load samples collected and referred for testing through the referral network are consistently meeting the standard requirement for sample quality.	Lab staff and other health care workers are being trained sample collection on an ongoing basis.	Activity will merge into GHSC integrated sample transport activity above and will focus on training related to sample processing, shipment, storage and handling.			~~HLAB~~	~~$ 50,400.00~~	~~IHVN, APIN, FHI360, MSH, CIHP, FGHIN, DoD~~	
	Outcome 4: An integrated sample referrals network system for viral load, EID, and TB samples is efficiently used to provide access to lab services	Merged into activity in Table 6.3					~~HLAB~~	~~$ 100,000.00~~	~~DoD~~	
	Outcome 5: Viral load, EID, and GeneXpert services are optimized, and test results are delivered to care providers in good time for efficient clinical care	A single mechanism is responsible for viral load and EID, sample pick-up from health facilities and shipment to labs, and return of test results within acceptable turn-around-time	The process of engaging a single mechanism (GHSC) for sample shipment is on-going.	Activity will be completed in FY17.			~~HLAB~~	~~$ 150,000.00~~	~~IHVN~~	
	Outcome 6: Quality of VL reagents consistently maintained through the logistics chain	Develop Lab Logistics Management Information System (LMIS) plan and begin first coordinated distribution.	Lab LMIS developed with SOPs & deployed to PCR labs	Activity will be completed in FY17.			~~HTXS~~	~~$ 1,200,000.00~~	~~GHSC~~	Element 10: Laboratory (Emphasis on Lab Quality Monitoring, Viral Infrastructure and Capacity of Laboratory Workforce - **SID Score: Yellow**

Table 6.1.3 Key Programmatic Gap #3: THIRD 90 - there is a low uptake of viral load services for treatment monitoring in the thirty-two scale-up local government areas (LGA)										
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Year One (COP16) Annual Benchmark**	**Status Update on Year One Annual benchmark**	**Year Two (COP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Proposed COP 2017 Activities**	**Budget Code**	**Activity Budget Amount**	**Associated IM Mech. ID**	**Relevant SID Element and Score (if applicable)**
Barrier Four: There is inefficient use of resources available for PCR labs	**Outcome 1:** Determinants of virological outcome in children available to guide program implementation	**New Activity**	**New Activity**	Study conducted and report released	Availability of report	Evaluation of determinants of virological outcome among pediatric patients on ART	PDTX	$400,000.00	UMB	
	Outcome 1: Supported PCR laboratories are fully optimized and are meeting or surpassing service delivery and quality performance	Merged into activities in Table 6.3					~~HLAB~~	~~$ -~~		~~Element 10: Laboratory (Emphasis on Lab Quality Monitoring, Viral Infrastructure and Capacity of Laboratory Workforce - **SID Score: Yellow**~~
	Outcome-2: All supported PCR Labs are implementing continuous quality improvement program, including increased capacity utilization, and reduced turn-around-time for result delivery to health facilities						~~HLAB~~	~~$ -~~		
	Outcome-3: All supported PCR labs and lab staff are performing at the required proficiency level						~~HLAB~~	~~$ -~~		Element 6: Service Delivery - **SID Score: Red**
	Outcome-4: Supported PCR labs in priority LGAs are adequately staffed and are providing viral load services at optimal level	Merged with activity below (outcome 6)					~~HLAB~~	~~$ 99,000.00~~	~~IHNV, APIN, FHI360, DoD~~	
	Outcome-5: All biosafety cabinets in supported labs are certified annually and are providing the needed biosafety protection to lab staff and the patients accessing the labs	Moved to Table 6.3					~~HLAB~~	~~$ 48,004.00~~	~~IHVN~~	
	Outcome-6: Host facilities management and lab staff are leading laboratory optimization efforts and are meeting or surpassing performance targets	Host facilities management and lab staff are leading laboratory optimization efforts and are meeting or surpassing performance targets	Stakeholders meetings on viral load scale-up and coordination have started in Abuja, with FMOH, WHO, and CHAI participating in addition to USG IPS. Other states in planning phase.	Will be covered through the new activities below.			~~HLAB~~	~~$ -~~	~~CDC TBD, FHI360, MSH, DOD~~	
		New Activity		1- 95% of eligible PLHIV have Viral load testing within the last 12 months 2- 95% of HIV test results are provided within 10day	Coverage of VL testing of PLHIV enrolled on ART.	Consolidation of PCR Labs for increased Viral Load testing efficiency: Activities would include: 1- Assessment of lab spaces and determination of		$ 200,000	CDC TBD	
								$ 66,667	HJF	
								$ 33,333	USAID Comp TBD	
							HLAB	$ 100,000	FHI360	
		New Activity		95% of supported PCR labs in priority LGAs are adequately staffed and are providing viral load services at optimal level	# of Viral load tests reported by PCR facility relative to its PEPFAR target	Personnel Support to PCR Labs in Priority LGAS for VL and EID Scale-up	HLAB	$ 125,000	CDC TBD	
								$ 70,312	FHI360	
								$ 31,250	HJF	
								$ 23,438	USAID Comp TBD	
TOTAL								**$ 3,290,000**		

Table 6.2.1 : Key Policy Gap : Test and Start										
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Year One (COP16) Annual Benchmark**	**Status Update on Year One Annual benchmark**	**Year Two (COP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Proposed COP 2017 Activities**	**Budget Code**	**Activity Budget Amount**	**Associated IM Mech. ID**	**Relevant SID Element and Score (if applicable)**
Barrier One: While PEPFAR has been given special approval by the Ministry of Health to implement the policy in the thirty-two scale-up local government areas (LGA), the policy cannot be implemented outside this specific geographic region		**Outcome 1**: Within the next six to nine months, the GON formally adopts the new WHO Test and START recommended guidelines for HIV testing and initiation for the national HIV/AIDS response	New guidelines have been written and disseminated in March 2017.	Activity has been completed.			N/A	$ -	N/A	Element 6: Service Delivery
Barrier Two: There isn't a rapid response plan for the drafting and adoption of new recommended guidelines			PEPFAR partners are helping sites adopt the new guidelines.	Activity has been completed.			N/A	$ -	N/A	Element 6: Service Delivery
Barrier Three: There isn't a rapid response plan for the dissemination and implementation of the new recommended guidelines		**Outcome 1:** Within the next six to nine months, the GON develops a rapid response plan for the dissemination and implementation of national Test and START guidelines	In Q1 developed national response plan for the dissemination and implementation of new Test and Start policy; supported stakeholders engagement - National ART Task Team and State Action Committee on AIDS (SACA); production and dissemination of new/updated guidelines to facilities in 7 scale-up states will bec completed by the end of FY17.	Activity has been completed.			~~OHSS~~	~~$ 100,000.00~~	IHVN	Element 6: Service Delivery
