Nigeria

Country Operational Plan (COP) 2019

Strategic Direction Summary

May 1, 2019

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1.0 Goal Statement

The Nigeria 2019 PEPFAR Country Operational Plan (COP19) is rooted in the results of the recently completed Nigeria AIDS Indicator and Impact Survey (NAIIS). The NAIIS, one of the largest and most rapidly completed public health surveys under PEPFAR, revealed that the HIV prevalence in Nigeria among 15-49 year olds is 1.4%, a value almost half of previous estimates, and highlighted key geographic and programmatic gaps to be targeted in the COP19 strategy.

Geographically, Nigeria's COP19 strategy divides the country into four categories: the "surge" states of Akwa Ibom and Rivers, the "red" states with low saturation and high unmet (Delta, Enugu, Anambra, Imo, and Lagos), the "green" states with high saturation and low unmet need (Benue, Nassarawa, Gombe, and Kaduna), and all remaining states, with low saturation and low unmet need. The surge states of Akwa Ibom and Rivers will be of critical importance in the COP19 strategy, as these two states are currently the farthest from epidemic control, with the largest population of people living with HIV (PLHIV), lowest testing coverage, and lowest population viral suppression. It is Nigeria's aim to bring these two states to epidemic control by the end of FY2020, and PEPFAR is already beginning to shift resources to focus implementation in these two states.

Programmatically, Nigeria will continue to scale evidence-based interventions with fidelity to aim towards epidemic control. It will utilize the data from the NAIIS to tailor interventions for case finding, linking cases with immediate treatment initiation, and increasing viral suppression across all sites. While all states will implement the COP 2019 minimum requirements, interventions will be applied at differing levels of intensity within each group of states. In order to drive rapid progress in the red and surge states, enhanced site management (ESM) will be implemented in the highest burden facilities. This will provide closer monitoring and supervision of hospitals, and work with these facilities to eliminate barriers to service uptake while ensuring linkage and retention in treatment across all ages and sexes.

Nigeria PEPFAR is not working alone to achieve epidemic control. The relationships built with civil society are the strongest they have ever been, and will be instrumental in supporting patient education and empowerment. There is a close working relationship with the Global Fund to Fight AIDS, TB and Malaria (Global Fund), ensuring non-duplicated patient coverage and working to optimize commodity procurement. The Government of Nigeria (GoN) shares the vision to reach epidemic control in Nigeria, and continues to lead the effort to improve access to and quality of care for PLHIV across all states. The public health agencies have been further – and publicly – empowered by Nigeria's president, Muhammadu Buhari, who has directed them to chart a strategic path, work across ministries and sectors, and "not to relent in this fight, but to increase the momentum in a concerted effort to end the epidemic ahead of 2030."

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

Nigeria is a lower-middle-income country (GNI: 2,100 per capita, Atlas method[1]) with a current population estimate of 207,923,777 (population demographics: 49 percent female and 51 percent male[2]).

The HIV epidemic in Nigeria affects populations of all age groups and geographic locations. The prevalence trend peaked in 2001 (5.8%) from 1.8% in 1991, sliding slowly to 3.4% in 2012[3]. HIV prevalence data used in Nigeria have either been from the biannually conducted antenatal care (ANC) sentinel surveys or the National HIV/AIDS and Reproductive Health Survey (NARHS). In 2018, PEPFAR and Global Fund funded the NAIIS, a population-based HIV impact assessment conducted across all states in Nigeria. By providing more accurate data on HIV prevalence, the NAIIS has changed the understanding of HIV prevalence in Nigeria. It reports a national HIV prevalence of 1.5% among adults aged 15-64 years, which is significantly less than the last figure reported in 2014.

There remains significant variation in HIV prevalence across the 36 states and the Federal Capital Territory (FCT), as shown in Figure 2.1 below. Though much lower than previously reported, a few states such as Benue, Akwa Ibom, Rivers and Taraba continue to report prevalence rates much higher than the national average. The states of Abia, Anambra, Enugu, Delta, Bayelsa and Cross Rivers also report higher than average prevalence. HIV prevalence is highest in Akwa Ibom (5.5%) and lowest in Jigawa and Katsina (0.3%). Regionally, the HIV epidemic remains concentrated in the South-South, South-East and parts of the North-Central regions. The findings in the South-East are quite significant, as this region was previously thought to have the lowest prevalence in the country[4].

[1] World Bank, 2017 data https://data.worldbank.org/country/Nigeria
[2] 2018 Spectrum data, 2019
[3] NARHS 2012.
[4] NACA (2015) 'Nigeria GARPR 2015'[pdf]

