



NIGERIANS AND AMERICANS
IN PARTNERSHIP TO FIGHT HIV/AIDS

Nigeria

Country Operational Plan (COP) 2018

Strategic Direction Summary

March 15, 2018

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1.0 Goal Statement

The 2018 PEPFAR Country Operational Plan (COP18) focuses on what is known about the HIV/AIDS epidemic in Nigeria. While HIV/AIDS remains a significant public health issue in Nigeria, it has become increasingly difficult to find people living with HIV/AIDS, many of whom are otherwise healthy and unaware of their status, a situation that is aggravated by the prevailing high incidence of HIV-associated stigma and discrimination. Attempts made over the last three years to find new cases using the limited epidemiologic data available to prioritize a sub-set of high-burden Local Government Areas (LGAs) for scale-up to achieve the UNAIDS 90-90-90 targets, have not yielded the expected results. While in FY17 there was the highest number of people enrolled on therapy, the result was far below the target and used considerable resources to reach the number of people estimated to be living with HIV in the selected LGAs. The COP18 strategy shifts away from concentrating resources on community outreach in a limited set of scale-up LGAs and is primarily focused on closing gaps in patient retention and linkage of patients found at health facilities to treatment.

While most forms of community outreach did not yield the results expected, a few approaches have proven to be effective and will continue to be done in a targeted manner, namely: finding and treating Key Populations (KP) and performing Index Client testing for HIV and providing a facilitated linkage to treatment. These approaches have been shown to be especially effective in reaching the adult male population, which has been difficult to reach using conventional mass testing campaign strategies in open community settings and clinics. Similarly, the increased use of more granular program data to analyze program performance has revealed other opportunities to improve the quality and service outcomes of the programs.

Nigeria is on the verge of conducting the largest ever population-based HIV/AIDS indicator survey which will provide epidemiologic data to improve our understanding of the country's actual burden and distribution of HIV and AIDS. This data will begin to emerge and be used to define new areas of geographic prioritization within the COP18 implementation period.

Based upon these considerations, PEPFAR Nigeria will seek to shift away from a prioritized focus on a small sub-set of LGAs in COP18 for scale-up efforts. Instead, the program will aim to maintain its current footprint in all of the 534 LGAs currently being supported and will apply the most efficient strategies identified in previous implementation periods to improve case-finding for people living with HIV and AIDS (PLHIV) as well as their linkage and retention of HIV/AIDS treatment.

Our goals in COP18, expressed in terms of PEPFAR's five action agendas, are to:

- Impact: Implement sustained program growth across of the 534 LGAs in which the PEPFAR program currently supports HIV/AIDS care and treatment services.
- Efficiency: Increase the number of people currently receiving treatment from **772,510** in FY 2017, to **871,813** in FY 2018 and **966,027** by the end of FY 2019.
- Sustainability: Support the Government of Nigeria (GON) to conduct the National AIDS Indicator and Impact Survey (NAIIS) and utilize the data to prioritize geographical areas for programming towards epidemic control.

Partnership: Continue to collaborate with the GON, the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), Civil Society Organizations (CSOs), and private sector partners to ensure transparency, accountability and impact in the mobilization and deployment of resources in support of the National HIV/AIDS response.

Human Rights: Advocate for improving national laws and policies and serving the needs of PLHIV in health care settings in non-discriminatory ways.

To improve program performance at the implementing partner level, the program will support closer monitoring and supervision of hospitals serving the largest numbers of PLHIV in treatment and will work with these facilities to eliminate barriers to service uptake while ensuring linkage and retention in treatment across all age and sex disaggregation. These facilities will be supported to reach all clients accessing HIV/AIDS services with free Viral Load testing services at least once within the course of the implementation period.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and epidemic profile

Nigeria is a lower-middle-income country (GNI: 2,450 per capita, Atlas method¹) with a current population estimate of 195,300,343 (population demographics: 49 percent female and 51 percent male²).

Although concerns have been raised about the reference data for HIV in Nigeria³, the country is still considered to have a generalized epidemic with national average HIV prevalence rates among pregnant women attending antenatal clinics (ANC) estimated to be around 3.0 percent⁴ (compared with 4.1 percent in 2010). Data from the National HIV/AIDS and Reproductive Health Survey (NARHS)⁵ amongst adults between the ages of 15-49 years has been consistently lower however, at 3.6 percent in 2007 and 3.4 percent in 2012.

There is a great variance between the prevalence data reported at state-level from the various survey methods. For Akwa Ibom State, the 2012 NARHS reports a prevalence of 6.5 percent, while the 2015 ANC sero-prevalence has it at a prevalence of 10.8 percent and the 2015 HIV program data from NASCP reports a positivity rate of 4.1%. Similarly for Kaduna State, the 2012 NARHS reports a prevalence of 9.2 percent, while the 2015 ANC sero-prevalence has it at a prevalence of 2.2 percent and the 2015 HIV program data from NASCP reports a positivity rate of 3.7%. These data points vary consistently and in particular with the unpublished data from State AIDS indicator surveys in Akwa Ibom and Kaduna states

¹ World Bank, 2016 data <https://data.worldbank.org/country/Nigeria>

² US Census population data, 2018

³ Oleribe et. al (2018) <http://www.panafrican-med-journal.com/content/article/29/119/full/>

⁴ 2014 National HIV Sero-prevalence Sentinel Survey among pregnant women attending Antenatal clinics in Nigeria

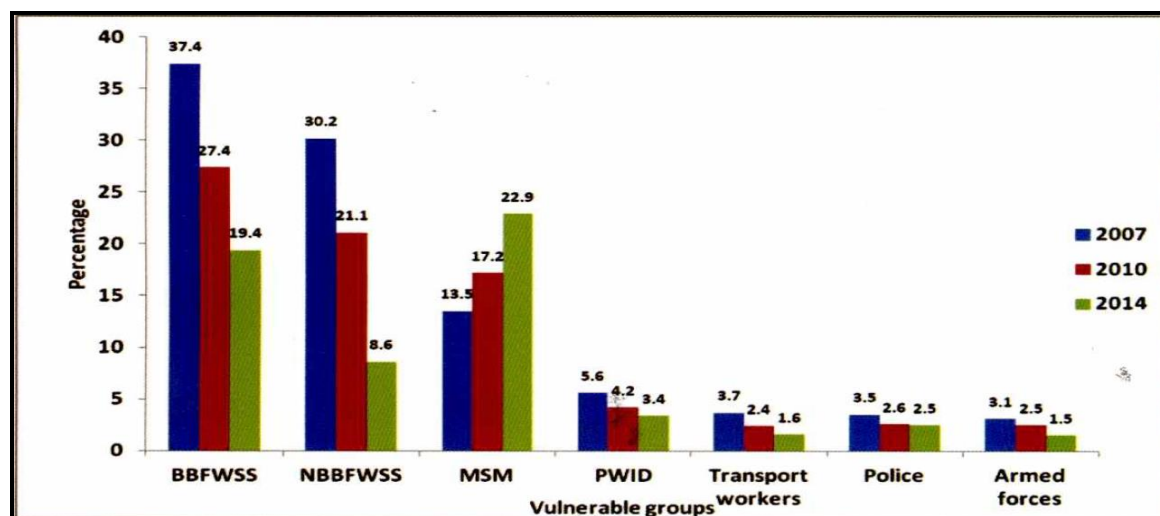
⁵ NARHS (2013)

revealed a state-level prevalence of 2.8⁶ percent and 0.6⁷ percent respectively. This new data derived from improved survey techniques poses significant program implications for the HIV/AIDS response in both states.

The planned National AIDS Indicator and Impact Survey (NAIIS) scheduled to be completed in 2018 will apply technically updated survey methodologies to provide more reliable prevalence data for future program planning and review. The nationwide survey will generate national and state estimates of HIV prevalence, incidence, and viral suppression.

Similar to the gaps in the national estimates of the burden of HIV and AIDS, the numbers of people facing increased risk of HIV infection from transactional and non-transactional sex-work, injection drug use and men having sex with men have also been recognized to be seriously underestimated. Concerns have been raised about Key Populations (KP) estimates from the national size estimation reports as 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 and other relevant statistical assumptions. Additionally, PEPFAR is supporting a population size estimation exercise in COP2017.

HIV prevalence among KP is much higher than the national average, at 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)⁸. 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.



⁶ AKAIS Survey, 2017

⁷ KADAIS Survey, 2017

⁸ Integrated Biological and Behavioral Surveillance Survey (IBBSS) 2014

Figure – 2.1.1a – HIV prevalence rates among vulnerable groups in Nigeria (2007-2014)⁹

Based on current estimates, about 3,200,000 people are thought to be living with HIV in Nigeria, the second highest burden of PLHIV in the world. About 1,050,594 PLHIV are currently receiving treatment and there has been a slow decline¹⁰ in the estimated incidence of HIV in Nigeria, with the number of new infections decreasing from an estimated 316,733 in 2003 to 220,000 in 2016¹¹. 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 globally (about 60,000 annually) due to high mother-to-child transmission rates. Only 21 percent of children living with HIV are receiving anti-retroviral drugs (ARVs).¹² Due to the high number of AIDS-related deaths, 160,000 in 2017 (down from 210,031 in 2013¹³) per year, the population of orphans and vulnerable children (OVC) is estimated at over 1,736,782.

Noting the likely issues with accuracy of epidemiologic data in the country, UNAIDS estimates that only 34 percent of PLHIV in the country are aware of their status. Of these, an estimated 88 percent are on treatment and 81 percent of those on treatment are virally suppressed.

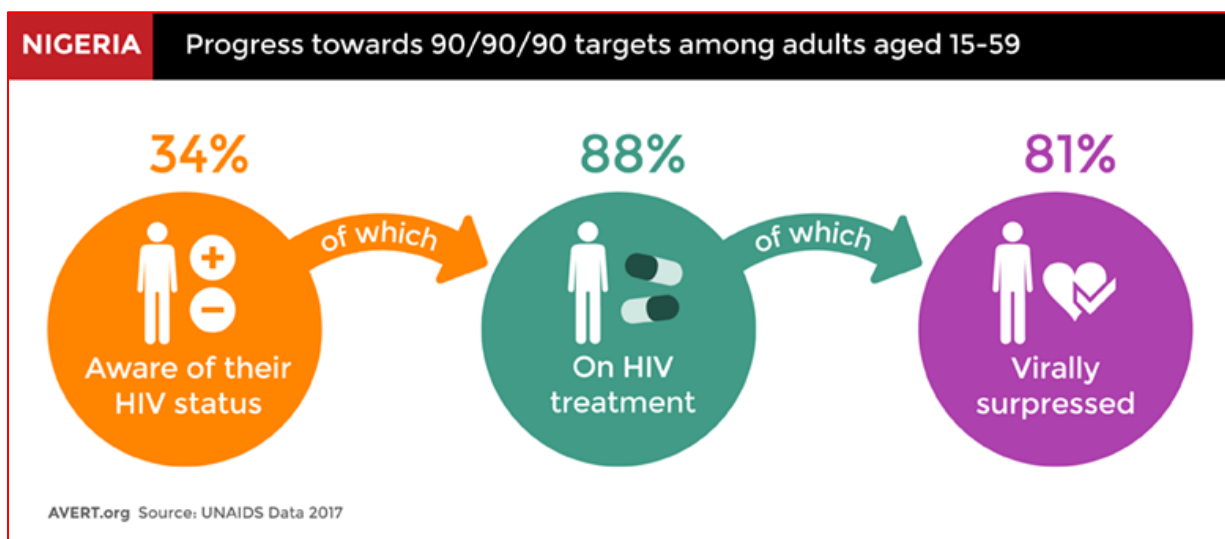


Table 2.1.1 below provides a summary of demographic and epidemiological data while Table 2.1.2 provides programmatic data on the clinical cascade.