		Outcome 2: Tracking site-by-site implementation in the thirty-two PEPFAR-supported scale-up local government areas (LGAs) as proof of concept; transmitting the lessons learned for national implementation	The PEPFAR team is having ongoing discussions with the GON on the positive impact of the early implementation of test and start in the scale-up LGAs. In addition the team plans to call partners and the GON together for a day long consultation on differentiated models of care and treatment (including shortening timelines for newly diagnosed patients under test and start). The team will also support the Federal Ministry of Health to conduct a study on test and start implementation.	Activity will be completed by the end of FY17.			N/A	$ -	N/A	**SID Score: Red**

Table 6.2.1 : Key Policy Gap : Test and Start										
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Year One (COP16) Annual Benchmark**	**Status Update on Year One Annual benchmark**	**Year Two (COP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Proposed COP 2017 Activities**	**Budget Code**	**Activity Budget Amount**	**Associated IM Mech. ID**	**Relevant SID Element and Score (if applicable)**
Barrier Four: There are inadequate financial resources for a national roll-out of Test and START	65% increase in state government financing-for testing and treatment.	**Outcome 1:** *Modified outcome* - Increased capacity of state level structures to sustainably plan & execute resource mobilization strategies for HIV/AIDS service delivery to fully implement test and start. Sustainable Finance Initiative (SFI) central funding will address this outcome in Lagos & Rivers states. COP17 funding will address this outcome in Akwa Ibom, Benue, Cross River, FCT & Nassarawa states plus DOD	1. Lagos & Rivers states selected for SFI interventions 2. Partner selected based on scope and workplan kicked off in February 2017	50% increase in domestic resource mobilized for HIV/AIDS activities at the state and local levels	1. Percentage (and absolute monetary value) increase in public budget allocation to HIV/AIDS programming 2. Percentage (and absolute monetary value) increase in public expenditure to HIV/AIDS programming	Using information from health accounts and HIV sub accounts, advocate for more resources dedicated to the health sector and HIV in additional states. This will also include evaluating and addressing inefficiencies in budgetary execution.	OHSS	$1,800,000.00	Health Finance and Governance Project	Element 11: Domestic Resource Mobilization
					1. Number of clients receiving ART services from Private Health Facilities 2. Number of Antiretroviral pick up visits to Community Pharmacies 3. Number of Public/Private Partnership contracts established with private laboratories 4. Percentage of private health facilities/Community Pharmacies/ Laboratories reporting health data into the Government of Nigeria database 5. Return on SFI investments	Support for DRM strategy in additional states - to support use of private pharmacies or diagnostic labs.	~~OHSS~~	~~$ -~~	TBD partner for TA in coordination with comprehensive service delivery partners (funded under target based budgeting)	Element 11: Domestic Resource Mobilization
	Continuous activity to ensure state-level ownership and coordination of HIV/AIDS commodities Supply chain	**Outcome 2:** Improved methods and processes for budget planning for HIV testing and initiation	1. LMCUs operational in 36+1 states 2. 75% of the states to produce at least one Quarterly Stock Status report		1: Quarterly Stock Status reports submitted on the 15th of the following month 2: LMCUs collecting and collating facility level logistics data 3: LMCUs submitting bi-monthly orders for re-supply	Support Logistics Management Coordination Units (LMCUs) to provide feedback to state governments on the total cost of commodities in the state.	OHSS	$ 483,000.00	GHSC	Element 11: Domestic Resource Mobilization
TOTAL								**$ 2,283,000**		

Table 6.2.2 Key Policy Gap : New and efficient service delivery models										
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Year One (COP16) Annual Benchmark**	**Status Update on Year One Annual benchmark**	**Year Two (COP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Proposed COP 2017 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Associated IM Mech. ID**	**Relevant SID Element and Score (if applicable)**
Barrier One: While PEPFAR has been given special approval by the Ministry of Health to implement the policy in the thirty-two scale-up local government areas (LGA), the policy cannot be implemented outside this specific geographic region		**Outcome 1**: Within the next six to nine months, the GON formally adopts the new WHO recommended guidelines for efficient HIV/AIDS service delivery models in the national HIV/AIDS response	Completed			Addressed through service delivery partners (does not require a system investment)	N/A	$ -	N/A	Element 6: Service Delivery **SID Score: Red**
Barrier Two: There isn't a rapid response plan for the drafting and adoption of new recommended guidelines		PEPFAR partners are helping sites adopt the new guidelines.	Will be completed by the end of FY17.			Addressed through service delivery partners (does not require a system investment)	N/A	$ -	N/A	Element 6: Service Delivery **SID Score: Red**
Barrier Three: There isn't a rapid response plan for the dissemination and implementation of the new recommended guidelines		**Outcome 1:** Within the next six to nine months, the GON develops a rapid response plan for the dissemination and implementation of national guidelines for efficient HIV/AIDS service delivery models	Completed			Addressed through service delivery partners (does not require a system investment)	N/A	$ -	N/A	Element 6: Service Delivery
		Outcome 2: Tracking of site-by-site implementation in the thirty-two PEPFAR-supported scale-up local government areas (LGAs) as proof of concept; transmitting the lessons learned for national implementation	Completed			Addressed through service delivery partners (does not require a system investment)	N/A	$ -	N/A	SID Score: Red
		Outcome 3: Working through the national professional cadres on implementing fully the existing task shifting policies and changing norms	Will be completed by the end of FY17.			Addressed through service delivery partners (does not require a system investment)	N/A	$ -	N/A	

Table 6.2.2 Key Policy Gap : New and efficient service delivery models										