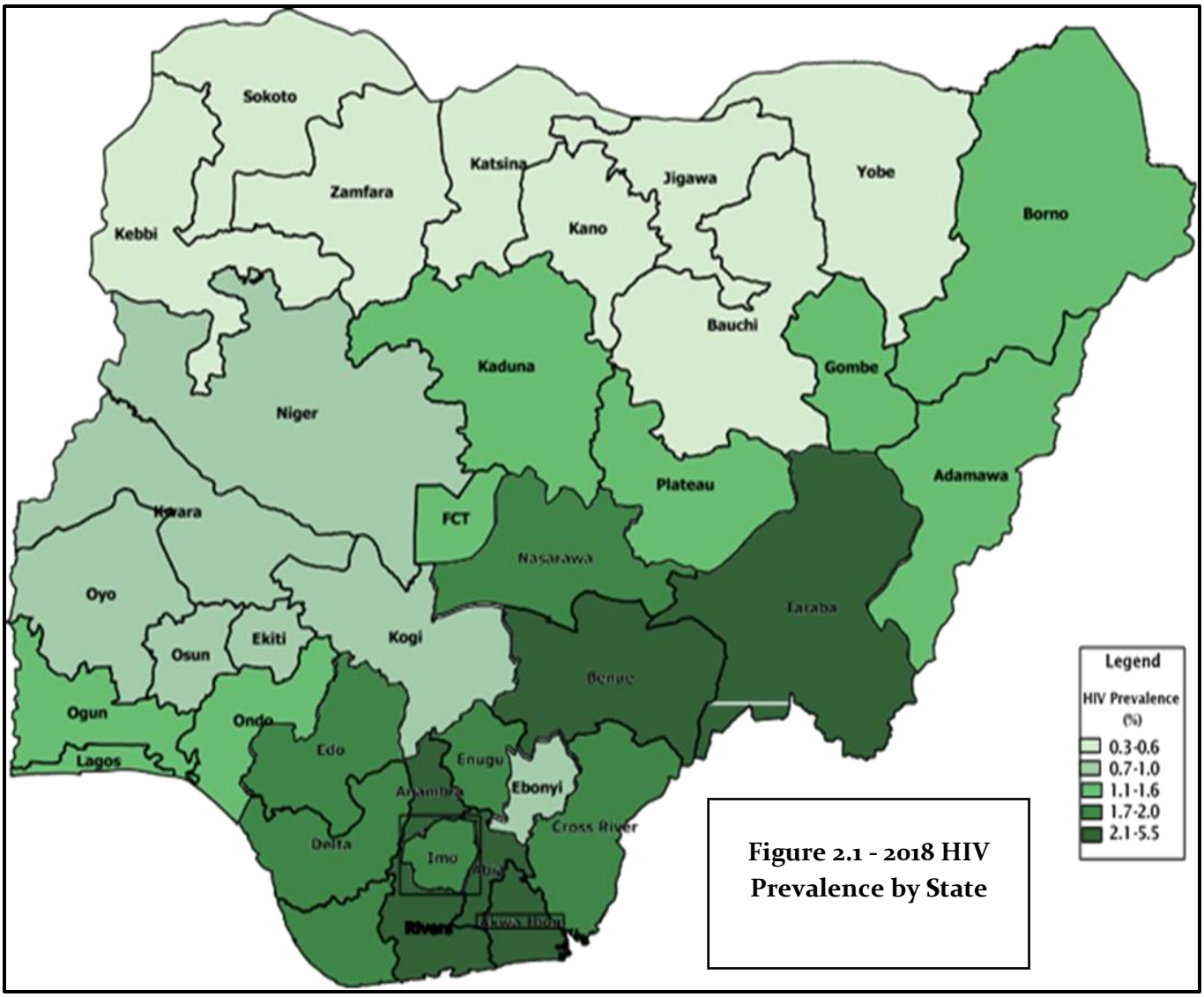


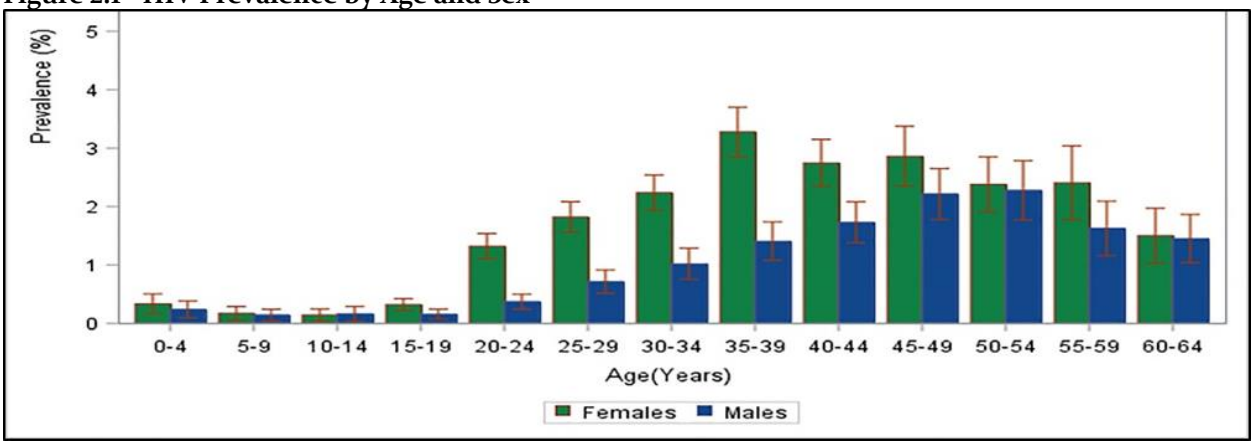
Figure 2.1 - 2018 HIV Prevalence by State

Apart from the geographical variation, the prevalence of HIV in the country also varies across age and sex disaggregation. Overall, the national HIV prevalence among females and males, respectively, was 1.9% and 1.1%. The prevalence among children 0-14 years old was 0.2%. Starting from the 15-19 years age group, a gender-specific inflection point is observed with the prevalence amongst girls being substantially higher than that of boys of a similar age group. The point of inflection is observed to align with the mean age of sexual debut for young women, reflecting the significant risk of sexual and other forms of violence facing adolescent girls and young women. This clearly calls attention to the need for more structured and expanded interventions targeting girls and women in this age group.

Among the 20-24 year olds, the difference in prevalence between men and women is noticeably greater, with prevalence among young women being more than twice as high as among young men of similar age; this pattern continues through most of the childbearing years, with the gender

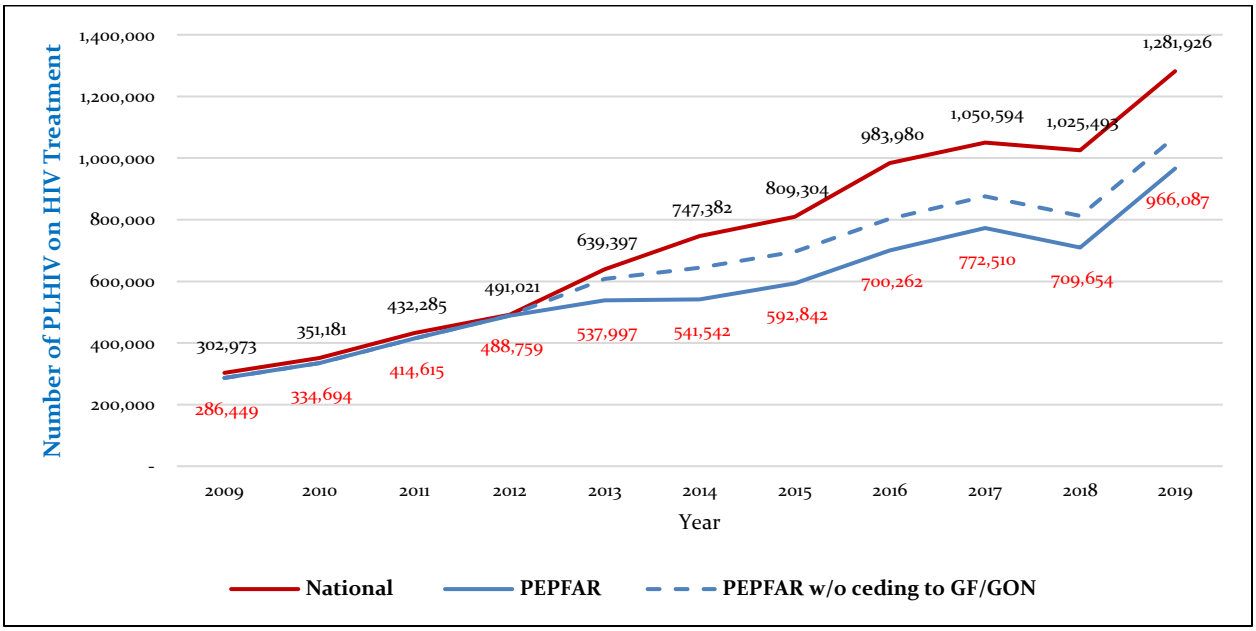
gap narrowing at the ages of 50-54 years, but widening again at 55-59 years. HIV prevalence is highest among 35-39 year old females (3.3%) and 50-54 year old males (2.3%).

Figure 2.1 - HIV Prevalence by Age and Sex



The new survey results were used to update the UNAIDS Spectrum data for the country, which subsequently estimated that approximately 1,996,000 people are living with HIV in Nigeria, and approximately 1,025,000 of those were reportedly on treatment at the end of 2018. This suggests that about 50% of the estimated number of PLHIV in the country are on treatment. Based on the COP19 target projections and the Global Fund targets for the year, the country is expected to have about 1,281,926 people on treatment by the end of 2019, raising the national treatment coverage to about 65%.

Figure 2.1.3 National and PEPFAR Individuals Currently on Treatment



One major conclusion from the NAIIS is that case-finding (first 95) remains the biggest challenge for the HIV/AIDS response efforts in the country. This has informed the ambitious case finding targets the PEPFAR program has set for COP19. Whereas the COP18 treatment new target was just slightly above 150,000, the target for COP19 is about 384,000. These targets are focused mostly on the two states with the highest burden for unmet needs, Akwa Ibom and Rivers, account for about 58% of the targets, while five other high burden, low ART saturation states (Anambra, Imo, Enugu, Lagos, and Delta) account for 15.5%. The targets in Akwa Ibom and Rivers reflect the fact that these two states have been prioritized for program scale-up efforts to reach epidemic control in COP19.

The program also continues to have huge gaps in case-finding among HIV+ pregnant women; the annual estimate for this population remains about 176,000, with only about 41,000 reported nationally to have received ARVs. This reflects the huge gap in the coverage of prevention of mother to child transmission of HIV (PMTCT) services in the country,[5] with just between 10-20% of ANC sites offering PMTCT services[6]. It also reflects the gap in the uptake of ANC services, with just 76.5% of pregnant women attending ANC services at least once during their pregnancy[7]. These findings highlight the need for a more integrated approach to the delivery of reproductive health services in the country.

Among those who participated in the survey, 29.2% of PLHIV aged 15-64 years were aware of their status, and out of those, 88.4% were on ART and 83.1% were virally suppressed. Population viral load suppression (PVLS) data provide a useful proxy for determining the proportion of HIV-infected patients who are currently receiving and adherent to ART at the population level. The PVLS among all PLHIV aged 15-64 years found in the study was 44.5% (46.2% among females and 40.9% among males). This variation between the sexes highlights the issues with health-seeking behavior among men, who have been identified as a priority population for case-finding efforts in COP19. The variation in PVLS is also observed across states and age groups.

Key populations (KPs) constitute about 1% of the adult population in Nigeria, but they contribute as much as 23% of new HIV infections. Together with their partners, KPs account for 3.4% of the adult population and 32% of new HIV infections.[8] Additionally, a high prevalence of HIV was reported in the 2014 Integrated Biological and Behavioral Surveillance Survey (IBBSS) among several KPs: brothel-based female sex workers (FSW; 19.4%), non-brothel-based FSWs (8.6%); people who inject drugs (PWID; 3.4%) and men who have sex with men (MSM; 22.9%). The relatively higher prevalence among KPs is exacerbated by unsupportive cultural beliefs and

[5] FHI360 (2014), 'Rapid Health Facility Assessments in Eight Nigerian States'. https://www.fhi360.org/resource/rapid-health-facility-assessments-eight-nigerian-states
[6] Afe, J.A., Aknimurele, T., Oduola, A., Adeola, O. & Agboola, G. (2016), 'Assessing PMTCT service coverage in Southwest Nigeria: A step towards universal coverage', GLOBAL JOURNAL OF MEDICINE AND PUBLIC HEALTH 5(1). Available on at http://www.gjmedph.com/uploads/O4-V05N01.pdf
[7] NAIIS (2019)
[8] NACA (2017)

practices, societal and religious biases, stigma and discrimination, and punitive national laws.