⁹ Integrated Biological and Behavioral Surveillance Survey (IBBSS) 2014

¹⁰ Unpublished FMOH mid-year estimate 2017

¹¹ Nigeria GARPR 2017

¹²UNAIDS Global Progress Report 2017

¹³ 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	%	
Estimated Population Size of FSW	103,506														UNAIDS 2017
Brothel Based FSW HIV Prevalence		19.4%													IBBSS 2014
Non Brothel Based FSW HIV Prevalence		8.6%													IBBSS 2014
Estimated Population Size of PWID	44,415														UNAIDS 2017
PWID HIV Prevalence		3.4%													UNAIDS 2017
Estimated Size of Priority Populations (specify)															
Estimated Size of Priority Populations Prevalence (specify)															

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%	3,420,000	1,161,600	1,050,594	30.7%	81.2%*	7,766,623	212,201	162,614
Population less than 15 years	79,615,259		256,995		58,000	23.0%		824,682	10,715	9,107
15-24 year olds	36,243,817							2,018,635	37,506	32,494
25+ year olds	75,891,957							4,924,270	164,030	121,029
MSM	597,036	22.9%								
FSW	256,282	19.4% (BBFSW)								

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 **		
		8.6% (NBBFSW)							
PWID	7,415	3.4							
Priority Pop (specify)									

*- Derived from PEPFAR APR 17 Viral Suppression data (for PLHIV who have received a viral load test in the last one year).

** - PEPFAR only data

Figure 2.1.3 compares the trend of individuals currently receiving ART from 2005 to 2017 at national level and PEPFAR’s contributions. As of September 30, 2017, PEPFAR contributed 772,510 patients currently on ART while the number of PLHIV currently receiving ART in Nigeria is 1,050,594¹⁴. The figures for 2018 and 2019 are projections based on current trajectory and PEPFAR program targets.

Between 2013 and 2014 a total of 107,600 patients on ART were transitioned from PEPFAR support to the GON and GF.

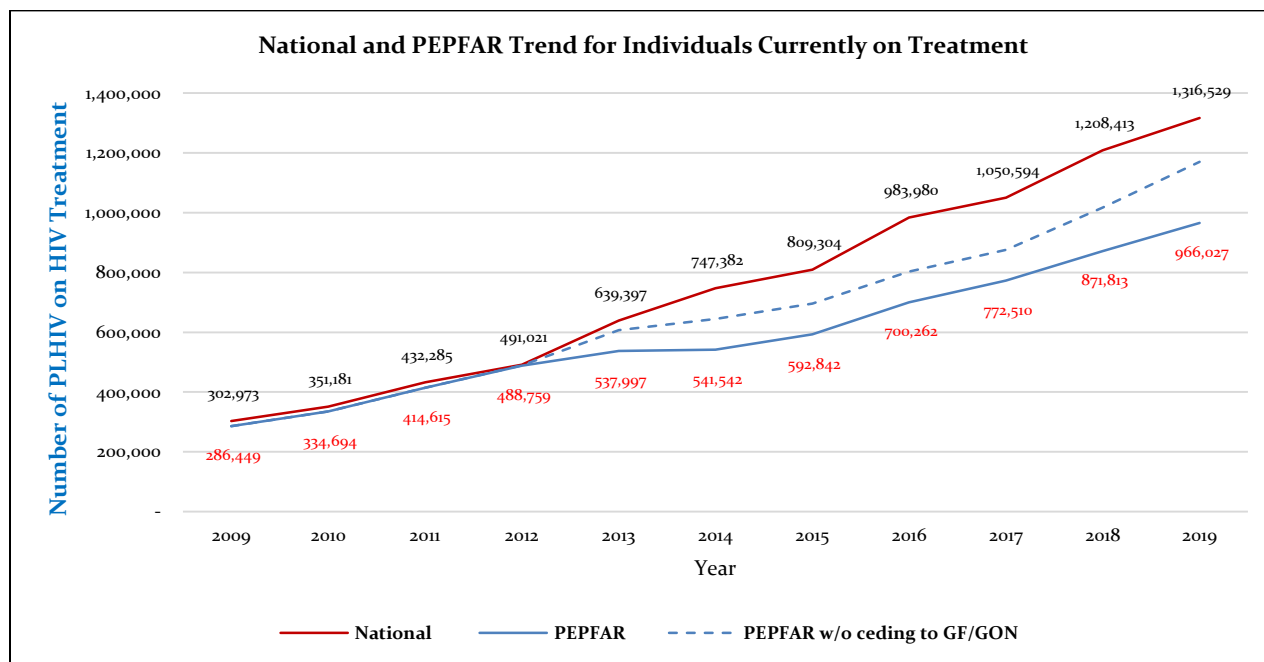


Figure 2.1.3 National and PEPFAR Trend for Individuals currently on Treatment

2.2 Investment Profile

Low oil prices and ongoing security concerns continue to produce a wide 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. Consumer inflation rose to 18.7 percent in January 2017, but fell gradually to 15.1 percent a year later. 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.

¹⁴ Unpublished FMOH mid-year estimate 2017

Nigeria's substantial economic challenges translate into a continued reliance on international donors to finance the HIV response, which has been 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, 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 2016 through September 2017 shows that about US\$ 150,869,961.52 million was spent to procure HIV commodities for the National program. Overall PEPFAR, the Global Fund and the GON contributed 63.5 percent, 35 percent and less than 1 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 2.2.1 Investment Profile By Program Areas (NASA 2014)						
AIDS Spending Categories	Govt. of Nigeria	Private Sector	PEPFAR	Global Fund	Other	Total Expenditure
Prevention	\$ 27,545,208	\$ 11,342,144	\$ 105,319,911	\$ 14,582,757	\$ 3,240,613	\$ 162,030,633
Care and Treatment	\$ 24,799,691	\$ 1,907,669	\$ 162,151,827	\$ 1,907,669	\$ -	\$ 190,766,855
Orphans & Vulnerable Children (OVC)	\$ 883,434	\$ -	\$ 16,785,239	\$ 4,417,168	\$ -	\$ 22,085,841
Program Management & Administration	\$ 15,508,893	\$ 861,605	\$ 51,696,311	\$ 17,232,104	\$ 861,605	\$ 86,160,519
Human Resources	\$ 100,867,988	\$ -	\$ 15,798,600	\$ 3,645,831	\$ 1,215,277	\$ 121,527,696
Social Protection and Social Services	\$ -	\$ -	\$ 11,052,641	\$ 225,564	\$ -	\$ 11,278,205
Enabling Environment	\$ 325,641	\$ 325,641	\$ 31,912,800	\$ -	\$ -	\$ 32,564,082
HIV-Related Research	\$ 119,295	\$ -	\$ 5,427,939	\$ 119,295	\$ -	\$ 5,964,768
Total	\$ 170,742,222	\$ 12,647,572	\$ 404,722,303	\$ 44,266,502	\$ -	\$ 632,378,599

Table 2.2.2 Procurement Profile for Key Commodities (Oct 2016-September 2017)-FY 17				
Commodity Category	Total Expenditure	PEPFAR	Global Fund	Government of Nigeria (Sure-P and others)
ARVs	\$ 113,057,579	\$ 62,216,658	\$ 50,394,930	\$ 445,992
Rapid test kits	\$ 17,231,406	\$ 13,968,237	\$ 2,756,965	\$ 506,204
Opportunistic infection drugs	\$ 1,567,048	\$ 1,233,319	\$ 333,729	\$ -
Lab reagents – CD4	\$ 9,562,489	\$ 8,994,964	\$ 567,524	\$ -
Lab reagents – Viral load	\$ 6,807,606	\$ 6,807,606	\$ -	\$ -
EID kits	\$ 738,696	\$ 738,696	\$ -	\$ -
Other commodities (PCR consumables & GeneXpert Cartridges)	\$ 1,905,138	\$ 1,905,138	\$ -	\$ -
Total	\$150,869,962	\$95,864,619	\$54,053,148	\$952,196

For the period of 2017-2019, the Global Fund has allocated to Nigeria, 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 certain conditions.

Nigeria submitted a joint TB/HIV application in May 2017 which was rejected. New proposals, one for each disease, will be submitted during the first half of 2018. 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.

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. NACA is working to set up an HIV trust fund with the private sector for the procurement of commodities. In addition, the administration has communicated a willingness to commit increasing budgetary resources to HIV, despite economic challenges. The FMOH is setting up a National Treatment Program to guide the National response to HIV and harness government resources. PEPFAR will seek to support these efforts.

In FY 18, the PEPFAR resource envelope shrank 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 streamlined broad health systems investments while continuing to improve linkages with other United States Government (USG), Global Fund, and World Bank investments. PEPFAR will continue to work with all stakeholders to focus investments that prioritize epidemiologic impact.

Table 2.2.3 documents non-PEPFAR United States Government funding for HIV and other health programs.