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Year One (COP16) Annual Benchmark**	**Status Update on Year One Annual benchmark**	**Year Two (COP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Proposed COP 2017 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Associated IM Mech. ID**	**Relevant SID Element and Score (if applicable)**
Barrier Three: There isn't a rapid response plan for the dissemination and implementation of the new recommended guidelines	Sites providing multi-month scripting have <5% stock-outs; reduced timeframe between site reporting and control tower decision making on distribution and procurement.	**Outcome 4:** Change in the SOPs of the national supply chain systems for forecasting, procurement, warehousing and distribution Outcomes expected are comparable stock-out rates (currently low) in sites using the new multi-month scripting versus those not using the new standard operating procedures in sustained LGAs. Please note: this budget is not exclusively for the change in SOPs, it does address the wider support on LMIS but it contributes to the achievement of this outcome.	1. Digital data collection from 30% of PEPFAR supported sites this FY 2. Co-host system design workshop on multi-scripting and community ART 3. Justification for COP17: PEPFAR is working with the GF, BMGF, UNICEF to develop an integrated LMIS for health commodities in Nigeria. UNICEF has already made considerable investments with the Microsoft Enterprise software: NAVISION. The GF is funding the dashboard output for the national and state "control towers" while GHSC-PSM will digitalize site-level LMIS	Multi-month scripting mainstreamed into supply logistics operation with sites submitting re-supply information electronically.	1: HIV/AIDS LMIS database established at the national and state levels within the LMCUs 2: One National HIV/AIDS System Review Workshop conducted 3: SOP for the new system implementation developed and disseminated	The Logistics Management Information System (LMIS) technical assistance on data collection directly contributes to the achievement of the 90-90-90 goals by ensuring timely and accurate data on stock availability influences procurement and distribution plans.	OHSS	$ 1,250,000.00	GHSC	
	Warehouses upgraded to hold stock levels suitable for multi-month scripting.	Upgrades to warehouses - Kaduna Completed. Abuja and Lagos to be completed next FY	Upgraded and furnished warehouses by APR 17	Upgrade two additional warehouses for storage of commodities.	Upgraded and furnished warehouses by APR 17	Upgrading military regional warehouses to support the 6 monthly prescriptions.	OHSS	$ 200,000.00	DOD HJF	**SID Score: Red**
		Outcome 5: Adequately prepared for the new needs for monitoring and evaluating	Will be completed by service delivery partners by the end of FY17 (shifted to bi-weekly or monthly reporting of cascade indicators).					$ -	N/A	
TOTAL								**$ 1,450,000**		

Table 6.3 : Other Proposed Systems Investments										
Activity	Addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control.	Outcomes expected after 3 years of investment	Year One (COP16) Annual Benchmark	Status Update on Year One Annual benchmark	Year Two (COP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Budget Code	Activity Budget Amount	Associated IM Mech. ID	Relevant SID Element and Score (if applicable)
Human Resources for Health (HRH): Personnel Costs for Service Delivery										
In-service training - Strengthening military training institutions to support in-service trainings	All three 90-90-90 goals.	Trained and skilled HCWs to provide HIV diagnosis, care and treatment	In-service trainings conducted.	Completed			~~OHSS~~	~~$ 422,000.00~~	~~DoD-HJF~~	Element 7: HRH **SID Score: Yellow**
Supply Chain Management Pre-Service Training in Nigerian Universities and In-Service Training for selected GON officials critical to the National Supply Chain	All three 90-90-90 goals.	Supply chain staff within GON trained.	Mentorship plans concuded, supply chain training will conclude by the end of FY17.	Will be completed by the end of FY17.			~~OHSS~~	~~$ 250,000.00~~	~~GHSC~~	
HRH incentive fund to strengthen linkage and retention across the clincal cascade							OHSS	$ 600,000.00	Strengthening HIV Field Epidemiology, Infectious Disease Surveillance, and Lab Diagnostics Program (SHIELD)_1976	
Sub-total HRH								**$ 600,000**		
Laboratory										
Integrated Sample Transfer for Viral Load, EID and TB samples from Hub sites to PCR and GeneXpert laboratories and return of results within defined turn-around-time	This activity addresses first-90, second 90, and third-90.	Combined with activity under TB.					~~HLAB~~		~~GHSC~~	Element 10: Laboratory (Emphasis on Lab Quality Monitoring, Viral Infrastructure and Capacity of Laboratory Workforce - **SID Score: Yellow**
Laboratory Maintenance and equipment mangement for all supported 22 PCR Labs for EID and Viral load.	This activity addresses first-90, second 90, and third-90.	At least 95% of supported PCR Laboratories provided un-interrupted EID and viral load services with no major equipment down-time or service interruption	At least 95% of supported PCR Laboratories provided un-interrupted EID and viral load services with no major equipment down-time or service interruption	1-95% of supported PCR Laboratories provided un-interrupted EID and viral load services with no major equipment down-time	At least 95% of supported PCR Laboratories provided un-interrupted EID and viral load services with no major equipment down-time or service interruption	Proportion of supported PCR laboratories that provided uninterrupted EID and VL services	HLAB	$ 578,200.00	CDC TBD	
							HLAB	$ 289,110	FHI360	
							HLAB	$ 96,370	HJF	
							HLAB	$ 96,370	USAID Comp TBD	
Laboratory Maintenance and equipment mangement for all supported 352 clinical labs for HIV testing/repeat testing and CD_4 assays. This includes National Reference, and EQA Labs	This activity addresses first-90, second 90, and third-90.	At least 95% of supported clinical Laboratories provided HIV testing/repeat testing and CD_4 assays	At least 95% of supported clinical Laboratories provided HIV testing/repeat testing and CD_4 assays	95% of supported PCR Laboratories provided un-interrupted EID and viral load services with no major equipment down-time	At least 95% of supported clinical Laboratories provided HIV testing/repeat testing and CD_4 assays	Proportion of supported clinical Laboratories that provided HIV testing/repeat testing and CD_4 assays	HLAB	$ 2,436,795	CDC TBD	
							HLAB	$ 672,238	FHI360	
							HLAB	$ 188,122	HJF	
							HLAB	$ 318,150	USAID Comp TBD	
							HLAB	$ 282,183	CaTSS	