This situation is worsened by the Same Sex Marriage Prohibition Act of 2013 which criminalizes homosexuality and same-sex marriage, discriminates against MSM, and creates a barrier to accessing comprehensive HIV prevention, treatment and care services. Other drivers of the epidemic in Nigeria include the persisting incidence of sexual and gender-based violence targeting the lesbian, gay, bisexual, transgender, and queer community.

Other barriers which may impact health-seeking behaviors among PLHIV include the persistence of user fees, stigma and discrimination, as well as more operational issues such as those with patient flow; which result in long wait times in facility settings. The rollout of differentiated models of care has helped to mitigate these challenges to an extent, but even these efforts have been limited by the seeming resistance of health service providers to adopt longer periods between patient appointments, as well as drug prescribing and dispensing practices. The current eligibility standards which qualify patients to receive multi-month scripting and dispensing of ARVs beyond three months have been posing an impediment to the scale-up of these interventions. Stakeholders in Nigeria's HIV/AIDS response efforts are mobilizing to address these issues head on, and PEPFAR will continue to report progress on these efforts.

Figure 2.1.4 Trend of New Infections and AIDS Death among PLHIV

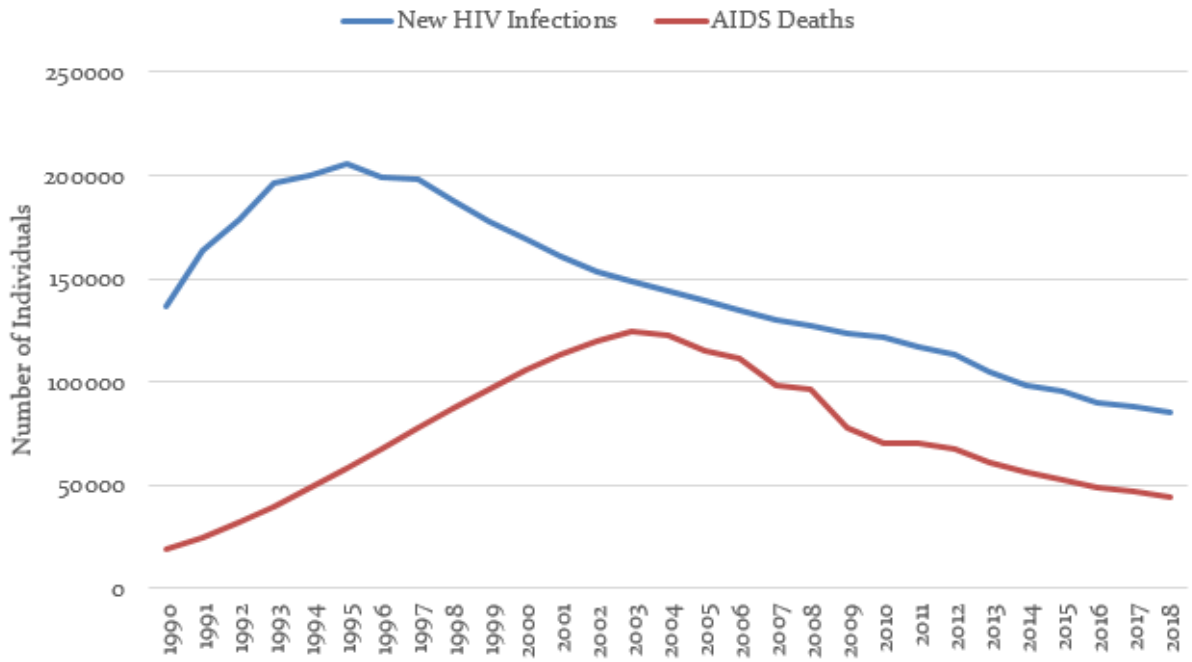


Table 2.1.1 Host Country Government Results															
	Total		<15				15-24				25+				Source, Year
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	207,923,777	100%	41,516,808	20	43,938,217	21	19,714,963	9	20,800,101	10	40,774,200	20	41,179,487	20%	Spectrum, 2019
HIV Prevalence (%)		1.4%													NAIIS, 2018
AIDS Deaths (per year)	58,520	100%	25,367			43	33,153							57%	Spectrum, 2019
# PLHIV	1,996,081	100%	116,021	6	124,351	6	167,425	8	108,179	5	808,946	41	671,157	34%	Spectrum, 2019
Incidence Rate (Yr)		8%													NAIIS, 2018 (Preliminary)
New Infections (Yr)	222,000	100%	22,385			17	107,272							83%	Spectrum 2019
Annual births	31,828,000														Spectrum, 2019
% of Pregnant Women with at least one ANC visit		76.5%													NAIIS, 2018
Pregnant women needing ARVs	176,395														Spectrum, 2019
Orphans (maternal, paternal, double)	1,140,537,														Spectrum, 2019
Notified TB cases (Yr)	104,904														FMoH Report 2018
% of TB cases that are HIV infected	14,082	14%													FMoH Report 2018
% of Males Circumcised[9]		98.9%													Morris et. al (2016)
Size & Prevalence Estimates of MSM[10]	238,522	22.9%													1. Nigeria KP Size Estimates Studies[11] 2. IBBSS 2014
Size & Prevalence Estimates of FSW	621,219	19.4%													
Size & Prevalence Estimates of PWID	227,068	8.6%													

[9] Morris, B. J., Wamai, R. G., Henebeng, E. B., Tobian, A. A., Klausner, J. D., Banerjee, J., & Hankins, C. A. (2016). Estimation of country-specific and global prevalence of male circumcision. Population health metrics, 14, 4 (Accessed 3 April, 2018 from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4772313/

[10] Estimates are for 15 states only: Akwa Ibom, Anambra, Benue, Cross River, Edo, Enugu, FCT, Gombe, Imo, Kaduna, Kano, Lagos, Nassarawa, Oyo, Rivers

[11] Based on the University of Manitoba's 2018 Key Population Geographic Mapping and Size Estimation-Nigeria 2018 and CDC's 2018 Key Population Geographic Mapping and Size Estimation

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[12]**		
	Total Population Size Estimate[13] (#)	**HIV Prevalence[14] (%)**	**Estimated Total PLHIV (#)**	**PLHIV diagnosed (#)**	**On ART (#)**	**ART Coverage (%)**	**Viral Suppression (%)**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population	207,923,777	1.4%	1,996,081	582,856	515,244	25.8%	44.5%*	7,344,869	159,318	134,910
Population less than 15 years	85,455,025	0.98%	240,372	54,977	54,977	28%	31%	687,771	6,421	6,990
15-24 year olds	36,243,817	0.55%	275,604	1,135,040	996,959	70%	48%	1,988,827	24,949	18,609
25+ year olds	75,891,957	2.03%	1,480,103					4,668,271	127,948	109,311
MSM		22.9%								
FSW		19.4% (BBFSW)								
		8.6% (NBBFSW)								
PWID		3.4%								

[12] PEPFAR data only
[13] Data source: Estimates from Nigeria 2018 Spectrum File
[14] Data source: Viral load suppression data from NAIIS 2018

2.2 Investment Profile

The most recent official country expenditure data on HIV/AIDS program investments was released in 2015[15]. The report captured Nigeria's HIV/AIDS spending data for the years 2013 and 2014. It shows total expenditure of $723,917,352 in 2013 and $632,378,599 in 2014. Public domestic sources totaling about $132,534,227 accounted for 18.3% of the total expenditure in 2013, with a reported increase to **$170,050,150** in 2014, representing 27% of total expenditure.

International donor contributions accounted for 80.4% and 70.8% of expenditure in 2013 and 2014, respectively, with PEPFAR alone accounting for 59% and 63.7% of total expenditure, while the Global Fund accounted for 21% and 6.5%, respectively.

About 75% of the investments in 2015 were expenditures reported by public-sector service providers, predominantly federal and state-owned health facilities. Private sector non-profit service providers, mainly faith-based hospitals and clinics, reported 17% of the expenditure, while 8% of the funds were deployed directly through bilateral and multi-lateral entities.