Table 2.2.3 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	\$10,800,000				Accelerate case-finding and increase national case detection rate.
USAID Malaria	\$60,000,000				Reduce malaria burden compared to 2010 levels under the PMI.
USAID Maternal & Child Health	\$48,000,000				End preventable child and maternal deaths.
USAID WASH	\$3,000,000				Water supply and sanitation.
USAID NUT	\$2,500,000				Reduce under-nutrition among women and children.
CDC GHS/Ebola	\$1,246,569				<ol style="list-style-type: none"> To detect threats early including characterizing and transparently reporting emerging biological threats early through real-time bio-surveillance. To respond rapidly and effectively to biological threats of international concern. 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	\$20,512,396				To support the polio eradication efforts in Nigeria and to strengthen Nigeria's routine immunization system.
DOD JWARG	\$1,960,000				Joint West Africa Research Group.
DOD Ebola vaccine	\$240,000				Ebola vaccine development
DOD AFRICOS Science	182,000				African cohort study: longitudinal follow up of PLHIV
DOD Trust study	\$273,000				Reduce HIV/STI incidence and risk behaviors among MSM
DOD PMI	\$376,000				Malaria-associated mortality
Total	\$149,089,965				

Table 2.2.4 PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP						
Funding Source	Total PEPFAR Non-COP Resources	Total Non-PEPFAR Resources	Total Non-COP Co-funding PEPFAR IMs	Number of Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
Other PEPFAR Central Initiatives - CDC	\$30,200,000					For the Nigeria HIV/AIDS Impact Survey (NAIS) to accurately determine and characterize Nigeria's HIV epidemic.
Other PEPFAR Central Initiatives - CDC / - USAID/ - DOD	\$5,717,076 \$6,301,406 \$181,518					To strengthen PMTCT program, HRH and increase KP HIV testing and treatment services for men who have sex with men (MSM).
Other non-COP resources - Global Fund***	\$20,000,000				\$20,000,000	Global fund contribution to the Nigeria HIV/AIDS Impact Survey (NAIS) for accurate determination and characterization of Nigeria's HIV epidemic

Table 2.2.4 PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP						
Funding Source	Total PEPFAR Non-COP Resources	Total Non-PEPFAR Resources	Total Non-COP Co-funding PEPFAR IMs	Number of Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
HOP (2 year implementation Science Project- FY18 & FY19)	\$1,000,000		\$1,000,000	1		To conduct a randomized control trial of Point Of Care Viral Load (VL) monitoring using the Cepheid Xpert HIV-1 VL assay versus Standard Of Care VL monitoring in patients newly initiating ART.
Total	\$63,400,000		\$1,000,000		\$20,000,000	

2.3. National Sustainability Profile

The 2017 Sustainability Index and Dashboard (SID 3.0), was developed using an iterative consultation process with technical experts from local civil society groups, the Nigeria UNAIDS team, the GON and program implementing partners. Relative to the previous iterations, stakeholders reported improvements in all of the SID domains (see Figure 2.3.1) and gave recommendations on how to sustain these improvements going forward.

The newly launched National HIV/AIDS Strategic Framework (2017-2021) was recognized as an opportunity to improve program planning and coordination at National and State level. Focusing on the goal of fast-tracking the National HIV and AIDS response towards ending Nigeria’s HIV/AIDS epidemic by 2030, the framework incorporates the UNAIDS 90-90-90 targets as well as the global recommendation to “test and treat” all persons diagnosed with HIV and AIDS. This aligns with the thrust of the PEPFAR program since FY16. In the “planning and coordination” SID element, 11 out of the 36+1 states in the country were reported have developed “state sustainability plans” to guide the prioritization of domestic investments towards the gradual transitioning of support from donors to the GON.

PEPFAR Categorization: Long-term Strategy (Co-finance)			
PEPFAR COP 17 Planning Level: \$383,614,281			
	2015 (SID 2.0)	2017 (SID 3.0)	2019
Accountability			
1. Planning and Coordination	8.17	9.67	
2. Policies and Governance	5.44	6.57	
3. Civil Society Engagement	6.33	8.33	
4. Private Sector Engagement	4.93	7.42	
5. Public Access to Information	7.00	5.00	
Delivery			
6. Service Delivery	2.50	6.06	
7. Human Resources for Health	4.92	6.09	
8. Commodity Security and Supply Chain	5.73	6.18	
9. Quality Management	6.24	7.38	
10. Laboratory	4.44	5.83	
Strategic Investments, Efficiency, and Sustainable Financing			
11. Domestic Resource Mobilization	3.06	5.71	
12. Technical and Allocative Efficiencies	4.51	8.00	
Strategic Information			
13. Epidemiological and Health Data	3.75	5.71	
14. Financial/Expenditure Data	5.00	8.33	
15. Performance Data	3.74	6.23	

Figure 2.3.1 SID 3.0 Dashboard

Stakeholders reporting on the SID also recognized the progress that has been made in engaging with more private sector service providers and also recommended the mainstreaming of HIV/AIDS care and treatment into the service package of private-for-profit health institutions. These institutions may be better placed to support the service needs of those who can afford to pay. For poorer persons living with HIV, user fees, introduced by health facilities in the wake of the flat lined funding of the HIV/AIDS program, are perceived to pose significant barriers to service uptake and retention on treatment. Stakeholders recommended that stakeholders engage health service providers and the FMOH and State Ministries of Health (SMOH) in bid to ensure sustained access to treatment for PLHIV while exploring opportunities to evaluate and address the resource needs of the providers.

Domestic financing for HIV/AIDS was flagged as a continuing health system challenge. While acknowledging the GON's effort in resourcing and managing the complete HIV/AIDS response in Taraba and Abia States, the need to scale-up domestic funding to address the continued dependence on donors for the most critical program element i.e. ARV procurement was stressed. Stakeholders suggested that the GON take responsibility for most of the country's ARV drug needs while donor funds were deployed towards case-finding, prevention, and health system support activities as this would be more sustainable.

The results of previous PEPFAR investments in that National Health Management Information System, Laboratory Systems for Viral Load and Early Infant Diagnosis (EID) services and the National Commodities and Drug Supply Chain systems were demonstrated in the relevant SID domains and elements.

The Master Facility List for the National DHIS 2.0 health data reporting platform was launched on the 1st of January, 2018 and the governance mechanism for adding and delisting health facilities in the system is currently being rolled-out. Relatedly, the National Data Repository of patient level data for program quality and cohort analysis has been expanded to cover about half of those currently receiving HIV/AIDS treatment in Nigeria.

Bottlenecks in the delivery of free viral load services are being addressed. PEPFAR is supporting the National Integrated Sample Referral System (NISRS) for transport of viral load, EID and tuberculosis (TB) tests to laboratories and strengthening the capacity of the labs to manage the increasing demands for these services. The goal in COP18 is to reach all of the estimated 1.05m currently receiving HIV treatment in the country with at least one viral load test in the course of the implementation year and to significantly reduce turn-around-time for completion of these services and ensure timely delivery of lab results to clinicians for decision-making. Similar targets have been set for improved access to EID and GeneXpert services.

Logistics Management Coordination Units in all the State Ministries of Health are helping to ensure that State Governments are now able to track 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.

Stakeholders in the SID 3.0 process recommended a review of progress of health systems investments which impact on the National HIV/AIDS response and strengthened national technical groups and networks driving these system building efforts. While many of these health systems investments will be phased out in COP18, the GON expressed a desire to better share information on the outcomes from prior PEPFAR health systems investments.

In COP18, the critical health system support investments in the health management information system and supply chain have been re-aligned to service delivery and patient-level outcome targets within the Financial Allocation and Strategy Tool (FAST). Only three activities are now captured as “above-site” support. The details of these activities are provided in section six of this document and on Table 6 (Appendix C).

2.4 Alignment of PEPFAR investments geographically to disease burden

Since COP14, PEPFAR Nigeria has supported the prioritization of sub-national geographical units based on the assessment of burden of unmet need for HIV/AIDS treatment services. In FY15, this was reflected in a redirection of funds to support the scale-up of services in eight of the reported 12+1 highest burden states which were believed to be responsible for 70 percent of the HIV burden in the country¹⁵. Two of the states; Kaduna and Akwa Ibom, designated as priority one states (based on reported unmet need and prioritized for massive scale-up), in COP14 received 11 percent of total PEPFAR funding aligned to their expected contribution of 18 percent of the national HIV burden. Six other states; Benue, Cross River, Lagos, Nassarawa, Rivers, and the FCT were designated as priority two (reflecting the desire to pursue a “moderate scale-up) and were reported to be responsible for 25 percent of the National burden and accordingly received 35 percent of the program expenditure in the COP14 implementation period.

A more granular prioritization process which focused on 32 LGAs reported to have the highest unmet need, was implemented in COP15 and COP16. These LGAs were spread across seven of the initial eight priority states. This new categorization was envisioned as an opportunity to demonstrate a “proof of concept” of the ability to achieve the UNAIDS 90-90-90 targets albeit in a small sub-set of sub-national units (32 out of the 774 LGAs in the country) and as evidence supporting the need for a greater mobilization of resources for the push towards nationwide epidemic control.

State level program expenditure has consistently been highest in Benue State which has reported the highest HIV prevalence and the highest level of unmet need in all of the National HIV surveys and burden estimation processes. The state has consistently received between 10-13 percent of all of the

¹⁵ National Agency for the Control of AIDS Annual Report (2013)

PEPFAR investments in the country and reported the highest numbers of new PLHIV diagnosed and maintained on treatment since the year 2010.

Relative to the investments made, the program outcomes have been significantly less consistent in all of the other states. The realization is that, despite the huge mobilization of resources and the prioritized focus on the sub-set of 32 scale-up LGAs, program outcomes did not reflect that these LGAs indeed had significant unmet need. Comparative reviews of program results across the three different categorizations of scale-up, sustained-plus and sustained-support LGAs had little to justify the continued differential pooling of resources in the 32 LGAs and similarly did not appear to impact the estimates of population-wide progress towards the 90-90-90 targets. These findings aligned with most stakeholders' position that the epidemiologic data and relative estimates of PLHIV in the country were not adequately reliable to monitor population coverage rates and support the push towards the epidemic control.

COP18 is built on this position and represents a shift from the previous efforts at sub-national geographic prioritization. In this plan, PEPFAR will pursue sustained program implementation based passive enrollment and limited targeted case-finding approaches like index client testing and testing among KPs. Other field-level investments will support program activities to improve linkage and retention in treatment especially in the facilities with large client loads. This program is expected to commence implementation of this "sustained program model" in the latter half of the COP17 implementation period to ensure appropriate adjustments are made in the field and to generate savings for use during the COP18 implementation period. The expectation is that the results of the NAIIS will provide needed evidence to support future geographic prioritization, ensuring that investments are indeed aligned to the areas with the greatest need.

2.5 Stakeholder Engagement

A more targeted stakeholder engagement approach was adopted this year in order to improve opportunities for stakeholders to fully understand the scope of PEPFAR program in Nigeria and the priorities that are currently being addressed. The targeted approach included opportunities for stakeholders to review and analyze the challenges currently facing the program and to pool recommendations and resources to mitigate these challenges.

Two roundtable meetings were convened under the leadership of the NACA DG to review key health system components driving the success of the National HIV response. The first of these roundtable meetings focused on the national laboratory system and stakeholders were updated on the processes to improve access to viral load, EID and GenXpert services through the optimization of a National Integrated Laboratory Network. Stakeholder contributions focused on emerging opportunities to address bottlenecks in the process through the planned rollout of an integrated sample transfer system, the improved resourcing of key laboratories in the network, and the integration of Laboratory Information Management Systems (LIMS) into the hospital electronic medical records (EMR) to facilitate improvements in turn-around-time for lab tests and the tracking of lab processes through the National LIMS Dashboard supported by the Clinton Health Access Initiative (CHAI).

The second meeting focused on the investments in the National Health Management Information System (NHMIS) which, through the USAID-supported Measures Evaluation project, received support to complete a Master Facility List (MFL) for the entire health system. This list forms the basis for updating the National DHIS instance for routine health data reporting. Measures Evaluation is now working with Federal and State Governments health authorities to institute a governance process for the period update of the MFL. The status of the National Data Repository (NDR); a database to store periodically updated de-identified patient level data for qualitative monitoring of the treatment program, was also presented.