Continuous quality Improvement program for EQA-Proficiency Testing, Quality management Implementation for Viral load and EID/CD_4 assay, and TB geneXpert Labs	This activity addresses first-90, second 90, and third-90.	At least 95% of the supported PCR labs (22), and clinical labs (352), and geneXpert Labs (148), are implementing Continuous Quality Improvement program; and are achieving required performance standards (90% or more on lab audit)	At least 95% of the supported PCR labs (22), and clinical labs (352), and geneXpert Labs (148), are implementing Continuous Quality Improvement program; and are achieving required performance standards (90% or more on lab audit)	1. At least 95% of the supported PCR labs (22), and clinical labs (352), and geneXpert Labs (148), are implementing Continuous Quality Improvement program; and are achieving required performance standards	At least 95% of the supported PCR labs (22), and clinical labs (352), and geneXpert Labs (148), are implementing Continuous Quality Improvement program; and are achieving required performance standards (90% or more on lab audit)	Proportion of PEPFAR supported PCR/Clinical/GeneXpert Lab audited and received score 90% or more	HLAB	$ 135,236	FHI360	
							HLAB	$ 45,079	USAID Comp TBD	
							HLAB	$ 36,630	HJF	
							HLAB	$ 18,315	CaTSS	
							HLAB	$ 675,163	CDC TBD	

Activity	Addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi	Outcomes expected after 3 years of investment	Year One (COP16) Annual Benchmark	Status Update on Year One Annual benchmark	Year Two (COP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Budget Code	Activity Budget Amount	Associated IM Mech. ID	Relevant SID Element and Score (if applicable)
Laboratory										
Continuous quality Improvement program for: HIV testing Quality Improvement Initiative in all HIV testing points in the priority LGAs	This addresses first-90	100% of HTS sites are enrolled into HIV Rapid Testing Quality Improvement Initiative (RTQII)	At least 45% of HTS sites in the Priority LGAs are enrolled into HIV-Rapid Testing Quality Improvement Initiative (RTQII).	2. At least 45% of HTS sites in the Priority LGAs are enrolled into HIV-Rapid Testing Quality Improvement Initiative (RTQII).	At least 80% of HTS sites in the Priority LGAs are enrolled into HIV-Rapid Testing Quality Improvement Initiative (RTQII).	Proportion of HTS sites enrolled in RTQII	HLAB	$ 175,882	FHI360	Element 10:
							HLAB	$ 535,998	CDC TBD	
							HLAB	$ 58,627	USAID Comp TBD	
							HLAB	$ 29,493	HJF	
		At least 95% of HIV testing sites are scoring 90% or more on standard audit	Of sites enrolled in RTQII, at least 95% are scoring 90% or more on standard audit		Of sites enrolled in RTQII, at least 95% are scoring 90% or more on standard audit	Proportion of enrolled HIV testing sites with standard audit score of 90% or more	HLAB			
Continuous quality Improvement program: Repeat testing for the validation of positives before inititation into ART	This addresses first-90	95% of newly identified HIV positive cases are validated through a repeat testing prior to ART initiation	At least 45% of HIV positive cases are validated through a repeat testing prior to ART initiation	3. At least 45% of HIV positive cases are validated through a repeat testing prior to ART initiation	At least 75% of HIV positive cases are validated through a repeat testing prior to ART initiation	Proportion of newly initiated into ART with validated HIV positive result	HLAB	$ -		
Lot Testing and Post Market Validation(PMV) for HIV Rapid Test Kits and GeneXpert Cartridges (in collaboration with Global Fund)	This addresses first-90, and second-90	At least 95 % of each batch of procured HIV rapid test kits are subjected to post market validation before distribution to health facilities for use	At least 95 % of each batch of procured HIV rapid test kits are subjected to post market validation before distribution to health facilities for use	At least 95% of each procured batch of HIV Rapid test kits are subjected to Post market validation before use	At least 95% of each procured batch of HIV Rapid test kits are subjected to Post market validation before use	Proportion of procured batches of RTK validated before distribution for use,	HLAB	163,412	CDC TBD	
		At least 95% of each batch of procured GeneXpert cartridges are subjected to post market validation before distribution to health facilities for use	New activity in COP17		At least 45% of each batch of procured GeneXpert cartridges are subjected to post market validation before distribution to health facilities for use	Proportion of procured batches of GeneXpert cartridges validated before distribution for use,	HLAB			
Biosafety Cabinets and ancillary PCR equipment (pipittes, centrifuges) calibrations and certification program. This activity includes: Training and deployment of local bioengineers to sites for callibration/certification of viral load and EID testing ancillary equipment	This addresses first-90, second-90, and third-90	1- At least 95% of supported PCR/TB labs have callibrated and certified biosafety cabinets and other ancillary equipment for viral load and EID test	At least 20% of supported labs have callibrated/ certified biosafety cabinets and other ancillary equipment for viral load and EID tests	At least 20% of supported labs have callibrated/ certified biosafety cabinets and other ancillary equipment for viral load and EID tests	At least 50% of supported labs have callibrated/ certified biosafety cabinets and other ancillary equipment for viral load and EID tests	Proportion of suppotred PCR/TB labs with functional, callibrated, and certified biosafety cabinets and ancillary lab equipment	HLAB	200,000	CDC TBD	
		At least 30 bioengineers have been certified to service and certify biosafety cabinets	**New activity in COP17**	New Activity	At least 10 bioengineers from USG IP/GON are trained and certified to service biosafety and ancillary equipment for PCR labs	# of Trained bioengineers that are certified to service and certify biosafety cabinets	HLAB			
Biosafety Assessment of PCR Labs and Biosafety improvement activities (Technical assistance from CDC-International Lad Branch)	This addresses system level laboratory safety issues	At least 11 supported PCR labs in priority LGAs meet minimum Biosafety standards	**New activity in COP17**	New Activity	At least 75% of supported PCR labs in priority LGAs meet minimum Biosafety standards	Proportion of assessed labs that meet minimum biosafety standards	HLAB	$ 40,000	CDC TBD	
							HLAB	$ 37,500	FHI360	
							HLAB	$ 20,000	HJF	
							HLAB	$ 12,500	USAID Comp TBD	
International Technical Assistance support for Lab Systems strengthening (APHL, ASM, ASLM)	This addresses first-90, second-90, and third-90	Standardized procedure for the optimization of GeneXpert developed and implemented in at	**New activity in COP17**	New Activity	Standardized procedure for the optimization of GeneXpert developed in implemented in at least 95% of	Proportion of PEPFAR-supported GeneXpert sites with standard procedure	HLAB	$ 100,000	ASM	