Programmatically, 30% of reported investments was spent to provide HIV/AIDS care and treatment services, while 25.6% was spent on HIV prevention services. About 19% of the expenditure in the same year was reported as human resources expenditure, including the public health service providers recruited by the national and state governments as well as lay workers recruited by non-governmental organizations (NGOs).

Table 2.2.1 Investment Profile by Program Areas (NASA 2015)

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	$0	$190,766,856
Orphans & Vulnerable Children (OVC)	$883,434	$0	$16,785,239	$4,417,168	$0	$22,085,841
Program Management & Administration	$15,508,893	$861,605	$51,696,311	$17,232,104	$861,605	$86,160,518
Human Resources	$100,867,988	$0	$15,798,600	$3,645,831	$1,215,277	$121,527,696
Social Protection and Social Services	$-	$0	$11,052,641	$225,564	$0	$11,278,205
Enabling Environment	$325,641	$325,641	$31,912,800	$0	$0	$32,564,082
HIV-Related Research	$119,295	$0	$5,427,939	$119,295	$0	$5,666,529
Total	**$170,050,150**	**$14,437,059**	**$400,145,268**	**$42,130,388**	**$5,317,495**	**$632,378,599**

[15] National AIDS Spending Assessment (NASA), 2015

Nigeria implements a pooled procurement system for HIV/AIDS drugs and commodities used in the country. This system captures data for commodity investments by PEPFAR, the Global Fund, and the Federal Government-funded program in Abia and Taraba. Expenditure data from this system reports a total investment of $181,581,906, with more than 75% of expenditures on anti-retroviral drugs and about 10% each on viral load reagents and HIV rapid test kits. PEPFAR accounted for 86.9% of the commodities procured, while the Global Fund and the Government of Nigeria accounted for 12.1% and 1.0%, respectively. By commodity type, PEPFAR procured 91.1% of the ARVs, 65.3% of the HIV rapid test kits, 91.7% of the CD4 reagents and 71.5% of viral load reagents, as seen in Tables 2.2.2a and 2.2.2b below.

Table 2.2.2a Annual Procurement Profile for Key Commodities (percentages)

Commodity Category	Total Expenditure ($)	PEPFAR		Global Fund		GoN		Other	
		%	$	%	$	%	$	%	$
ARVs	$137,606,787	91.1%	125,359,783	7.6%	10,458,116	1.3%	1,788,888	0.0%	0
Rapid test kits	$17,533,612	65.3%	11,449,449	34.7%	6,084,163	0.0%	0	0.0%	0
Other drugs (OIs)	$5,178,747	93.7%	4,852,486	6.1%	315.904	0.2%	10,357	0.0%	0
Lab reagents (CD4 commodities)	$3,729,041	91.7%	3,419,531	8.3%	309,510	0.0%	0	0.0%	0
Condoms	$-	0.0%	0	0.0%	0	0.0%	0	0.0%	0
Viral Load commodities	$16,369,555	71.5%	11,704,232	28.5%	4,665,323	0.0%	0	0.0%	0
EID commodities	$1,070,160	92.4%	988,828	7.6%	81,332	0.0%	0	0.0%	0
VMMC kits	$-	0.0%	0	0.0%	0	0.0%	0	0.0%	0
MAT	$-	0.0%	0	0.0%	0	0.0%	0	0.0%	0
Other commodities (GeneXpert Cartridges)	$94,003	69.1%	64,956	30.9%	29,047	0.0%	0	0.0%	0
Total	**$181,581,906**	**86.9%**	**157,839,265**	**12.1%**	**21,943,396**	**1.0%**	**1,799,246**	**0.0%**	**0**

The recent success of the National AIDS Control Agency (NACA) to secure increased budgetary commitment and a systematic approval for early funding release will ensure increasing domestic investment in the coming years. Expectedly, the recent re-launch of the National PMTCT and Treatment program and the commitment by the Federal Government to increasingly fund the provision of ARVs for 50,000 additional people annually will see the domestic contribution to commodities procurement grow significantly over the coming years.

To meet the growing funding need for the numbers of people being reached with life-long antiretroviral services, which has increased from 747,000 in 2014 to 1.05 million in 2018, the

proportion of PEPFAR expenditure on commodities has increased over time—from about 25% in 2014 to 42% in 2018. This has meant that the program has gradually shifted resources from other program areas like prevention, community services, blood safety and health systems strengthening. The adoption of more efficient testing modalities has afforded a reduction in the budget allocation for HIV rapid test kits.

The implication of this for the national response is that more investments, particularly from domestic sources, will be required to expand the coverage of HIV testing and treatment services and to support key interventions of continuing strategic importance. While soliciting for additional direct investments in the HIV/AIDS program, country stakeholders will also continue to explore opportunities to leverage existing related investments like that from the Government of Nigeria's Save-One-Million-Lives (SOML), Performance-for-Results (PforR) initiative, which is financed by a $500 million International Development Association credit to the Federal Republic of Nigeria over a period of four years. The program supports State governments with significant resources to invest in health programs across six investment pillars: (1) Improving maternal, newborn and child health; (2) Improving routine immunization coverage and achieving polio eradication; (3) Elimination of mother to child transmission of HIV; (4) Scaling up access to essential medicines and commodities; (5) Malaria control; and (6) Improving child nutrition[16].

The national HIV/AIDS program is also expected to benefit from the newly introduced Basic Minimum Health Care Provision Fund, which allocates an equivalent of at least 1% of the Consolidated Revenue Fund of the Federation for the provision of the essential package of health services, infrastructure upgrades, and drugs and consumables procurement within the primary healthcare system[17].

PEPFAR will be exploring similar opportunities to leverage funds across other related U.S. Government funding platforms summarized below in Tables 2.2.3 and 2.2.4.

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	$70,000,000				Reduce malaria burden under the PMI.
USAID Maternal & Child Health	$50,000,000				End preventable child and maternal deaths.
USAID Family Planning & Rep. Health	$37,000,000				Improve access to and use of quality and voluntary Family Planning services including long-acting and permanent methods to reduce unwanted pregnancies.

[16] SOMLPforR (2018), 'About us' [Webpage] Available at http://somlpforr.org.ng/About/

[17] Onwujekwe, O., Onoka, C., Nwakoby, I., Ichoku, H., Uzochukwu, B., & Wang, H. (2018), '*Examining the Financial Feasibility of Using a New Special Health Fund to Provide Universal Coverage for a Basic Maternal and Child Health Benefit Package in Nigeria*', Frontiers in Public Health, 6(200). Available at; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6064932/

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 NUT	$3,500,000				Reduce malnutrition among women and children.
USAID WASH	$3,000,000				Improve water supply and sanitation.
CDC GHS/Ebola	$1,631,328				Strengthen International Health Regulations core capacities to promote global health security primarily through: 1. Workforce development through frontline and advanced training programs for field epidemiologists through the NFELTP program. 2. Establishment and operationalization of Emergency Operations Centers. 3. Development/improvement/strengthening of Real-Time Surveillance and Border Health Security. 4. Development/improvement/strengthening of Information Systems and GHSA Reporting.
CDC GID	$16,978,709				Work towards: 1. Polio eradication through coordination and collaboration with global polio partners 2. Measles elimination: through increase in measles coverage, introduction of measles dose 2 and quality measles campaign. Improve routine immunization coverage from 33% at 6 weeks of age to 80% by 2028 through a variety of strategies.
CDC- Multiple sources for Multi-Plex Project	$774,000				Strengthen national disease surveillance by supporting GoN to address key gaps in surveillance and determine prevalence of malaria, vaccine-preventable diseases (VPDs), and other diseases of public health importance.
DOD JWARG	$1,161,569				Implement a study focused on determining the infectious etiologies and their frequencies among adult patients with acute fever, or other severe acute illness with a suspected infectious source, presenting to study hospitals in West Africa.
DOD Ebola vaccine	$86,710				Develop a Ebola phase II vaccine.
DOD AFRICOS Science	$89,401				Conduct an African cohort study with longitudinal follow up of PLHIV.
DOD PMI	$600,000				Focus on malaria-associated mortality; this portion of the response is focused on microscopy, quality assurance, and quality supervision.
Total	**$195,621,717**				

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-funded PEPFAR IMs**	**Number of Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
Other PEPFAR Central Initiatives – CDC (Key Population Investment Funds)	$9,000,000					1. Build capacity of KP-led local CBOs for KP program implementation. 2. Increase the number of KPs reached with evidence based prevention interventions. 3. Increase the number of KPs who know their HIV status and are linked to treatment. 4. Increase number of HIV positive KPs who are on ART and retained on treatment.
Other PEPFAR Central Initiatives - USAID (Key Population Investment Funds)	$4,000,000					1. Increase organizational and technical capacity of grassroots local KP-led organizations. 2. Increase access and improve coverage of high-quality comprehensive HIV/AIDS treatment, care and related services to KP PLHIV. 3. Ensure health systems strengthening to continuously improve HIV/AIDS/STI services for KPs.
Total	**$13,000,000**					

2.3 National Sustainability Profile Update

Nigeria last completed the biannual Sustainability Index and Dashboard (SID) reporting in November of 2017. This third iteration of the SID report (SID 3.0) was completed with a broad-based group of local subject matter experts in the different SID domains and elements. The group reported significant improvements across almost all of the domains, mostly due to improvements in reporting processes and greater ease of accessing reference materials and official information for reporting purposes.