Following the release of the COP18 guidelines on the January 18, 2018, the country team hosted a series of meetings between the 22nd and the 26th of January to review highlights of the planning memo and the country specific guidance received from S/GAC. Stakeholders aligned with the recommendations to focus on strategies to improve the efficiency of case-finding, linkage to and retention on treatment but expressed initial concerns about the reduced funding level. During the course of the week, the team also had the opportunity to discuss with stakeholders some program barriers such as; user fees, high loss-to-follow-up, client waiting times in clinics, the lack of specialized care for adolescents, and the concerns for potential stigma-related complications arising from index partner testing. To all of these concerns, the stakeholders received robust commitments from the GON, PEPFAR and implementing partners to pursue mitigation efforts.

The country continued to solicit and receive written feedback on the COP18 planning process by email and convened additional meetings prior to the Regional Planning Meeting (RPM) to provide updates to the CSOs, government and Multilateral Partners. The team worked closely with the PEPFAR implementing partners to review operational and management costs using the Financial Allocation and Strategy Tool (FAST). An interagency approach was adopted in the review and finalization of the FAST before it was submitted to S/GAC.

At the RPM, the team was privileged to host the most representative country delegation ever convened for a COP process, with the Honorable Minister of Health, DG NACA, NASCP Coordinator, UNAIDS Country Director, WHO Country Representative and two senior CSO leaders in attendance throughout the 5-day planning meeting.

In a free flowing series of dialogues with the S/GAC leadership and the PEPFAR country team, stakeholders were given the opportunity to fully dissect the COP18 plan and to make contributions for review and revision where possible. The meeting ended on a positive note with stakeholder consensus on the idea of shifting way from ongoing scale-up efforts based on poor knowledge of the country epidemic towards a sustained program that remains primed to respond expediently to more accurate data about the national HIV burden and distribution of disease based on the outcomes of the NAIIS.

The country team agreed to engage with stakeholders throughout the course of the implementation period and to meet with Civil Society partners on a regular basis to receive input on implementation strategies, feedback on programmatic progress.

3.0 Geographic and Population Prioritization

The absence of reliable epidemiologic data for HIV/AIDS at the sub-national level has posed a challenge to the PEPFAR program objective of prioritizing a subset of LGAs or scale-up of HIV/AIDS testing, treatment and viral load services to achieve the UNAIDS 90-90-90 targets. Based on this experience, the program, along with the Global Fund and the GON, will conduct a nationwide population-based HIV/AIDS impact assessment in 2018. The survey results will inform a revision of the country-wide estimates of PLHIV burden and unmet need and will form the basis for a new prioritization by geographical area.

Pending the completion of the survey, PEPFAR will sustain its program footprints in all of the currently supported LGAs. The program will focus on strategies which have demonstrated the potential for improved case-finding, linkage and retention of clients on treatment. In line with PEPFAR categorization definitions, the whole of the country program in COP18 is categorized as “sustained-support” only. This categorization reflects the pullback on cost intensive community testing, treatment and patient follow-up activities which have not yielded the desired results. Operating in this categorization, the program retains vital implementation infrastructure and systems and remains primed to mobilize rapidly and appropriately to address needs based on refined geographic burden and distribution estimates.

Table 3.1 shows summarizes the current status of the program in terms of LGAs covered, numbers of clients currently treatment and the proposed targets for the COP18 implementation year (FY19).

Table 3.1 Current Status of ART saturation

Prioritization Area	Total PLHIV/% of all PLHIV for COP18	# Current on ART (FY17)	# of SNU COP17 (FY18)	# of SNU COP18 (FY19)
Attained		14,767		
Scale-up Saturation		97,894	12	
Scale-up Aggressive		98,833	20	
Sustained-Plus			13	
Sustained	3,305,819/100%	561,016	489	507
Central Support				
Total	3,305,819	772,510	534	507

The on-going review of program data by age and sex disaggregation has noted challenges in reaching adult men, adolescents and children with services. It has also revealed the potential to reach more PLHIV through programs targeting sex-workers, MSM and IDUs. In COP18, the program will be modified to maximize opportunities for reaching these population sub-groups and addressing barriers that have limited their access to HIV/AIDS treatment.

4.0 Program Activities for Epidemic Control in Priority Locations and Populations

Not applicable

5.0 Program Activities in Sustained Support Locations and Populations

The 534 LGAs supported by the PEPFAR program in COP18 have been categorized as sustained support. PLHIV will continue to access PEPFAR-supported testing, care and treatment services in all of these LGAs while the program seeks to implement more efficient ways to support services.

5.1 COP18 Programmatic Priorities and Targets

Programmatic priorities for case-finding will focus on testing among high-risk key populations and testing of sexual partners and children of index clients. Other venues where testing will be prioritized include the TB-DOTS clinics and the blood banks (for those previously screened and considered to be “high risk” and therefore unable to donate blood). For all clients diagnosed with HIV, resources have been prioritized to support their facilitated linkage to treatment services through escort services provided by volunteer and lay-workers in the facilities. This support staffing pool along with data clerks will also work to ensure patient adherence, retention and follow-up where necessary. Optimizing the use of available laboratory resources will ensure that all PLHIV enrolled on treatment have the opportunity to receive viral load testing services at least once within the course of the implementation year and in line with national guidelines.

Similarly, the KP and orphan and vulnerable children (OVC) programs will continue to support services in LGAs in line with previous year program plans. The details of the planned interventions and the service packages are provided in the appropriate sections below. High volume facilities in 171 out of the 534 LGAs supported by PEPFAR have been selected for roll-out of partner notification services (PNS.) Efficiencies from the scale-up of PNS will allow the program to test significantly fewer clients to reach expected targets in COP18 (See Figure 5.1 below).

Table 5.1.2 Expected Beneficiary Volume Receiving Minimum Package of Services

Sustained Support Volume by Group		Expected result APR 18	Expected result APR 19
HIV testing in PMTCT sites	<i>PMTCT_STAT</i>	2,461,504	1,544,084
HTS (only sustained ART sites in FY 17)	<i>HTS_TST/HTS_TST_POS</i>	11,061,275/344,041	5,262,917/147,950
Current on ART	<i>TX_CURR</i>	871,813	966,027
OVC	<i>OVC_SERV</i>	912,687	940,068

5.2 Establishing service packages to meet targets in sustained districts

Sustained service package has been divided into three components; Facility-based programs (including HCT, Treatment and Viral load), KP programming and programs for OVC.

5.2.1 Facility-Based Programs (HCT, Treatment and Viral Load)

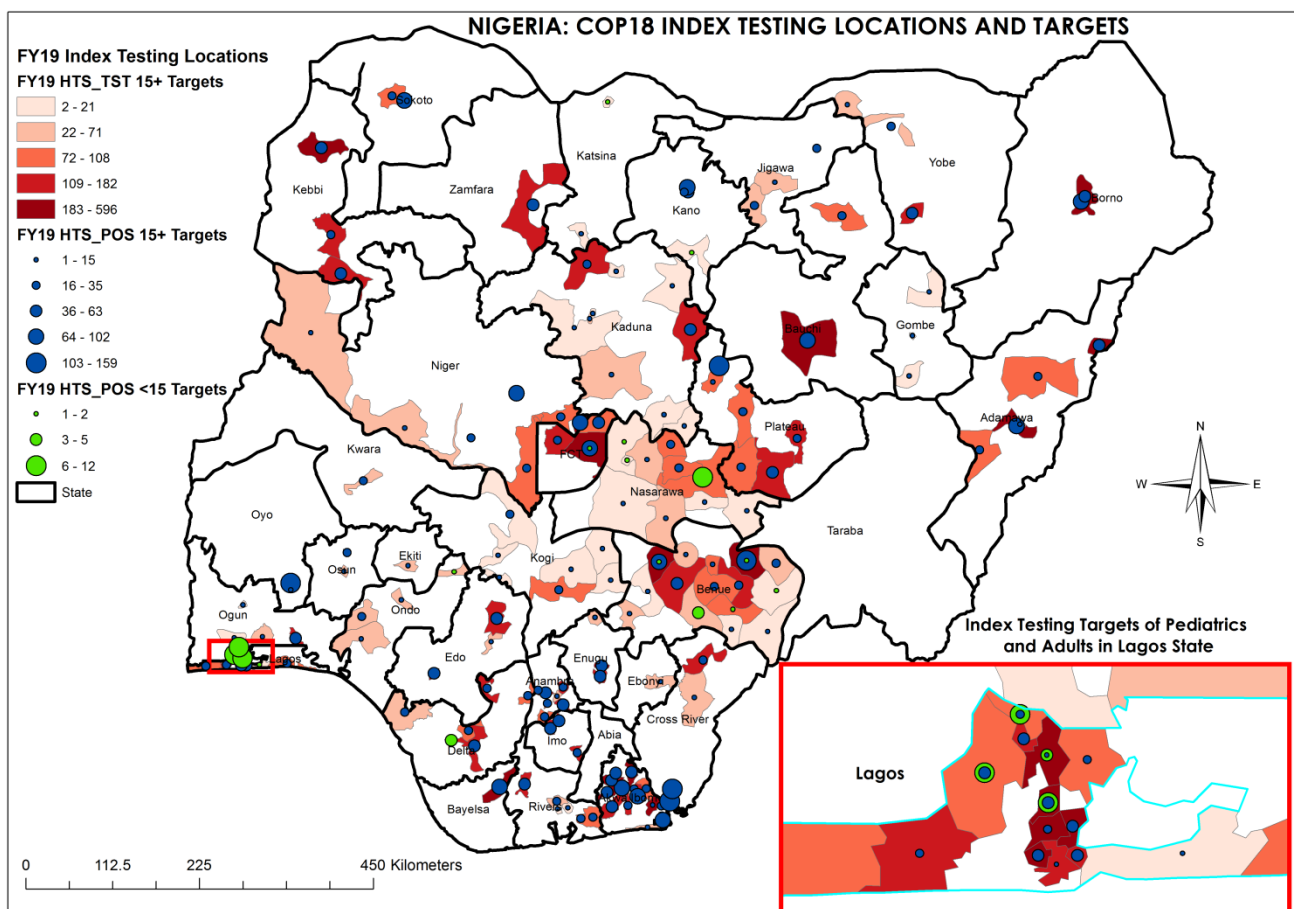
For descriptive purposes, facility-based programs to be supported are categorized in line with the UNAIDS 90-90-90 target framework. A separate section on pediatric (similarly categorized) can be found in section 5.2.1.4 below.

5.2.1.1 First 90 - HIV Testing Services (HTS)

In COP18, PEPFAR Nigeria will only provide HTS within supported health facilities to clients with clinical indications or on demand. Additional efforts will be made to improve case-finding and

maximize efficiencies in a select number of high volume sites. Community based HTS will be limited to the KP program within the 6 +1 States only (Akwa Ibom, Benue, Cross-River, Lagos, Nassarawa, Rivers and FCT). Furthermore, within the selected health facilities, testing modalities with a high-yield of positives and/or proportionately high absolute number of positives identified will be optimized and taken to scale, including index partner testing, TB clinic, facility VCT, STI clinic and inpatient wards. Risk profiling tools (to determine clinical indication) will be deployed at other testing points such as antenatal clinic, pediatric outpatient, immunization clinic, and general outpatient to further enhance testing efficiency.