							HLAB	$ 50,000	ASLM	
							HLAB	$ 100,000	APHL	
		Training of 30 biomedical engineers facilitated by ASLM	**New activity in COP17**	New Activity	Training of 10 biomedical engineers facilitated by ASLM	# of biomedical engineers trained	HLAB	See budgets above	See partners above	
		At least 95% of supported PCR and clinical labs are operating optimally within a network	Roles and responsibilities of each level of lab within network defined		At least 95% of supported PCR labs and 50% of clinical labs are operating optimally within a network	Proportion of PCR and clinical labs operating within a network	HLAB	See budgets above	See partners above	
Decommissioning of obselete/retired laboratory Equipment in supported sites	This addresses human and environmental safety in supported labs.	A national policy on equipment retirement and decommissioning is developed; and obselete/retired lab equipment and decommissioned from at least 95% of supported labs	**New activity in COP17**	New Activity	Policy on equipment retirement and decommissioning is being implemented in at least 45% of supported sites	Proportion of supported labs where equipment retirement/decommissioning has been implemented	HLAB	-		
Sub-total Laboratory								**$ 7,391,373**		

Table 6.3 : Other Proposed Systems Investments										
Activity	**Addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control.**	**Outcomes expected after 3 years of investment**	**Year One (COP16) Annual Benchmark**	**Status Update on Year One Annual benchmark**	**Year Two (COP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Budget Code**	**Activity Budget Amount**	**Associated IM Mech. ID**	**Relevant SID Element and Score (if applicable)**
Strategic Information										
Establishment of Routine Program Data Validation and Data Quality Assessments -	All three 90-90-90 goals.	Data quality assessement conducted for sample of sites from all comprehensive service delivery	Data quality assessement conducted for sample of sites from all comprehensive service	DQA ongoing.	Data quality assessement conducted for sample of sites from all comprehensive service delivery partners annually.	Annual DQA Reports submitted	HVSI HVSI HVSI	$ 400,000 $ 400,000 $ 100,000	UMB MEL HJF	Element 9: Quality Management
Roll out of DHIS 2.0 in military health facilities	All three 90-90-90 goals.	Functional DHIS 2.0 in all military health facilities	1: Develop Standard Operating Procedures for military routine program data validations and data quality assessments by end of Q1 FY17 2: Modules for data validation and data analysis for the military DHIS 2.0 created by end of Q1 of FY17.	On-going Procurements	Will be completed in FY18		HVSI HVSI	150,000	HJF	
Strengthen the Nigeria Health Management Information System (NHMIS)	All three 90-90-90 goals.	Functional (user friendly, complete reporting, and usable by government staff) data reporting system established	1. Establishment MFL TWG2. Determination MFL data elements 3. Harmonized HMIS data collection tools	MFL TWG established; data elements for MFL and Heatlh Facility Registry established; and guidance for harmonization of the existing 17 MFLs developed.	1. Updated and validated MFL incorporated into the national District Health Information System (DHIS 2) platform.2. SOP developed for MFL implementation3. Advisory committee (HDCC), led by FMOH/DHPRS, to guide the implementation of the harmonized health 4. Review of DHIS interoperability between DHIS and DATIM	Availability of SOP; TWG meeting reports; # of people trained on use of DHIS	HVSI	1,500,000	MEASURE Eval	
SI17 RV 329 Study	All three 90-90-90 goals.	Impact of clinical practices, biological factors and socio-behavioral issues on HIV infection and disease progression in an African context.	Annual progress reports on Nigeria component of multi-year, multi-country study.	RV329 Study, First enrollments completed currently protocol ammendments	Annual progress reports on Nigeria component of multi-year, multi-country study.	Evaluation of the impact of clinical practices, biological factors and socio-behavioral issues on HIV infection and disease progression in an African context. Progress report shared at APR 17	HVSI	450,000	HJF	
A study of epidemiology and immunological interactions between helminth infections, HIV and TB	All three 90-90-90 goals.	Report completed and disseminated	New activity in COP17	Ongoing IRB review	Report completed and disseminated	Study implementation, data analysis and report writing.	HTXS	$0	DoD-HJF	
Nigeria HIV Quality Program (NigQual)	All three 90-90-90 goals.	Establish a functional national CQI system that includes: National, state and facility level CQI team Routine reporting of quality	Comprehensive treatment facilities in scale up LGAs have functional CQI system and linked and routinely reports through Nigeria Qual software	Activty to be comleted by the end of FY17.	NOT APPLICABLE	ACTIVITY TO BE DISCONTINUED IN FY18	HVSI	~~$400,000.00~~		Element 9:
Strengthening the deployment and use of management information system at NMOD of existing grant closing out this fiscal year.	All three 90-90-90 goals.	Strengthened management information system at military health facilities	Timely reporting of sites.	Sites have reported on a timely basis with this support.	Timely reporting of sites.	Strengthened management information system at military health facilities by end of FY 17	HVSI	822,000	HIFASS	
Sub-total Strategic Informtion								**3,822,000**		

Table 6.3 : Other Proposed Systems Investments										
Activity	**Addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control.**	**Outcomes expected after 3 years of investment**	**Year One (COP16) Annual Benchmark**	**Status Update on Year One Annual benchmark**	**Year Two (COP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Budget Code**	**Activity Budget Amount**	**Associated IM Mech. ID**	**Relevant SID Element and Score (if applicable)**
Institutional and Organizational Development										