The group identified outstanding issues with the lack of implementation of several key plans, including the "sustainability plans" developed by 14 of the 36+1 states, for which there does not appear to be an implementation process in place.

They identified opportunities to improve domestic financing at the state and federal levels through a better coordinated planning process linked with government budget cycles. In this area, the NACA, reports a major strategic improvement in its ability to access budgetary allocations in support of the Federal Government-sponsored HIV/AIDS care and treatment program in the states of Abia and Taraba, which were supported with funding from the Subsidy

Reinvestment Empowerment Program (SURE-P) of the GoN in 2014 and 2015[18]. NACA is now able to access increasing allocations for treatment as a first-line charge early in the year, guaranteeing its ability to plan effectively and secure commodity investments in support of the program. In addition, NACA is also in advanced stages of planning for the launch of private sector-led "National HIV Trust Fund" in collaboration with the Nigerian Business Coalition Against AIDS, a coalition of leading local businesses and conglomerates, which will serve as another source of secure funding for future domestic contributions to the national antiretroviral and HIV commodities pooled procurement system.

PEPFAR Categorization: Long-term Strategy (Co-finance)
PEPFAR COP 17 Planning Level: $383,614,281

SUSTAINABILITY DOMAINS and ELEMENTS	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

SID 3.0 reported improvements in opportunities for participation of local private sector health service providers and civil society organizations in the provision of HIV/AIDS services, but the gaps identified with the lack of coordination and standards management among these groups have yet to receive significant attention. Plans to train and provide supportive supervision to private sector service providers to link them to the national HIV commodities pooled procurement system have so far only been successful through direct support of PEPFAR

[18] NACA Annual Report (2014), https://naca.gov.ng/wp-content/uploads/2016/11/NACA-Annual-Report-20141_0.pdf

implementing partners (IPs), Global Fund sub-recipients, and a few others supported by the AIDS Healthcare Foundation.

Key systems-level investments in the Strategic Information domains have developed since the last report. The NAIIS survey brings the benefit of having a more reliable picture of the national HIV/AIDS epidemic, even at subnational levels. This survey provided the basis for the recalibration of the country epidemiologic data in Spectrum 2019 and for program planning in COP19. The National Data Repository (NDR) now has de-duplicated patient-level data for more than 75% of people living with HIV receiving treatment in PEPFAR-supported facilities, allowing for real-time assessments of the clinical experiences and outcomes of these clients. The ongoing introduction of Patient Biometrics Solutions (PBS) in the electronic medical records (EMR) systems of most of high-volume facilities (i.e., those with more than 400 persons on ART) and improvements to the NDR will further help to ensure timely interventions to improve patient service activities at key facilities. It is one of the key strategies for partner performance management in the COP19 "Nigeria Treatment Surge" plan.

The National Integrated Sample Referral System (NiSRN) currently includes about 3,200 HIV treatment sites, 2,000 tuberculosis (TB) directly observed treatment, short course (DOTS) sites, and almost 2,500 patent medicine vendors. Improved coordination has led to an almost 700% increase in the total number of laboratory samples being processed by the reference labs. This improvement in efficiency and coordination is supported by local third-party logistics agents and is perceived to contribute to the sustainability of these investments.

The 2018 PEPFAR Expenditure Report shows that the portion of the PEPFAR program managed by international partners has increased from 66% in FY17 to 75% in FY18. While the local partner proportion reduced from 34% to 25%, with yet-to-be-awarded mechanisms accounting for 1% in 2017 and less than 1% in 2018. The reduction in local partner expenditure was because of increased commodities procurement and funding for implementing the country's survey project. About 68% of the expenditure by international partners in FY2018 was from two mechanisms: the USAID-supported mechanism responsible for the pooled procurement of all PEPFAR drugs and commodities, and the CDC-supported mechanism, which implements the NAIIS. Despite the status, planned changes to funding arrangements across both agencies will see the country reach the target of 70% funding allocation to local partners by the end of the COP19 implementation period. This is validated by the current budget allocations in COP18 and COP19. COP18 budget allocations currently shows a 37% budget allocation to international partners and 63% budget allocation to local partners, while COP19 budget allocations currently shows a 31% budget allocation to international partners and 69% budget allocation to local partners if the budget allocations to the USAID pool procurements for commodities and CDC NAIIS mechanisms are excluded.

In-country discussions on how to mitigate the impact of user fees on patients accessing HIV and AIDS-related services have identified the need to key into the country's evolving agenda on social health insurance. To this end, in COP19, PEPFAR will fund a project to facilitate the inclusion of

HIV/AIDS services in the National Health Insurance service matrix and the gradual onboarding of health facilities providing HIV/AIDS services into the national or state health insurance site listing. These interventions will have an additional positive impact on the Domestic Resource Mobilization domains of the SID when the next report is collated in October/November 2019.

2.4 Alignment of PEPFAR investments geographically to disease burden

PEPFAR investments over the past five years have been aligned to reflect the prioritization of program investment across geographical areas (states and local government areas; LGAs) and populations. The program has spent about 45% of the budget allocated to program activities in eight sub-national units (SNUs) – seven states (Benue, Lagos, Kaduna, Akwa Ibom, Nassarawa, Cross River and Rivers) and the FCT, Abuja – which were previously identified to have the highest burden of unmet need for HIV/AIDS services. At the time of these investments, these eight SNUs accounted for about 33% of the total HIV burden in the country.

Based on the findings of the NAIIS, these investments appear to have achieved the intended outcomes of improving ART coverage and reducing the burden of unmet needs, especially in states like Benue and Nassarawa, with both states now contributing less than 1.5% of the national unmet need combined. However, three states—Akwa Ibom, Rivers and Lagos—remain of significant relevance, contributing a combined 44% of the current national unmet need (with Akwa Ibom and Rivers each contributing 18%).

The COP19 geographical prioritization recognizes the huge unmet need in these two states and essentially makes them the focus of planned scale-up efforts, with the aim of reaching at least 81% ART coverage in these states by the end of FY 2020. The effort anticipated to achieve these objectives is captured in what has been termed "the Nigeria Surge Plan," which recognizes the need for cross-agency collaboration within the PEPFAR country team, deploying recently available program innovation for ESM, near-time data monitoring using electronic medical record systems, and facilitated knowledge sharing and learning platforms supported through the ECHO project.

One key aspect of the surge plan is the focus on supportive supervision activities for a subset of health facilities with the unique characteristics of having a high client load and being located in densely populated, urban communities in the two states. These sites will form the learning hubs for the ESM strategy. The goal of the current implementation period is first to engage with State Government and other stakeholders to address all policy and program-level barriers which may pose a challenge to the planned scale-up efforts. The program will engage each site in a deep-dive analysis of service delivery processes to understand the issues impairing delivery of services at the prescribed optimum levels. The HIV client load and location of these facilities relative to population distribution in the two states is represented in the maps below.