Index partner testing/PNS will be scaled up in an additional 118 high volume health facilities in COP18. An analysis of FY17 PNS data revealed low acceptance of PNS by index patients and poor elicitation and notification of contacts by providers as chief among the bottlenecks in the program. In FY18 (COP17 implementation year), the program will provide refresher PNS trainings focused on addressing these bottlenecks in collaboration with our PNS technical assistance partner and headquarters technical backstops for HTS, and use identified “expert elicitors” within the program to coach and mentor others.



Map showing COP18 Index Testing Sites and Targets

The program has set up PNS Core Teams comprised of PEPFAR staff and relevant partner staff to review PNS cascade data monthly at implementing partner and health facility level and brainstorm on solutions to identified bottlenecks. These teams will be sustained and strengthened in COP18. Our

PNS strategy will also ensure that HTS is provided to children of newly identified adult PLHIV (whether index or partner of index) and that HIV-positive children are linked to pediatric treatment services.

The PEPFAR Nigeria program will also deploy a self-testing strategy to reach partners of index patients who decline to come to health facilities for testing after being notified. The program will intensify efforts at finding men by expanding HTS into accident and emergency units; linking high risk and HIV positive men screened at blood banks with HTS services within same health facilities either using dedicated lay counsellor/testers at the blood banks or using referral escorts that will take them into the HTS unit. In addition, the program will increase number of facilities providing adolescent and men friendly HTS as well as weekend/afterhours services in order to expand access for adolescents and men.

Best practices that resulted in high linkage success rates in the 32 scale-up LGAs in FY17, including the use of peer navigators, referral escorts and facility linkage coordinators (monthly meeting to ensure referrals are completed), will be deployed across the entire program in COP18 to ensure an overall linkage rate of 90% or higher.

Standard Table 5.2.1

Table 5.2.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients			
Entry Streams for ART Enrollment	Tested for HIV (APR FY19) <i>HTS_TST</i>	Newly Identified Positive (APR FY19) <i>HTS_TST_POS</i>	Newly Initiated on ART (APR FY 19) <i>TX_NEW</i>
Total Men	1,350,089	51,509	44,537
Total Women	3,441,163	108,302	98,536
Total Children (<15)	474,363	7,270	7,698
Adults			
TB Patients	34,322	4,240	
Pregnant Women	1,493,614	13,577	
*VMMC clients	NIL	NIL	NIL
Key populations	283,295	15,150	
Priority Populations			
Other Testing	3,404,000	257,987	
Previously diagnosed and/or in care			
Pediatrics (<15)			
HIV Exposed Infants	34,363		730
Other pediatric testing	440,000	7,261	6968
Previously diagnosed and/or in care			

**PEPFAR does not support VMMC in Nigeria*

5.2.1.2 Second 90 – Adult HIV Care and Treatment

In COP 18, PEPFAR Nigeria will support an equitable treatment program that leaves no population behind by identifying gaps in service delivery across age and sex disaggregations, consolidating lessons learned in COP 17 and instituting continuous quality improvement initiatives to improve outcomes. PEPFAR will continue to implement and consolidate the “test and start” approach across all supported LGAs in Nigeria ensuring quality of care and improved treatment outcomes. Additional

work will be done to determine the effects of user fees of different varieties on service uptake. The treatment service delivery package will include: provision of ARVs; facility-based adherence monitoring; retention activities; and, viral load assay to monitor treatment efficacy. Strategies that will improve linkage and retention of PLHIV on treatment will be strengthened. These include accompanied referral, documentation of repeat testers, same day ART initiation, fast-tracked adherence counseling, and improved client education. In addition, PEPFAR will continue to support use of peer-navigators, active client tracking, appointment diary system/SMS reminders, and use of electronic medical records to improve tracking. In LGAs with a negative net new on ART, continuous quality improvement initiatives such as the use of a case management approach to HIV care will be strengthened. Using this approach, a case load is assigned to each case manager (mostly expert clients, mentor mothers, or PLHIV) for follow up, active tracking of clients lost to follow up, and improving standards of care. Other client-friendly services known to improve retention will also be scaled up across all facilities, but prioritized in high volume sites. These include differentiated care, for example, using community pharmacies to support refills of ART for stable patients on treatment, multi-month scripting, flexible clinic hours targeting males, continuous quality improvement, and scale up of adolescent friendly clinics. In addition, increased drive will be targeted at improving access of HIV treatment services to men. Strategies for achieving this will include: partnering with key community leaders & gate keepers to stimulate access and retention of HIV services; engagement of male expert clients to promote increased uptake of HIV services; support partners to encourage their male partners to seek HIV services; utilization of men living positively to promote HIV services among men; and targeted HIV testing for high risk men at blood banks and accident/emergency units.

PEPFAR will continue to support cotrimoxazole prophylaxis, nutritional assessment and counselling, and Positive Health, Dignity and Prevention (PHDP) services that aim to reduce morbidity and mortality, optimize retention in care, improve quality of life, and prevent ongoing HIV transmission. PEPFAR will also scale up virtual clinical mentoring using information, communications technology platform to build the capacity of healthcare workers in secondary health facility to improve quality of care and patient outcomes.

Program activities to ensure improvements in the treatment cascade are summarized in the table below.

Strategy Highlights For Improving Treatment Cascade

Improve linkage	Improve Retention	Client-friendly service
<ul style="list-style-type: none"> • Accompanied referral • Documentation of repeat testers • Same day ART initiation • Fast Track adherence counselling • Improved client education 	<ul style="list-style-type: none"> • Use of peer-navigators • Active client tracking • SMS reminders • Appointment diary system • EMR to improve tracking • Client-friendly appointment scheduling 	<ul style="list-style-type: none"> • Differentiated care • Multi-point refill • Flexible clinics hours targeting males • Improved patient engagement • Continuous Quality improvement • Adolescent and Pediatric friendly clinics

PEPFAR Nigeria will work closely with implementing partners to leverage best practices, QI initiatives targeting high volume ART sites, and innovative approaches to service delivery. Efficiencies will be gained through the National Integrated Sample Referral Network to improve viral load coverage, deepen EID penetration, strengthen TB/HIV collaboration and ensure optimal turnaround times are achieved. The newly supported service delivery models of care will be strengthened to improve the gains in treatment outcomes and enhance client friendly services. Client level efficiencies will also be achieved through the accelerated, aggressive transition to Tenofovir disoproxil fumarate, Lamivudine and Dolutegravir fixed-dosed combination (TLD) with the rapid adoption by the FMOH of TDF/3TC/DTG as the preferred first line treatment regimen for adults and adolescents, proactive order of TLD in December 2017 and timely convening of the National Supply Chain Planning technical working group meeting which will codify GON, PEPFAR, Global Fund and other stakeholders commitment to the adoption of TLD. This transition will result in improved linkage and retention of clients due to significantly reduced side effects and adverse drug reactions. In addition, facilitate the rapid achievement of community viral suppression will be beneficial in improving outcomes of the treatment program.

5.2.1.3 Third 90 - Viral Load (VL)

In COP18, the country program will continue the scale-up of VL testing for all eligible patients on treatment. The VL testing target for COP18 has been set to ensure that at least 90% of all eligible patients on treatment are tested and their results documented in their folders. To achieve this, the PEPFAR program will leverage on its investments in PCR laboratory network optimization in FY18. This optimization process has resulted in the streamlining of the number of PCR labs supported by PEPFAR from 27 to 11. An additional four PCR labs are now supported by the Global Fund, and one by the GON. The country will increase its viral load coverage for eligible patients on treatment by using this fully functional network of 16 PCR Labs. In FY18, the country program rolled-out the National Integrated Sample Referral System (NISRS). PEPFAR will expand the rollout of the NISRS in COP18 to cover additional states/clusters, prioritizing clusters with high volumes of patients. The country program has also rolled-out the use of dry blood spot (DBS) samples for VL testing in FY18. This

approach will be expanded in COP18 to reach eligible patients in hard-to-reach or remotely located health facilities where plasma sample collection and handling poses a challenge.

A review of VL testing performance for FY17 and quarter one of FY18, indicated that; coverage for patients in supported facilities remains very low, the turn-round-time (TAT) for VL test results are unacceptably high, and significant VL results released by the labs do not make it into the patients folders. The country team is addressing these systems limitations by supporting the deployment of medical laboratory scientists and data clerks in all the PEPFAR supported 11 PCR labs. The PEPFAR program is also supporting the provision of un-interrupted power supply in the labs and expanding the hours of operations of the labs to between 16 and 24 hours per day. These interventions will be sustained in COP18. In addition, PEPFAR will strengthen the lab-clinic interface by identifying VL focal persons in each of the PEPFAR supported treatment facilities who will be responsible for ensuring that VL results are filed in patients' folders. In the long-term, PEPFAR continued support for the inter-operability of the LIMS and the patients EMR will ensure that VL results are automatically relayed to the EMRs and used for clinical care.

Granular management of PEPFAR implementing partners with regards to VL testing will continue to ensure that patients who fail to achieve viral suppression are adequately linked to enhanced adherence counseling and that their VL test are repeated afterwards. Prioritization of infants, pregnant women, and KPs for VL testing will commence in COP18.

PEPFAR will continue to partner with the Global Fund, CHAI, WHO, and AHF, using the laboratory platform to ensure activities are well coordinated and have an impact. The National Laboratory Technical Working Group will continue to monitor PCR lab performance, while collaborating with key civil society groups for championing of VL service uptake and quality of service tracking.

5.2.1.4 Pediatric Case-finding, Treatment and Viral Suppression

PEPFAR Nigeria will intensify efforts at early identification and efficient linkage of HIV infected children and adolescents to quality treatment services and retention on ART in order to achieve and sustain viral load suppression.

Intensified case finding will be strengthened by developing and deploying a modified risk assessment tool to optimize facility-based provider initiated testing and counseling (PITC) especially for children of index clients, and in in-patients wards, out-patients, malnutrition clinics, and TB clinics, . In the scale up of PNS, the pediatric/adolescent cohort will be systematically elicited and tracked as a distinct cohort via family index testing. Key interventions will focus on: intensifying screening of mother-infant pair across all service points to determine exposure status; strengthening CQI; and strengthening the use of longitudinal registers to track mother-infant pairs. In addition, EID services will be prioritized for all HIV exposed infants.

Use of escort services for children and adolescents using health care workers, volunteers, peer navigators or referral coordinators to physically escort the newly identified HIV positive children and adolescents to the enrolment center will be strengthened. ART Initiation Tracking Registers will also be used to further strengthen ART linkage. Bidirectional collaboration and linkages between Pediatric

HIV services, PMTCT services and OVC services will be strengthened. All HIV positive children, including children of co-infected adults will be screened for TB at every clinic contact.