The 4Children interagency TA mechanism supports **USAID and CDC partners** to improve case management, sustainability planning and engagement, Household Economic Strengthening and parenting and adolescent programming. In COP 17 this TA mechanism will further strenghten the investments in case management by providing demand-driven capacity building to IPs and CSO,s to strenghten gaps that were already identified in assessments conducted with IPs , CSOs and Health facilities. As an above-site / national TA, 4C is also mandated to work with the government in strenghtening systems and structures (national, state and LGA levels) as required, to advocate, plan for and use funds for OVC programs towards sustainability, community- and country ownership.	1st 90 2nd 90	By end of FY17: 1. OVC in sustained support LGAs graduated and/or transitioned to government. In scale-up areas, increased pediatric case-finding and linkage to treatment 2. MER Outcomes monitoring survey completed and report available	1. All IPS have sustainability plans 2. 33 states have costed sustainability plans 3. Development of standardized case management package and supporting tools. 4. Health facility mapping/assessment conducted 5. Develop tools and build capacity of CSOs on adolescent girls programming	1. Sustainability framework (SAF-T) developed with 16 IPs, Trainings conducted on application, 10 states have commenced implementation of costed sustainability plans with 6% implementation by Kwara and 43% implementation by Imo. 2. Case management package finalized and waiting for approval from the FMWASD 3. Health Facility mapping concluded.	1. National investment case for OVC developed, 15 states have their OVC budget included in the states' budget 2. Case management and referral tools approved by the government and in use by all IPs 3. Design core package of interventions to reduce vulnerabilities to HIV among adolescents and increase uptake of HIV services. 4. OVC tracer study implemented to track the impact of interventions from graduating/transitioning and scale up states.	1. All IPS have sustainability plans 2. 33 states have costed sustainability plans 3. All CSOs supported by IPs use standardized case management and referral tools and approaches 4. All CSOs supported by IPS implement evidence-based HES interventions 5. All CSOs supported by IPS implement evidence-based Adolescent Girls interventions	HKID	$ 1,200,000.00	4Children	
UNICEF will strengthen the capacity of Federal and State Governments, as well as civil society organizations, to implement a comprehensive child protection system, in order to improve care and support for orphans and vulnerable children and prevent and respond to all forms of violence, abuse, neglect and exploitation of children	1st 90 2nd 90	By end of FY 17: regulatory framework for child protection with a child protection systems model for two states developed and piloted. This will support replication of the model in other states.	1. Child protection policy developed 2. Child protection systems mapping of Cross River and Lagos completed	1. National child protection policy development in progress 2. Child protection systems mapping of Cross River and Lagos completed	1. Financial benchmark for child protection in Nigeria assessment conducted 2. Child protection policy and systems strengthening for two additional states completed 3. Development of harmonized in service training manual for social welfare officers.	1. Child protection policy developed 2. Child protection systems mapping of Cross River and Lagos completed 3. Guidance documents for establishment and operationalization of a model child protection system developed	HVOP	$ 500,000.00	UNICEF	
Twinning for Health Support Initiative - Nigeria (THSI - N); a local partner institution to American International Health Alliance (AIHA) will build the capacity of tertiary institutions in Nigeria by training and providing adequate and relevant skills to social work practitioners to provide social services to vulnerable children and families, orphans, HIV infected and affected children and families. TA will also strengthen social work institutional and professional partnerships in Nigeria (building from Tanzania experience), and develop a social welfare workforce database.	1st 90 2nd 90 3rd 90 Sustained Epi Control	Capacity of social health workers in tertiary health facilities built to provide OVC services	1. Institutionalize ASW curriculum in one Nigerian higher institution 2. Train and graduate 200 100 Auxiliary Social Workers (ASW) 3. Strengthen the capacity of the National Association of Social Workers (NASW)	1. Memorandum of understanding with Federal School of Social Work - Enugu and Benue State University, which spelt out the responsibilities of each partner in the institutionalization program. 2. Developed, reviewed and finalized of Auxiliary Social Work (ASW) Curriculum 16th – 18th November 2016 3. Trained faculty members on the updated Curriculum, and use of ICT. 28th November – 1st December 2016 4. Trained 55 Auxiliary Social Workers (December 7th – 16th 2016) 5. Ongoing Coaching, Supervision and Mentoring of 55 trained ASW Trainees 6. Carried out advocacy visits to Ministry of Women Affairs, Social work Union, Universities, and other relevant stakeholders in the focal states		Not funded in COP17	~~HKID~~	~~$ 700,000.00~~	~~CCCRN~~	
Measure Evaluation OVC MEASURE will also focus on working with the government to update the OVC M&E tools, upgrade the NOMIS (National OVC Management Information System) and build the capacity of the Federal and State Ministries of Women Affairs and Social Development (FMWASD and SMWASD) to use the data it contains for planning and decision making around OVC care and support. MEASURE will also support USG to conduct the MER 1.5 OVC Outcomes Monitoring baseline and end-line survey and provide a report.	1st 90 2nd 90	MER 1.5 baseline survey carried out and NOMIS reviewed and upgraded.	1. MER 1.5 baseline survey carried out and report submitted to USG 2. National OVC M&E tools revised and updated 3. NOMIS updated with revised modules/indicators	1. OVC MER 1.5 baseline survey conducted (interviews completed), data currently being analyzed and report to be ready and submitted to USG by February 2017 2. National OVC M&E tools revised and NOMIS updated (Dec. 2016) 3. Government to ratify and adopt updated tools (February or March tentatively)	1. Provide TA as needed to ensure operationalization of the NOMIS instance 2. MER 1.5 outcomes monitoring endline survey completed and report submitted to the USG. 3. Improved data quality and collection from Communities to the national reporting system.	Complete the MER 1.5 OVC outcomes monitoring survey	HVSI	$ 1,200,000.00	MEASURE Eval	
Strengthen Capacity of State governments, CSOs, IPs and USG staff to prevent, identify and respond to Gender Based Violence	1st and 2nd 90	Increased GBV reporting and reduced HIV transmission through sexual violence	New Activity in COP17	N/A	1.Develop National GBV reporting tools for facility and community interventions 2.Strengthen GBV cross referral between facilities and other community services 3. Train Health Care workers and community volunteers to identify and respond to GBV 4. Train HTC service providers in counsel and appropriately refer women and men who report experiencing GBV/IPV	Number of people receiving postgender based violence (GBV) clinical care based on the minimum package 1.National GBV reporting tools for facility and community interventions developed 2.GBV cross referral between facilities and other community services strethened 3. Health Care workers and community volunteers trained to identify and respond to GBV	HVOP HVOP	$ 69,400.00 $ 800,000.00	Health Policy Plus ADVANTAGE	