Figure 2.4.1 – Location of priority Sites in Akwa Ibom in high density population areas

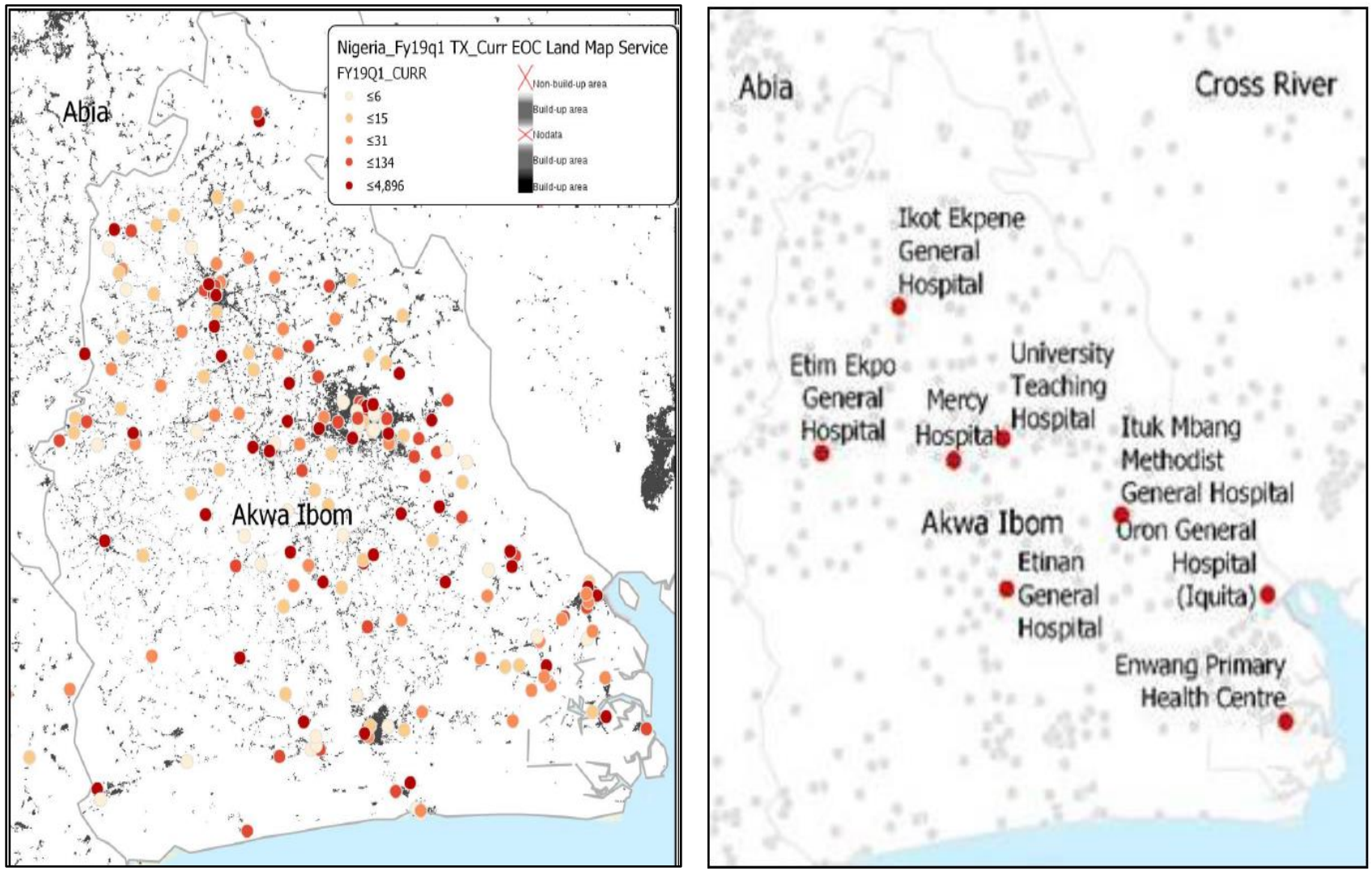
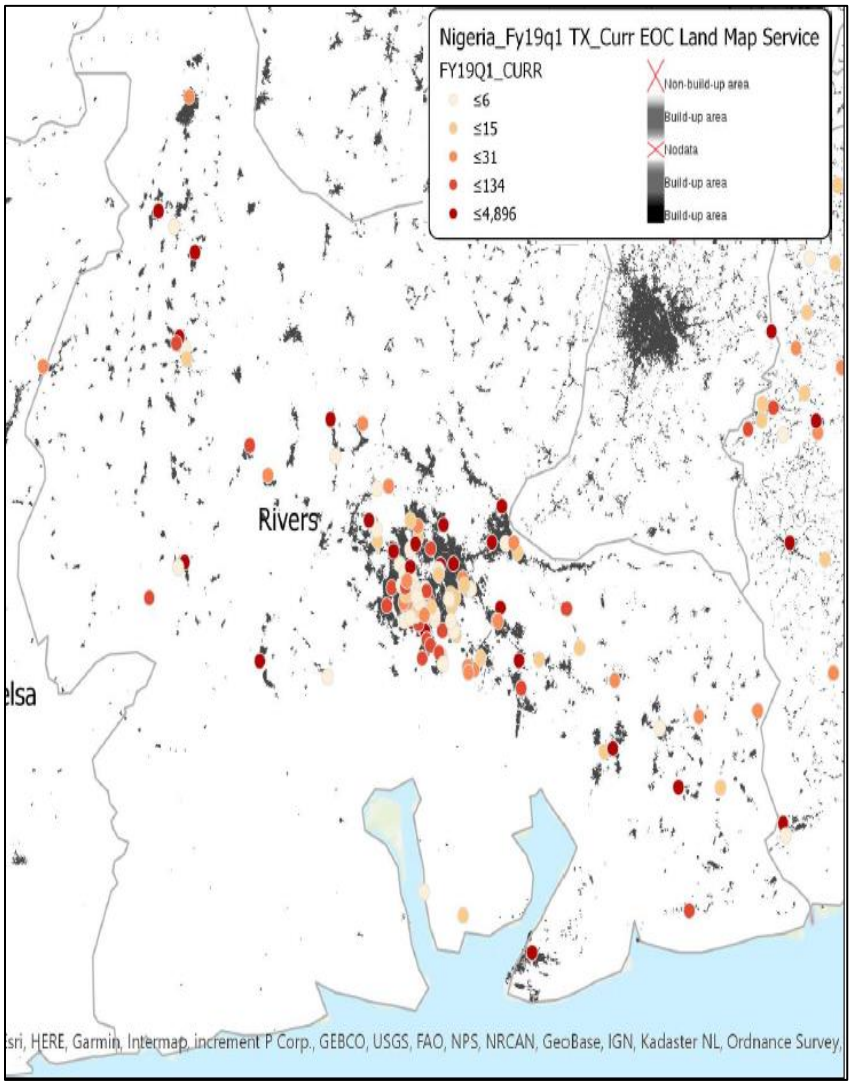
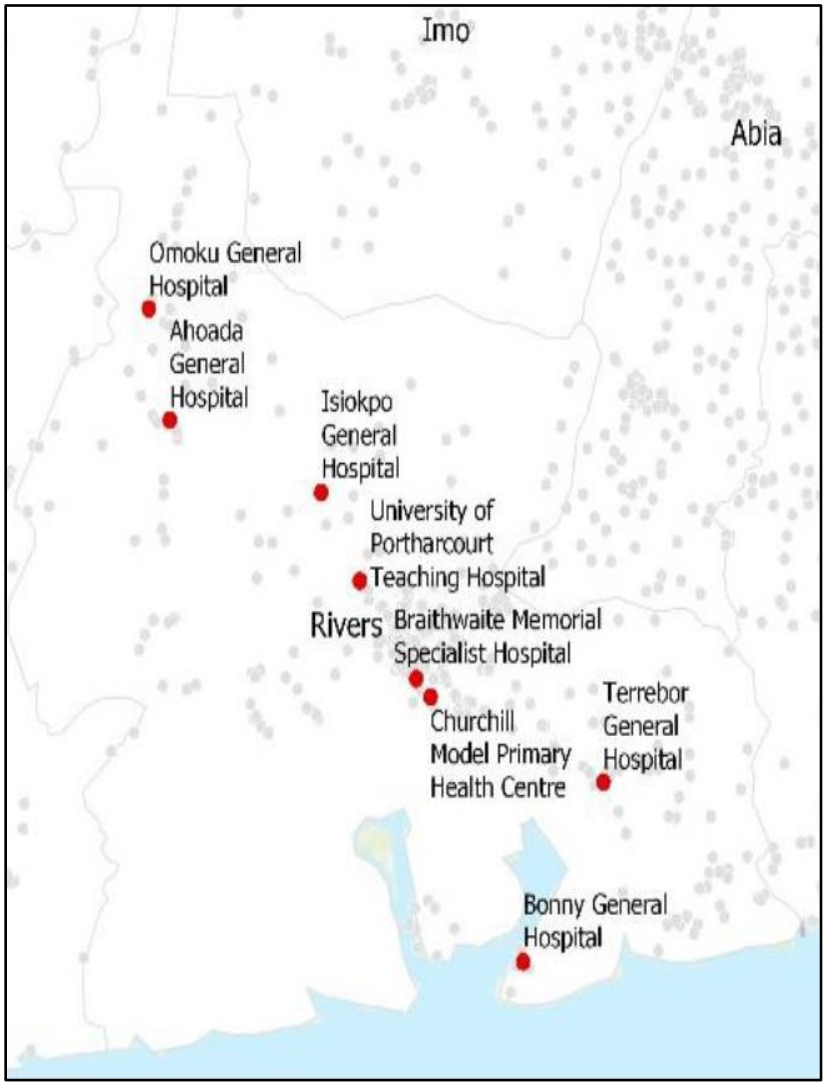


Figure 2.4.2 – Location of priority Sites in Rivers in high density population areas





Apart from the two surge states, five other states (Anambra, Delta, Enugu, Imo and Lagos) have also been targeted for scale-up activities and will be the beneficiaries of any proven strategies for efficient case finding, linkage and retention that are validated through the surge plan.