The pediatric-biased family centered differentiated care model will be strengthened. Co-scheduling appointments for parent-child pairs as well as Pediatric/Adolescent friendly clinic systems and structures will be strengthened. The scale up of Lopinavir/Ritonavir pellets in FY18 will result in availability of a more efficacious ARV regimen. 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. To improve adherence support for children and their caregivers at ART initiation and at each contact with a health care worker, child centered adherence counselling will be employed in addition to deploying standardised age appropriate disclosure packages adapted to the Nigerian context. Continuous tracking of clients who default or are lost to follow up, as well as co-scheduling of ART services with other health services the child may need such as immunisation as an integrated package of care, will be prioritized. To improve adherence and retention among adolescents, standardized disclosure support, standardized transition to adult care, and peer support mechanisms will be brought to scale.

5.2.1.5 TB/HIV Co-infection

PEPFAR Nigeria 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 presumptive TB and TB cases, ensure universal ART for all PLHIV, ensure timely TB diagnosis and treatment completion, scale up TB Preventive Therapy (TPT) and sustained joint TB/HIV programming and monitoring.

Programming for TPT will be prioritized and scaled up across all PEPFAR supported sites. PEPFAR Nigeria reviewed the key bottlenecks to TPT implementation in 2016 and worked with the GON to integrate INH logistics into the ARV Logistics Management and Information System (LMIS). PEPFAR will work with the GON to revise the drug order and requisition forms at the facility level to include INH and initiate training of logistics staff at sites on appropriate quantification and requisition of INH alongside the existing ARV practices. Support will continue to be provided for last mile delivery of INH directly to every implementing site alongside ARVs. Buffer stock of INH will also be procured to argument that provided by the GON.

TB intensified case finding will be strengthened especially among the PLHIV population. The revised National TB Control Program guideline has recommended Chest X-ray along with symptom screening for all newly enrolled PLHIV in care and treatment. PEPFAR will support this effort through a voucher system for chest x-ray screening across all high volume ART sites. Funding for TB/HIV Referral Coordinators/Volunteers to ensure improved referral and linkages to treatment for all co-infected PLHIV will continue at these sites.

PEPFAR is currently implementing GeneXpert optimization strategies as per the recommendations from the SGAC technical assistance visit to Nigeria in July 2017. This is being implemented in collaboration with stakeholders and the National TB control program. The optimization is focused on addressing key systems barriers to TB diagnosis and TB-laboratory services uptake through systems

interventions for increased capacity utilization of the GeneXpert instruments, TB-GeneXpert continuous quality improvement (CQI), and the use of laboratory evidence to inform TB program decisions. A key element of the GeneXpert optimization strategy is the introduction of the National Integrated Sample Referral Network (NiSRN) this FY in collaboration with key stakeholders and the GON. This will ensure linkage of GeneXpert sites to ART/DOTS facilities for pick-up of clinical samples for TB diagnosis, treatment monitoring, and drug sensitivity testing. The results of the testing will also be returned through the same mechanism. This will improve GeneXpert capacity utilization and as well as uptake for TB services with a reduced turn-around-time for TB diagnosis. These optimization efforts will be further prioritized in COP18. National level forecasting, quantification, coordinated supply plan and commodities distribution between PEPFAR and Global Fund will be implemented.

As part of efforts to ensure a fully functional Lab Information Management System, the TB GeneXpert GX-Alert system, will be integrated with the National Viral Load and EID Testing Dashboard which is linked to the facilities EMR systems and the National Data Repository. This will provide comprehensive laboratory data for quality care of ART patients and evidence informed decision-making.

5.2.2 Key Population Programs

PEPFAR Nigeria's KP strategy for COP18 is focused on achieving the UNAIDS 90-90-90 among key populations. The use of evidence-informed prevention-based peer-led networks will form the fulcrum for the 90-90-90 service delivery. In COP 18, the KP program will continue to implement the one-stop-shop (OSS) strategy that primarily seeks to provide the complete cascade of HIV services in a safe space that is nuanced to the behavioral inclinations of KPs. The OSS will act as a hub for community based ART delivery using peer-led networks and community outreach workers. The target population for the PEFAR Nigeria KP program will include FSW, MSM, People who inject drugs (also known as PWID) and incarcerated populations. Mapping of new hotspots within prioritized geographic areas will be the strategy for identifying KPs in COP 18. Implementing partners will continue to engage key stakeholders including the Nigeria Police Force, and the National Human Rights Commission to address issues of harassment, discrimination and criminalization of KPs.



Direct service provision will include elements of the nationally approved Minimum Prevention Package of Interventions. A suite of mutually reinforcing prevention services including peer education, interpersonal communication, a total market approach to condom/lubricant programming, social media engagement, sexually transmitted infections (STI) management, community level system strengthening and appropriate structural level interventions will reduce the risk of new infections among targeted KPs.

HIV testing services will be highly targeted and based on a nuanced risk profile based testing algorithm that seeks to identify KPs with the highest level of risk. Where populations other than KPs are tested (e.g. clients of sex workers or female partners of MSMs), testing results will be disaggregated accordingly. Behavioral and biological markers for risk profiling will be specific and based on evidence from well-designed operational research. Index testing and PNS and self-testing especially for sexual partners of KPs will be prioritized in active case finding. KP PLHIVs will be actively linked to ART services based on their preference using a same day initiation approach.

ART services will be available at the OSS and through mobile community ART (mCART) teams. Differentiated care models will be employed in the delivery of ART services. Based on evidence of adherence for a minimum period of six months, evidence of clinical stability and evidence of viral suppression, patients will be classified as stable and unstable. Stable patients will have multi-month scripting for ARVs delivered through community structures while unstable patient will be seen at least once monthly. Treatment algorithms for first and second line drugs will be in line with National standards.

5.2.3 Orphans and Vulnerable Children (including Adolescent Girls and Young Women)




In FY 19, the OVC program will deliver need-based, age-appropriate interventions consistent with the integrated case management package and National OVC Service Standards. Improved access to HIV/AIDS and OVC services for vulnerable children, especially prioritized sub-population groups including children living with HIV, children of PLHIV, children of key populations, high risk

adolescents and other children affected by HIV, will be prioritized. Emphasis will be on expanding HIV prevention including testing, enrollment and retention on treatment and care. The OVC program will contribute to HIV epidemic control through active case finding with focus on priority sub-population groups. There will be targeted testing of OVC using contextualized clinical and social criteria. Implementing partners will improve pediatric case finding through the use of a pediatric HIV screening tool. The program will ensure all identified HIV-positive children are tracked and initiated on treatment using bi-directional linkage coordinators and the introduction of OVC services adapted for delivery at facilities. The bidirectional referral between facility and community will ensure high risk adolescents are targeted by the OVC program. It will also ensure integration between the care and treatment program and OVC. Case managers will ensure those due for VL test have samples taken when due. Strategies to empower households and communities for better parenting, sustainable care and support to OVC will be emphasized.

Partners will also focus on intensive household economic strengthening interventions. Using a case management approach, community-based OVC programs will provide household based services in the different OVC service areas to ensure family stability and increase resilience. Case managers will refer beneficiaries to other services where they may not be available on site. Adolescents, especially girls and young women, who have dropped out of school will be re-enrolled in formal or vocational education where feasible and targeted with HIV prevention interventions with linkages to adolescent-friendly reproductive health services and economic strengthening activities. PEPFAR Nigeria OVC program will support the creation of safe spaces for adolescent girls with special focus on socially marginalized adolescents such as children of commercial sex workers and teen mothers. A need based package of services will be deployed for adolescent girls and their partners, including group HTS where appropriate. Financial literacy skills for adolescents will be expanded and opportunities to translate such skills into concrete economic opportunities explored. Ongoing norms interventions that identify and address gender issues which predispose individuals to HIV, especially adolescent girls and young women will be supported. Community and school based gender based violence (GBV) prevention activities for children and adolescents will be expanded through existing clubs and school-based programs.

OVC programs will continue to build the capacity of local partners to identify and engage government and the community on transition of girls to secondary schools and harmful community practices that increase adolescent vulnerability.

COP18 Strategy for OVC & Children

 <p>Knowing HIV Status</p>	<p>1st 90: Increase testing for children/adolescents</p> <ul style="list-style-type: none"> • Focus on priority sub-population • Disclosure counselling/support for caregivers • Targeted testing of OVC using contextualized clinical and social criteria
 <p>On ART</p>	<p>2nd 90: Support/contribute to treatment initiation and long-term care</p> <ul style="list-style-type: none"> • Use of bi-directional linkage coordinators • Introduction of OVC services adaptable for delivery at facilities • Ensure ALL identified HIV-positive children are initiated on treatment • Tracking of linkage success rate with custom indicators
 <p>Viral Suppression</p>	<p>3rd 90: Support adherence, Viral load testing</p> <ul style="list-style-type: none"> • Adherence support/counselling by community OVC case workers • Accompaniment of CLHIV to clinical appointments

Significant community-based organization 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. PEPFAR Nigeria will continue to build capacity of the Ministries of Women's Affairs and Social Development, especially at state and LGA levels and continue to advocate for workforce development. Implementing partners will also work with community-based organizations to strengthen prevention of and response to violence against children. GBV survivors will receive escorted referrals to clinical and non-clinical services and capacity of OVC case workers engaged in home visits will be built for GBV screening during routine visits.

Implementing partners will continue to work with community based organizations (CBOs) and government to strengthen national OVC program data management and reporting systems including the National OVC Management Information System (NOMIS), by ensuring that implementing partner and GON capacity to use and manage the system is strengthened, in addition to continued community engagement and advocacy for increased government investment, ownership and sustainability of national OVC program. PEPFAR Nigeria OVC program will use an OVC logic model to monitor quality of program activities rendered to beneficiaries.

Table 5.2.3. below lays out COP 18 OVC targets and linkages to HIV services.

SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY19 Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY19 Target) OVC*
ALL PEPFAR Supported LGAs	1,800,000	940,068	711,872
TOTAL	1,800,000	940,068	711,872

5.3 Additional country-specific priorities listed in the planning level letter

Nigeria has been implementing “test and treat” since FY2017. Since then, all PLHIV previously enrolled on care and all those newly diagnosed have been commenced on treatment. Other policies to support improved case-finding for PLHIV like index partner testing and same-day ART initiation are covered in the revised Integrated National Treatment Guidelines but uptake of services has been sub-optimal mainly due to operational reasons. Training and supportive supervision activities are currently being rolled-out to support the scale-up of these services. Index partner testing services in particular have been demonstrated to offer unique opportunities to reach key populations, adult men and children at risk; populations for whom traditional HIV testing modalities have not always reached efficiently. Self-testing is also covered in the National Guidelines but due to funding limitations in COP18, PEPFAR will not procure self-test kits directly but will leverage test kits procured by other stakeholders such as the Global Fund (through the unified procurement and supply chain) and the GON’s Total Market Approach (TMA).