Sub-total Institutional and Organizational Development								**3,769,400**		

Table 6.3 : Other Proposed Systems Investments										
Activity	**Addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control.**	**Outcomes expected after 3 years of investment**	**Year One (COP16) Annual Benchmark**	**Status Update on Year One Annual benchmark**	**Year Two (COP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Budget Code**	**Activity Budget Amount**	**Associated IM Mech. ID**	**Relevant SID Element and Score (if applicable)**
HIV/TB Related Services										
Intensified TB case finding among PLHIVs specific activities include; TBHIV training for GHCWs in ART sites, TB Lab training, sputum sample transport logistic for Xpert diagnosis, tracing of all primary contacts of every PLHIV diagnosed with PTB, Basic facility upgrade for infection control, Printing of TB IC IEC materials and Procurement of basic IC equipment.	2nd and 3rd 90	Increased TB case detection and treatment among PLHIVs and reduced incidence of TB within the PLHIV population	Activities implemented and on track to meet FY17 targets.	GeneXpert diagnosis expanding and partners on track to meet FY17 targets.	Will be funded through target based budgeting in COP17.		HVTB	~~$ 5,736,760.00~~	All Treatment Partners	Element 6: Service Delivery - **SID Score: Red**
HTC for TB patients in Standalone DOTS sites not supported by Comprehensive IPs.	All three 90-90-90 goals.	Increased TB case detection and treatment among PLHIVs and reduced incidence of TB within the PLHIV population. Increased diagnosis of HIV among TB patients	1: Timely, complete and accurate HIV rapid test kit orders submitted from 85% of DOTS sites.	RTKs supplied and distributed.	Will be funded through target based budgeting in COP17.		HVTB	~~$ 550,270.00~~	~~Challenge TB~~ All Treatment partners	
Sputum sample transportation for FHI and MSH in Lagos, Rivers, Cross River, Akwa-Ibom, Kano, Bauchi and Niger.	2nd and 3rd 90	Increased TB case notification and treatment among the PLHIV population.	2: Sample transport system designed and implemented.	Transport system designed and on track in FY17. Moving forward, the sputum transport will be performed under GHSC.	Will be funded through GHSC activity below, in COP17.					
Last mile delivery of INH to PEPFAR supported Treatment sites.	2nd 90	Increased TB treatment among the PLHIV population.	Reduced stock outs of INH	INH procured and being delivered to sites.	Folded into integrated last mile delivery in COP17		HVTB	~~$ 41,504.00~~	~~GHSC~~	
Support for sputum tansport system from peripheral ART sites to GeneXpert sites		Increased TB case notification and treatment among the PLHIV population.	50% increase in TB case notification among the PLHIV population.	The process of engaging a single mechanism (GHSC) for sample shipment is on-going.	100% increase in TB case notification among the PLHIV population.	TX_TB	HVTB	$ 850,000.00	GHSC	
Sub-total TB								**850,000**		
Governance										
Lead IP support for State level M&E, coordination, capacity building & strengthening of State level M&E	All three 90-90-90 goals	Harmonized sub-national data collection system in place	Quarterly sub-national M&E meetings commenced	Quarterly sub-national M&E meetings held	Quarterly sub-national validation of HIV program data	Quarterly reporting of validated data	HVSI	$180,000	CDC TBD	Element 13: Epidemiological and Health Data - **SID Score:**
							HVSI	$90,000	FHI360	
							HVSI	$37,500	CaTSS	
							HVSI	$42,500	USAID Comp TBD	
Ambassador Self-help and PEPFAR Small grants: OVC	All three 90-90-90 goals	Grants issued and implemented.	Grants are being issued and implemented as planned.	Grant applications under review.	Grants issued and implemented.	Number of successful grants implemented.	HKID	$200,000	PCO	
PEPFAR Small grants: Civil Society Engagement	All three 90-90-90 goals	Grants issued and implemented.	Grants are being issued and implemented as planned.	Grant applications under review.	Grants issued and implemented.	Number of successful grants implemented.	HVOP	$100,000	PCO	
Sub-total Governance								**$650,000**		

Activity	Addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control.	Outcomes expected after 3 years of investment	Year One (COP16) Annual Benchmark	Status Update on Year One Annual benchmark	Year Two (COP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Budget Code	Activity Budget Amount	Associated IM Mech. ID	Relevant SID Element and Score (if applicable)
Systems Development										
Warehousing & Last Mile Delivery as part of the National Unified Supply Chain System: Storage and distribution of ARVs, RTKs and other commodities are directly contributing towards achievement of the 90-90-90 goals and sustaining treatment elsewhere. A viable alternative supply chain does not currently exist. Other supply chain interventions are geared at building a viable alternative so this cost to PEPFAR can	All three 90-90-90 goals.	The overall cost to PEPFAR may reduce next COP with the establishment of the National Supply Chain Integration Project (NSCIP) with the GF, UNFPA and other stakeholders	Stock-outs reduced to 5% On time delivery of commodities to 90% of sites Waste and expiries maintained at 0.5%	Last mile distributions ongoing and quarterly warehouse stock status reports shared.	Moved to Unit Based Budget in COP17	Stock-outs reduced to 5% On time delivery of commodities to 90% of sites Waste and expiries maintained at 0.5%	~~HTXS~~	~~$9,778,113~~	~~GHSC~~	Element 6: Service Delivery SID Score: Red
Biennial Quantification for the National Unified Supply Chain System: National Requirements for HIV/AIDS Commodities including Lab commodities. Estimate funding gaps (if any) and allocate resources with other stakeholders especially factoring in the requirements for test and treat, community based ART distribution and multi-scripting prescriptions	All three 90-90-90 goals.	Accurate estimation of procurement budget figures shared with stakeholders for inclusion in budgeting processes for GON and donors.	Five year Quantification plan (2018-2023)	National Quantification Exercise to hold in March/April 2017	Discontinued after FY17.		~~OHSS~~	~~$462,936~~	~~GHSC~~	Element 8: Commodity Security and Supply Chain