In all, the new seven-state prioritization for scale-up currently accounts for 46% of total PLHIV and an impressive 64% of total unmet need in the country. PEPFAR investments (program and commodities) in COP19 are aligned to reflect the significance of this, with 40% of COP19 resources planned to be invested in the surge states of Akwa Ibom and Rivers, and 16% in the other five states. Fifteen percent of the budget is planned for three states – Benue, Nassarawa and Gombe –where the program already reports greater than 81% treatment coverage and will now only focus on addressing age and sex disaggregation gaps in treatment coverage. The rest of the investments (30%) will be deployed to sustain services in the 22 remaining states, which currently show a comparatively low HIV burden.

2.5 Stakeholder Engagement

To kick off the COP19 planning process, the PEPFAR team hosted a launch in January with government (NACA and the National AIDS and STIs Control Program), UNAIDS, UNICEF, WHO, PEPFAR implementing partners, Global Fund principal recipients, civil society and other relevant stakeholders. The meeting, which had over a hundred participants in attendance, was used to disseminate information about the country specific COP guidance, funding level and targets, as well as to discuss plans for the rest of the current implementation period, focusing on the 13 minimum requirements. It was also an opportunity to inform stakeholders about the COP19 planning schedule and dates.

A follow-on meeting was also held with the Global Fund country team to discuss ongoing joint collaboration in the National Integrated Supply Chain program, the NiSRN, the NAIIS, and other joint strategic information investments. The meeting also deliberated on ways to align strategic technical direction across service delivery models and strengthening of service delivery in non-PEPFAR supported PCR labs.

Following the presentation of the COP19 planning process at the 2019/Q1 meeting of the Expanded Theme Group, a stakeholder task team was set up to review the challenges with "user fees" and provide recommendations to the Government of Nigeria on ways to address the issue. Under the leadership of the NACA Director General, a stakeholder plan was developed to initiate action to eliminate user fees in health facilities in Nigeria.

For civil society stakeholders, the COP19 engagement process started much earlier in August 2018 with a Trainer of Trainers communication workshop for PEPFAR staff and civil society organizations (CSO) leaders. The workshop was organized and facilitated in collaboration with the National Alliance of State and Territorial AIDS Directors, the U.S. Health Resources and Services Administration, and the America International Health Alliance (, and was funded by OGAC through the National Institutes of Health. It focused on building the capacity of PEPFAR and CSO staff to share data and communicate in a more effective manner. A follow-on step-down

knowledge and skills workshop was conducted in January 2019 and provided further insights into how to improve PEPFAR and CSO engagement in the national response.

As one of the outcomes of this engagement, PEPFAR Nigeria constituted an interagency task team for Stakeholder Engagement. The task team met on a weekly basis to discuss the collated inputs from CSO partners and review the ongoing CSO engagement process. Leveraging on previously established relationships with some committed CSO leaders and the different emerging CSO leadership structures, the task-team constituted a 32-person group of CSO leaders to be the primary focus for engagement throughout the COP19 planning and implementation process.

These CSO leaders were further engaged, primarily through email channels, to discuss and collate recommendations on the COP19 plan based on Country Guidance. In the course of the engagements, the CSO leaders recommended a focus on strategies to improve the efficiency of case-finding, linkage, retention on treatment, scale up of viral load services, pre-exposure prophylaxis (PrEP), and unique identifiers, and also expressed strong concerns about the lack of funding to support CSO capacity building and their participation in site monitoring of activities. Other issues highlighted centered on identified program barriers and gaps such as user fees, high loss to follow up (LTFU), and the lack of specialized care for adolescents.

The CSO leaders also expressed the need for patient literacy and empowerment interventions and in response, PEPFAR will invest about $150,000 in COP19 to develop and implement a Patient Education and Empowerment Plan (PEEP). The plan will focus on developing and disseminating updated literacy materials and knowledge about available services supported by the program and how to access these services to achieve optimal treatment outcomes. Addressing concerns about the limited budget planned for this activity, the PEPFAR CSO task team emphasized the need to first establish a proof of concept on the potential impact of such interventions on patient outcomes and committed to working with other stakeholders to leverage additional resources for this and other similar engagements with patients and the patient community.

Two CSO representatives – Ms. Olayide Akanni, the Executive Director of Journalists against AIDS, Nigeria chapter, and Mr. Ikenna Nwakanma, the Executive Secretary of the Association of Civil Society in Nigeria, a network body of several CSO groups – were nominated to participate in the COP19 Regional Planning Meeting (RPM). Along with GoN representatives (the Director General of NACA and the NASCP Coordinator),; and representatives of multilateral organizations (Global Fund, UNAIDS and WHO), and IPs, they supported the PEPFAR country team to refine and present the COP19 plan to the Office of Global AIDS and Global Health Diplomacy Coordinator

Since the RPM, country-level stakeholders have committed to working with the country PEPFAR team in further engagements with the federal and state governments to establish state-level Memoranda of Understanding (MOUs) which will detail the government's commitment to eliminate policy and program-level barriers, including user fees, that prohibit access to and improvements in patient care.

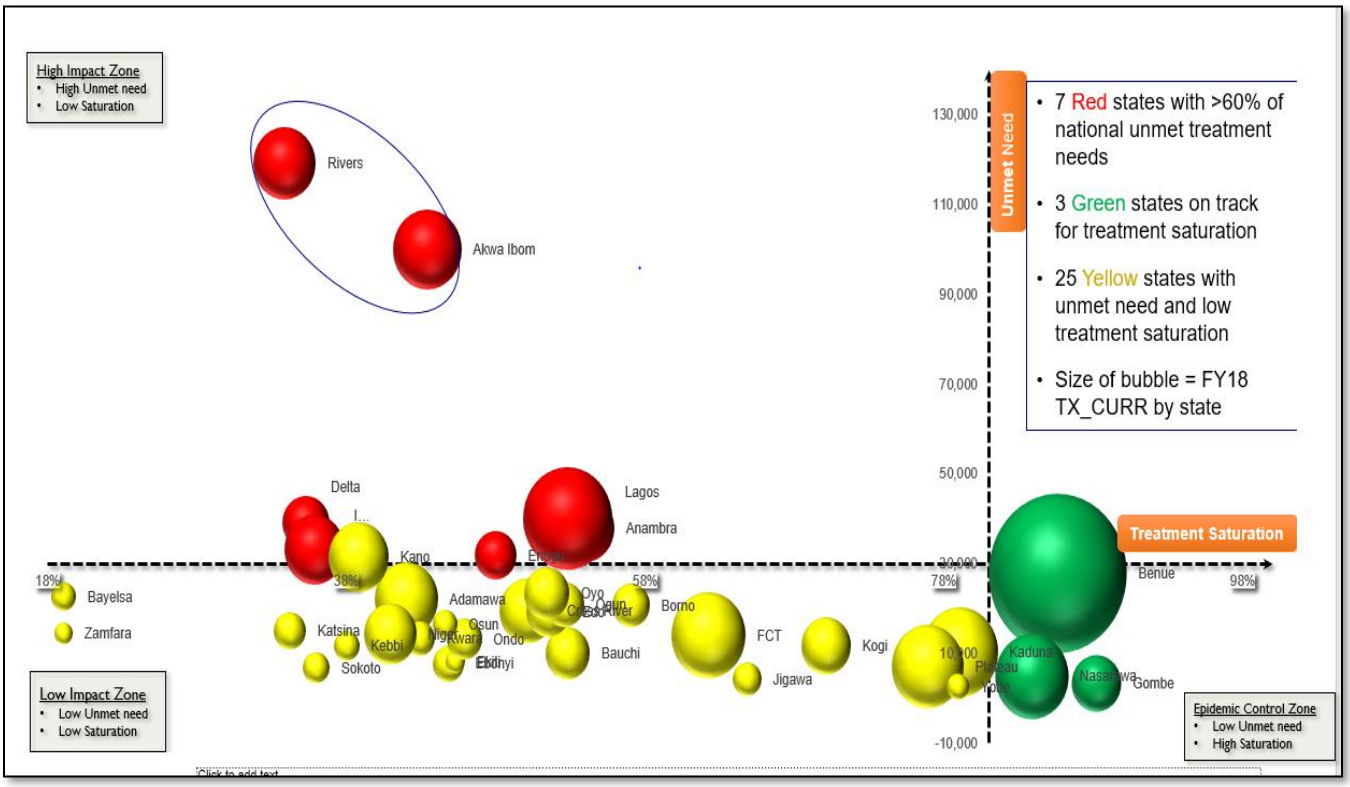
3.0 Geographic and Population Prioritization