Differentiated care models currently focus on decentralizing services for healthy stable clients receiving treatment and includes multi-month drug scripting (between 3 and 6 months) and flexible drug pick-up options using community pharmacies and lower level health facilities as outlets. In Cop18, PEPFAR Nigeria will scale up multi-month dispensing of ARVs from three months to six months in stable patients. For those still accessing services in the facilities, PEPFAR implementing partners are working with their supported health facilities to reduce client wait times and eliminate other barriers which may negatively impact on clients perceptions of the services received. To improve flexibility in attendance hours especially for men and for school-age children, the program will work with large volume facilities to provide weekend and after-hours clinic services. Opportunities will also be sought to provide specialized adolescent-friendly clinic services to meet the unique needs of this population. At the policy-level, advocacy efforts will aim to institutionalize these services delivery options in the country’s health system.

The program will reallocate resources from low volume sites to address gaps identified in the facility-based programs. Partner management efforts will focus primarily on the largest volume facilities located in 171 LGAs which currently support about 65% of the people receiving treatment in the program. A monthly review of the progress of PNS, HIV case-finding, linkage and retention on treatment and the client’s access to Viral Load and EID services will be instituted as way to monitor performance of these facilities.

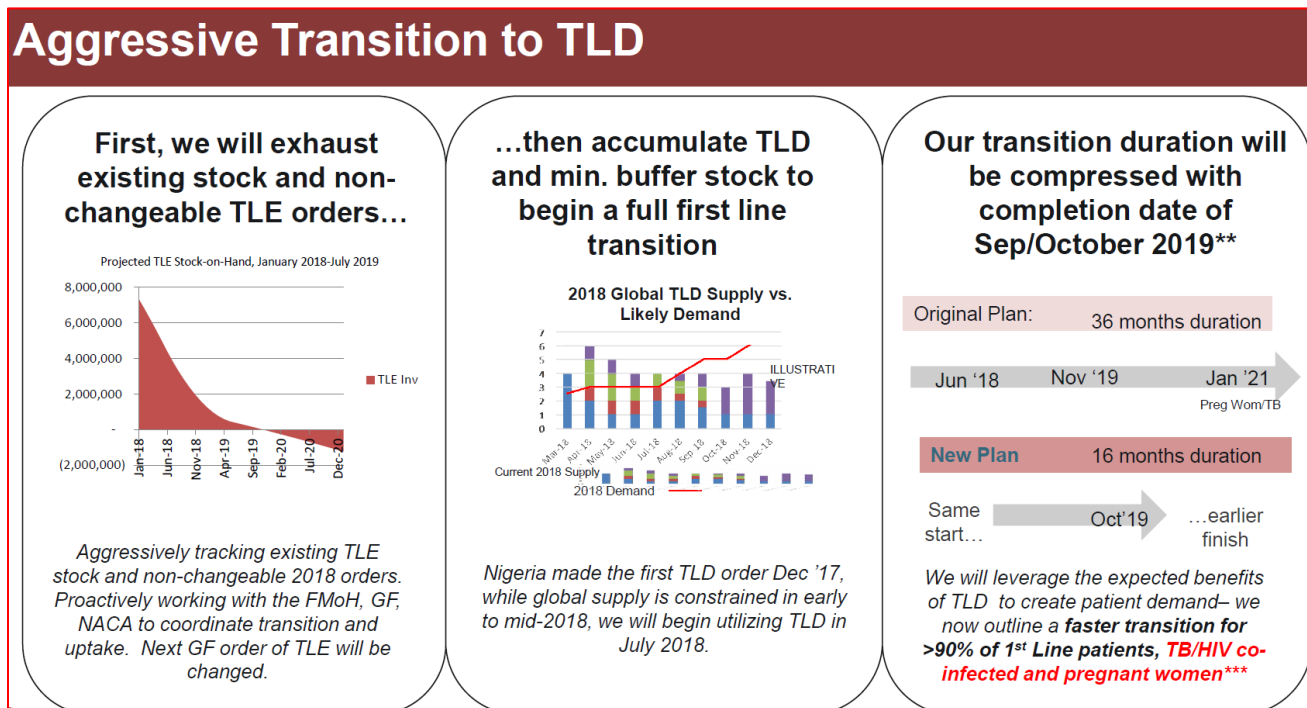
PEPFAR will sustain its engagements with Civil Society, the GON and multilateral partners, to negotiate the waiver of user fees, especially for pregnant women, children and other vulnerable populations. The program will continue to support government efforts to fund HIV/AIDS service delivery through the expansion of the National Health Insurance Scheme, the private sector trust fund and the National Treatment Program which is set to launch in 2018.

5.4 Commodities

PEPFAR has adopted an aggressive TLD transition plan, predicated on the global supply of TLD. Beginning in June 2018, with the first delivery of TLD, Nigeria will begin to transition patients by prioritizing all patients on Nevirapine, Efavirenz intolerant patients, new patients and tolerant TLE patients. By October 2019, Nigeria is expected to have transitioned to TLD, including, with the

release of update WHO guidelines, pregnant women and TB patients. This transition plan has been carefully created to account for the current level of TLE stock in country, by January 2019 to avoid wastage.

PEPFAR does not expect any stock-outs or funding gaps for ARVs, rapid test kits (RTKs), EID or viral load commodities; however, due to the significant reduction in testing, the PEPFAR team will need to closely monitor the utilization of RTKs to ensure targeted testing is within the bounds of the determined national targets to avoid stock-outs of RTKs.



Note: this plan will be updated once agreement has been reached on the availability of TLD from the manufacturers.

5.5 Collaboration, Integration and Monitoring

Technical collaboration to improve program outcomes is facilitated through PEPFAR participation in National Technical Working groups and more broadly through the Expanded Theme Group hosted by the NACA. In the recent past, these collaborations have led to the review of national program guidelines to incorporate new policies like test and treat, self-testing, differentiated care and pre-exposure prophylaxis (PrEP). They have also served as avenue to review program performance and to address emerging program challenges. The PEPFAR country team often takes the advantage of these established platforms to disseminate the outcomes of the quarterly Program Oversight and Accountability Review Team (POART) meeting and to mobilize stakeholder participation and inputs for the Country Operational Plan development process and collaborative efforts such as the SID reviews.

The PEPFAR team has collaborated with the GON and the Global Fund at multiple points, resulting in: a joint National Integrated Procurement and Supply Chain Distribution system; the National Integrated Laboratory Network System with shared platforms for sample transfer and laboratory services; and the expansion of EMR systems and improved coverage of the National Data Repository of de-identified patient level records.

The team also participates in the quarterly week-long Global Fund program reviews and through these engagements, has advocated for improved linkages and a joint national review of country-level HIV/AIDS program performance. Future engagements will seek to standardize age and sex disaggregated program-level indicators at a more granular level to facilitate the joint review processes.

The central focus of the collaborative effort of stakeholders in Nigeria is the NAIIS. Significant PEPFAR resources (roughly \$65m) have been obligated and aligned to other investments from the Global Fund to support this effort. Leading these efforts, the GON has inaugurated two governance structures, the National Steering Committee led by the Minister of Health and the National Technical Committee led by the NACA Director General. The technical committee will engage directly and drive the survey implementation with the CDC-funded implementing partner, the University of Maryland, Baltimore (UMB). Civil society stakeholders are currently represented on both committees and will work to mobilize the needed buy-in and support of the CSO and other communities at the grassroots.

Also the PEPFAR country team will engage the GON and multilateral partners on the design and launch a revamped National Treatment Program (NTP) which will serve as the principal avenue for channeling improved domestic resources into the National HIV/AIDS Response. PEPFAR will seek opportunities to ensure that these resources are targeted towards already identified gaps in the national response and applied in a manner that is catalytic to a sustained rapid expansion of treatment coverage and the country's efforts to reach the 90-90-90 targets.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

Reflecting the need to focus on improving the availability of quality HIV/AIDS program data for planning, monitoring and evaluation, three system investment activities have been prioritized in COP18. These three activities are summarized in Table 6 (Appendix C) below.

The major health system activity is the on-going collaborative effort on the NAIIS described above.

The second major system-level investment is on the National Data Repository (NDR). It's a multi-year investment and in COP18, PEPFAR will seek to improve the coverage of the patient-level data captured in the NDR with the objective to reach at least 90 percent of the PLHIV receiving treatment by the end of the implementation period. These resources will facilitate the linkage of facility EMR systems to the NDR as they are rolled out by PEPFAR and Global Fund-supported implementing partners and sub-recipients. In COP18, the country team will seek to build a unique identifier system in the NDR to enable deduplication of client registers and account for movement of PLHIV from facility to facility.

The last activity highlighted is also a multi-year investment, the multi-country study managed by DOD. AFRICOS is in its fifth year of the 15-year study that operates and has 47 publications and

presentation presented in the literature since inception and has sites in Kenya, Tanzania, Uganda and Nigeria. As a prospective cohort study, it has enrolled over 3,000 patients and every 6 months to collect from clients social, demographic, clinical and laboratory data as well as blood and sputum samples for storage in the AFRICOS repository.

This protocol and repository evaluates the prevalence and incidence of HIV related coinfections and comorbidities as well as the pathogenesis of these conditions, with particular emphasis on tuberculosis, viral hepatitis, malaria, malignancy and the metabolic and cardiovascular complications of HIV. Another secondary goal of AFRICOS is to facilitate investigation into the pathogenesis of HIV infection and HIV disease progression.

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

As part of COP17 planning, the PEPFAR Nigeria team conducted a detailed analysis of the programmatic alignment of staff and its 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. Thus, several positions were repurposed in FY18 and are currently being implemented which will allow PEPFAR Nigeria to efficiently manage the program going forward. Thus the overall staffing structure will remain the same for COP18.

Vacancies greater than six months are largely due to the recent administrative hiring restrictions or delays in classification. The implementing agencies continue to push recruitment actions as restrictions are lifted or waivers granted. The agencies work closely with the Embassy HR office and follow the DOS recruitment processes. Two CDC USDH positions (Epidemiologist and Behavioral Scientist) have been filled and selected staff will arrive at post in Q3 of FY18. All vacant positions are expected to be filled by Q4 of FY 18.

SIMS remains a priority for the Nigeria team. Special emphasis will be placed on high-volume sites to ensure maximum coverage within the constraints faced by the program. All CDC Nigeria's technical staff are fully involved in SIMS activities and follow annual SIMS schedules coordinated by the Epidemiology and Strategic Information team. Each SIMS team consists of staff from the different program areas to ensure programmatic balance and insight during the visits. CDC Nigeria has a dedicated SIMS Coordinator, whose responsibilities include preparing and updating SIMS schedules, updating the SIMS database, and coordinating all SIMS activities. CDC Nigeria uses its drivers and vehicles for SIMS travel and works closely with the Regional Security Office (RSO) to ensure that the necessary approvals are received before travel. The number of SIMS visits conducted by CDC depends largely on the availability of RSO resources to support any travel outside Abuja.