Supply Planning and Stock Status Coordination: Collaborate with other stakeholders to plan deliveries in a timely manner to ensure continuous availability and track consumption to minimize expiries or stock-outs. This activity involves continuous coordination of a team of data analysts that organize stakeholders to review stock levels and orders and plan new procurements to also minimize wastage.	All three 90-90-90 goals.	Minimized wastage of commodities due to coordinated delivery of commodities.	Continuous activity that involves engaging 64 logistics advisor in the 36+1 states to track commodity stock, travel to sites across the state, attend state and regional level TWG meetings, collate logistics data to inform re-supply, quarterly procurements ensuring commodity availability across PEPFAR supported sites	1. Co-hosted 2 national supply planning meetings and produced 2 national supply plan review reports to inform PEPFAR, GF & GON procurement of HIV/AIDS commodities 2. Stock-our rates remain under 10% across PEPFAR sites	Stock-our rates remain under 10% across PEPFAR sites	1: Semi-annual supply planning workshops 2: Two Supply Plan review reports annually 3: Effective tracking of procurements across all stakeholders 4: Four Quarterly National Procurement reports	OHSS	$ 1,562,500.00	GHSC	Element 6: Service Delivery
Waste management: Retrieve expired commodities biannually for environmentally friendly disposal		Reduced wastage and reduction of waste collection to a single drive per year.	Essential activity for the management of expired commodities	Annual Waste drive in process, to be completed before May 2017	One annual waste drive	1: Expiries retrieved to central warehouse every quarter One annual waste drive	HMIN	$275,000	GHSC	
Blood safety Commodities		Uninterupted and Consistence delivery of commodities, Reduced incidence of HIV infection through blood transfusion; Quality of blood safety commodities consistently maintained through the logistics chain	Quantification of Blood safety commodities, development of a supply plan, and Strengthen Logistics Management Information System (LMIS)	Activity will be concluded by the end of FY17	Discontinued after FY17.		~~HMBL~~	~~$690,000~~	GHSC	
Treatment Service Delivery cost for low volume (20-299) health facilities. This includes one monitoring visit and visit for emergency Technical Assistance		Routine monitoring oversight	Site visits continue for sites through the end of FY17 that were originally told not to report but are now reporting again.	Additional site volume analysis conducted and partner visits to sites are ongoing.	Budgeting no longer required as separate activity based budget in COP17.		~~HTXS~~	~~$716,383~~	All Treatment Partners	Element 6: Service Delivery
Sub-total Systems Development								**$ 1,837,500**		

Table 6.3 : Other Proposed Systems Investments										
Activity	Addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control.	Outcomes expected after 3 years of investment	Year One (COP16) Annual Benchmark	Status Update on Year One Annual benchmark	Year Two (COP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Budget Code	Activity Budget Amount	Associated IM Mech. ID	Relevant SID Element and Score (if applicable)
Other Activities										
Implementation of SI related activites including APR17 reporting on DATIM, monthly data validation and quarterly DQA exercise in Q1 FY18	All three 90-90-90 goals		New activity in COP17	New activity in COP17	All required data accurately reported.	Data entered on time during transition to new mechanisms.	HTXS	$48,000	Local Capacity Enhancement (LOCATE)_867	
Implementation of SI related activites including APR17 reporting on DATIM, monthly data validation and quarterly DQA exercise in Q1 FY18	All three 90-90-90 goals		New activity in COP17	New activity in COP17	All required data accurately reported.	Data entered on time during transition to new mechanisms.	HTXS	$104,000	Integrated Programs for Sustainable Action Against HIV/AIDS in Nigeria (IPSAN)_929	
Implementation of SI related activites including APR17 reporting on DATIM, monthly data validation and quarterly DQA exercise in Q1 FY18	All three 90-90-90 goals		New activity in COP17	New activity in COP17	All required data accurately reported.	Data entered on time during transition to new mechanisms.	HTXS	$176,000	Supporting Universal Comprehensive and Sustainable HIV/AIDS Services (SUCCESS)_922	
Implementation of SI related activites including APR17 reporting on DATIM, monthly data validation and quarterly DQA exercise in Q1 FY18	All three 90-90-90 goals		New activity in COP17	New activity in COP17	All required data accurately reported.	Data entered on time during transition to new mechanisms.	HTXS	$38,000	Sustaining Comprehensive HIV/AIDS Response through Parnerships (SCHARP+) in Oyo and Ogun State_937	
Implementation of SI related activites including APR17 reporting on DATIM, monthly data validation and quarterly DQA exercise in Q1 FY18	All three 90-90-90 goals		New activity in COP17	New activity in COP17	All required data accurately reported.	Data entered on time during transition to new mechanisms.	HTXS	$1,182,000	Action Plus-Up_925	
Implementation of SI related activites including APR17 reporting on DATIM, monthly data validation and quarterly DQA exercise in Q1 FY18	All three 90-90-90 goals		New activity in COP17	New activity in COP17	All required data accurately reported.	Data entered on time during transition to new mechanisms.	HTXS	$437,000	Comprehensive AIDS Response Enhanced for Sustainability (CARES)_924	
Implementation of SI related activites including APR17 reporting on DATIM, monthly data validation and quarterly DQA exercise in Q1 FY18	All three 90-90-90 goals		New activity in COP17	New activity in COP17	All required data accurately reported.	Data entered on time during transition to new mechanisms.	HTXS	$647,000	Bridges Plus_928	
Implementation of SI related activites including APR17 reporting on DATIM, monthly data validation and quarterly DQA exercise in Q1 FY18	All three 90-90-90 goals		New activity in COP17	New activity in COP17	All required data accurately reported.	Data entered on time during transition to new mechanisms.	HTXS	$197,000	Service Expansion and Early Detection for Sustainable HIV Care (SEEDS)_868	
Implementation of SI related activites including APR17 reporting on DATIM, monthly data validation and quarterly DQA exercise in Q1 FY18	All three 90-90-90 goals		New activity in COP17	New activity in COP17	All required data accurately reported.	Data entered on time during transition to new mechanisms.	HTXS	$474,000	Sustainable HIV care and Treatment Action in Nigeria (SUSTAIN)_934	
A study and viral load surveillance system	3rd 90		New activity in COP17	New activity in COP17	At least six sentinel facilities activated and functional	Number of sentinel facilities reporting on viral load supression	HVSI	$300,000	Strengthening HIV Field Epidemiology, Infectious Disease Surveillance, and Lab Diagnostics Program (SHIELD)_1976	
Sub-total Other								**$3,603,000**		
GRAND TOTAL								**$21,923,273**		

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