Although USAID continues to rely on a third party contractor to accomplish its SIMS required assessments, it continues to meet its 20 percent commitment to joint SIMS assessments as well as its commitment to reassessing failed sites (~10% of assessments in FY17). USAID reviews the third party contractor visit schedule quarterly, prioritizing sites and states that are high volume, need focused

quality improvement and/or coincide with other PEPFAR related activities. For example in FY18, USAID ensured that all newly activated OSS underwent a SIMS assessment. It should be noted that USAID sites continue to be concentrated in highly insecure areas which place great travel burdens on the RSO and motor pool, making the third party contractor invaluable. In FY17, the third party contractor began to develop quality improvement strategies with individual implementing partners by developing strategic and more impactful written responses and corrective actions to address SIMS findings. In FY18, the third party contractor will actively and routinely engage State Agencies for the Control of AIDS (SACAs) in the quality improvement activities in USAID states, as well as with NACA in conjunction with USAID in Abuja.

Given the budgetary constraints of COP18, the team looked for ways to reduce the cost of doing business (CODB) across the agencies, finding efficiencies in several areas including cost savings due to exchange rate fluctuations and a reduction of administrative costs. There is a 7% reduction in the overall CDC CODB budget from COP 17. Anticipated savings from the devaluation of the Naira, decreased local travel, and limited procurements in COP 18 reduced costs; however, the USDH line increased as four vacant positions will be filled for the 12 month period.

USAID filled all positions that were listed as vacant in COP17 but was still able to reduce its overall CODB budget. The largest adjustment came from reduced SIMS related travel due to the reduced number of health facilities that will need to be visited in FY19. Locally engaged staff salaries and benefits were updated to reflect current exchange rates and funds set aside for professional development, information technology upgrades and ICASS were reduced.

Similarly there is a 6% reduction in overall MSRPWRAIR's CODB budget from COP 17 mainly due to decrease in local travel and one vacant NSDD-38 position which will no longer be filled. This brings the total USDH positions to two. These reductions in management and operational costs allowed the program to prioritize placing as many PLHIV on treatment as possible while waiting for the results of the NAIIS to guide program scale-up.

APPENDIX A

SNU Prioritization – Not applicable as no SNU priority areas have been selected

APPENDIX B

B.1 Planned Spending in COP 2018

B.1.1 Total Funding Level				
Applied Pipeline	New Funding	Total Spend		
\$42,732,176	\$245,490,052	\$288,222,228		
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	\$9,213,360		\$9,213,360
HVAB	Abstinence/Be Faithful Prevention	-		-
HVOP	Other Sexual Prevention	\$4,159,894	\$250,000	\$4,409,894
IDUP	Injecting and Non-Injecting Drug Use	-		-
HMBL	Blood Safety	-		-
HMIN	Injection Safety	-		-
CIRC	Male Circumcision	-		-
HVCT	Counseling and Testing	\$9,899,111		\$9,899,111
HBHC	Adult Care and Support	\$5,863,650		\$5,863,650
PDCS	Pediatric Care and Support	\$5,368,380		\$5,368,380
HKID	Orphans and Vulnerable Children	\$30,987,532	\$2,555,811	\$33,543,343
HTXS	Adult Treatment	\$44,719,123	\$750,000	\$45,469,123
HTXD	ARV Drugs	\$84,738,706	\$24,317,528	\$109,056,234
PDTX	Pediatric Treatment	\$3,230,311		\$3,230,311
HVTB	TB/HIV Care	\$2,408,273		\$2,408,273
HLAB	Lab	\$1,779,810	\$250,000	\$2,029,810
HVSI	Strategic Information	\$14,121,971		\$14,121,971
OHSS	Health Systems Strengthening	\$1,149,004	\$12,550,000	\$13,699,004
HVMS	Management and Operations	\$27,850,927	\$2,058,837	\$29,909,764
TOTAL		\$245,490,052	\$42,732,176	\$288,222,228
*Central Funding - \$0.00				

APPENDIX C

c. Section 6 Tables: Systems Investments

Funding Agency	Implementing Partner Name	Prime Partner	Mech. ID	Prog. Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	Site/ Above-site	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score
HHS/ CDC	Strengthening HIV Field Epidemiology, Infectious Disease Surveillance, and Lab Diagnostics Program (SHIELD)_1976	University of Maryland Baltimore (UMB)	18439	HSS	Support mapping and size estimation to characterize HIV risk and burden for key and priority populations.	To strengthen the National Data Repository (NDR) with Patient Unique ID for accurate account of achievements, improved monitoring and evaluation, and surveillance.	Information systems	Above Site	-Unique identifier system to be introduced in the NDR platform -More treatment sites EMR platforms on-boarded in NDR - Begin to capture PMTCT data on NDR	Data systems are insufficient to accurately identify and track linkage, determine treatment status and retention of HIV clients in care	<i>Element 15, Performance Data</i>	6.23
HHS/ CDC	TBD	University of Maryland Baltimore (UMB)	18663	HSS	Develop Final study Protocols; Obtain Protocol Clearance; Data collection commenced in 2 of 6 regions/ states - based on phased implementation; Preliminary Regional reports available for 2 regions	Produce more accurate HIV epidemiology data for better program planning at national and sub-national level	Assessment, Evaluation and Operation Research	Above Site	- Further data cleaning and analysis - Report writing and disseminations - Establishment and support for sample repository - Establishment of data warehouse for use by the general public	Barrier One: Existing data, including national and sub-national surveys and statistics, may not reflect accurate population estimates, seroprevalence and HIV burden	<i>Element 13, Epidemiological and Health Data</i>	5.71
DOD	<Placeholder - 70255 Nigeria DOD>	<Placeholder>	70255	HSS	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 will be shared APR 17	To longitudinally assess the impact of clinical practices, biological factors and socio-behavioral issues on HIV infection and disease progression in a multi-country African context.	Assessments, evaluation, operation research	Above Site	AFRICOS study: Multi-country (multi-year) cohort which provides program evaluation data. Previously HOP15 funded for two years	Limited knowledge about local biological and socio-behavioural issues	<i>Element 13, Epidemiological and Health Data</i>	6.71

APPENDIX D

D. Summary of COP 18 Program Targets

Treatment			
Indicator	Pediatric	Adult	Total
TX_CURR	45,476	921,081	966,557
TX_NEW	7,698 (<1 = 1,436)	143,073	150,771
TX_NET NEW	5,075	89,139	94,214
PVLS (Denom.)	37,976	908,936	946,912

OVC		
OVC_SERV (Active)	940,068	
OVC_HIVSTAT	711,872	
PMTCT		
PMTCT_STAT (Denom.)	1,605,453	
PMTCT_STAT (Num.)	1,521,926	
PMTCT_STAT (newly tested)	1,519,480	
PMTCT_STAT POS	38,300	
PMTCT_ART	36,186	
PMTCT_EID	34,330	
	< 2 months	27,476
	2-12 months	6,854

HTS	
PMTCT_STAT (newly tested)	1,519,480
TB_STAT (newly tested)	35,627
Pediatric HTS_TST	470,238
Adult HTS (excludes, EID, PMTCT, TB)	3,237,572
Key Population HTS	192,085
HTS_SELF	3,954
KP	
KP_PREV	283,295
KP_PREV MSM	72,332
KP_PREV FSW	205,030
KP_PREV PWID	5,933
TB	
TB_STAT (Denom.)	42,243
TB_STAT (Num.)	42,243
TB_STAT (newly tested)	35,627
TB_STAT POS	10,232
TB_ART	10,296
TX_TB (Denom.)	965,972
TB_PREV (Denom.)	612,454
TB_PREV (Num.)	551,136

Table 6 Attachment

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score
1	HHS/CDC	Strengthening HIV Field Epidemiology, Infectious Disease Surveillance, and Lab Diagnostics Program (SHIELD)_1976	HSS	To strengthen the National Data Repository (NDR) with Patient Unique ID for accurate account of achievements, improved monitoring and evaluation, and surveillance.	Information systems	-Unique identifier system to be introduced in the NDR platform -More treatment sites EMR platforms onboarded in NDR - Begin to capture PMTCT data on NDR	Data systems are insufficient to accurately identify and track linkage, determine treatment status and retention of HIV clients in care	<i>Element 15. Performance Data</i>	6.23
2	HHS/CDC	TBD	HSS	Produce more accurate HIV epidemiology data for better program planning at national and sub-national level	Assessment, Evaluation and Operation Research	- Further data cleaning and analysis - Report writing and dissemination - Establishment and support for sample repository - Establishment of dataware house for use be the general public	Barrier One: Existing data, including national and sub-national surveys and statistics, may not reflect accurate population estimates, sero-prevalence and HIV burden	<i>Element 13. Epidemiological and Health Data</i>	5.71
3	DOD	<Placeholder - 70255 Nigeria DOD>	HSS	To longitudinally assess the impact of clinical practices, biological factors and socio-behavioral issues on HIV infection and disease progression in a multi-country African context.	Assessments, evaluation, operation research	AFRICOS study: Multi-country (multi-year) cohort which provides program evaluation data. Previously HOP15 funded for two years	Limited knowledge about local biological and socio-behavioural issues	<i>Element 13. Epidemiological and Health Data</i>	6.71

Row	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.
1	Improved quality of treatment current and viral load suppression data	2 years	% of clients on treatment who are covered by NDR	65% of clients on treatment captured within the National Data Repository	80% of clients on treatment captured within the National Data Repository	
2	More accurate estimates of HIV epidemiology in Nigeria	2 years	Number states data collection completed; Reports drafted (Y/N)	Final survey Protocol developed; SOPs, guidelines and training manuals developed; satellite laboratories identified;	Data collection completed and preliminary results released	
3	Long-term cohort results of key outcomes in the areas of: <ul style="list-style-type: none"> • Demographic, social factors • HIV Outcomes • Non-HIV Health Outcomes • Health and Risk Behaviors • Mental Health and Cognition Additional detail available in quarterly HOP reports.	1 year	Selected relevant indicators for program evaluation (not exhaustive) for which tracking is ongoing: <ul style="list-style-type: none"> o % of target enrolled (n=300/450 (67%)) o Viral load <50 copies/ml; <1000 copies/ml o Clinical Staging, Opportunistic infections o HIV diagnosis date, time to engagement in care, time to ART initiation o ART Uptake, duration, regimen o Genotype resistance testing (baseline and virologic failure) o Longitudinal HIV test results (HIV uninfected group) o HIV status of partners and children born to female volunteers o Adherence to medications and visits 	Selected data (not exhaustive) from FY17 HOP report: Q4FY17 enrollment: NG 251 (67%) 51 (67%);	70% of target enrolled; Ongoing reporting on relevant indicators for PEPFAR	

Row	Year Two (COP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP20) Annual Benchmark	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.
1	95% of clients on treatment captured within the National Data Repository			
2	Final Survey report produced and disseminated			
3	90% of target enrolled; Ongoing reporting on relevant indicators for PEPFAR		100% of target enrolled; Ongoing reporting on relevant indicators for PEPFAR	