3.1. Geographic Prioritization

Prior to having the NAIIS data, the prioritization of 32 LGAs within 7 states was based on the understanding of the distribution of the HIV burden and unmet need in the country at that time.

With the release of the NAIIS results in March 2019, the Nigerian HIV/AIDS response has been recalibrated with more reliable epidemiological data powered to the state level. Using the NAIIS PVLS rate and 2019 HIV spectrum projection of treatment gaps, the states were ranked based on total burden of HIV and the burden of unmet treatment need from highest to lowest, thus categorizing the epidemic into three categories, as depicted in Figure 3.1.

Figure 3.1 –Categorization of HIV burden in Nigeria



Based on the distribution of the states in figure 3.1 above, PEPFAR Nigeria categorized the 34+1 states supported by the program into three different prioritization zones:

1. High unmet need and low saturation, termed the high impact zone (Red States)
2. Low unmet need and low saturation, termed the low impact zone (Yellow States)
3. Low unmet need and high saturation, termed the epidemic control zone (Green States)

The seven Red States (Akwa Ibom, Rivers, Anambra, Imo, Enugu, Lagos, and Delta) contribute 50% of the total unmet need (PLHIV yet to be placed on treatment). The Green States (Benue,

Nasarawa and Gombe) have ART coverage of greater than 81% at APR18 and contribute 5% of the country's unmet need. However, in these states, there are still gaps in treatment saturation by age and sex disaggregation. The remaining 25 states (Yellow States) together contribute 45% of the country's unmet need. The foregoing analysis does not include Abia and Taraba state programs, which are managed by GoN.

3.1.1 - Target Setting

At APR18, PEPFAR Nigeria reported **807,094** as current on treatment. However, applying improved patient management standards in line with the study by Ananworanich et al (2017)[19], which showed significant reversal in viral load suppression in patients missing ARVs for longer 28 days, the program reported 664,699 as current on treatment at FY19 Q1, with 113,870 at risk of being LTFU. At the close of the FY19 Q1 reporting period, the program has accounted for 44,955 of these patients and, therefore, reported **709,654** current on treatment.

The program continues to follow up on all patients at risk of LFTU and remains on track to achieve FY19 current on treatment target of **966,087** by achieving a new on treatment target of **150,663**.

For COP19, the program intends to achieve a new on treatment target of 384,595 and a current on treatment target of 1,268,536. In the 35+1 PEPFAR supported states, this will move the program from the current FY19 Q1 treatment coverage of 40% to 71% at end of FY20 (COP19). Additional contributions to this achievement are expected from the Global Fund and other stakeholders in the national HIV response.

The COP19 targets are distributed across the geographic prioritization in line with the COP strategy to;

i. achieve 81% treatment saturation in two of the Red States - Akwa Ibom and Rivers (Scale-up to Saturation SNUs, or "surge" states);
ii. move the other four Red States closer to saturation (Scale-up Aggressive SNUs);
iii. address age and sex saturation gaps in the 3 Green States (Attained SNUs);
iv. And sustain services across the 25 Yellow States (Sustained Support SNUs).

To achieve this, the program will place 214,126 newly identified PLHIV on treatment in Akwa Ibom and Rivers using the "Nigeria Surge Strategy," described in subsequent sections. In addition, 66,755 newly identified PLHIV will be placed on treatment in the other four Red States, 32,032 in the Green States, and 67,125 in the Yellow States. The military program supported through DOD will place 4,557 newly identified PLHIV on treatment in military facilities across the country. All of these targets are summarized in table 3.1 below.

[19] Ananworanich et. al., (2017), 'HIV RNA Rebound Post-interruption In Persons Suppressed In Fiebig I Acute HIV', CROI 2017. http://www.croiconference.org/sessions/hiv-rna-rebound-postinterruption-persons-suppressed-fiebig-i-acute-hiv

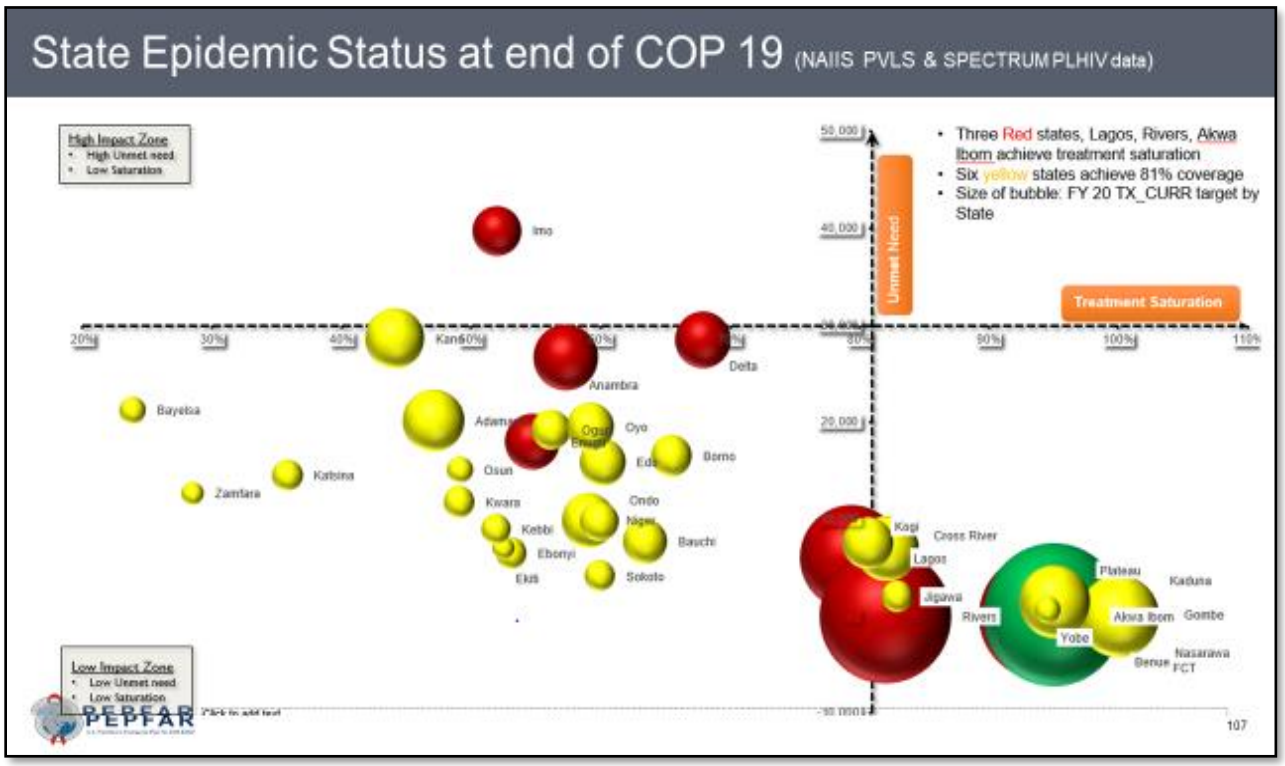
Table 3.1 Current Status of ART Saturation				
Prioritization Area	**Total PLHIV/% of all PLHIV for COP19**	**# Current on ART (FY18)**	**# of States COP18 (FY19)**	**# of States COP19 (FY20)**
Attained	-	0	0	0
Scale-up Saturation	20%	0	0	2
Scale-up Aggressive	16%	0	0	4
Sustained	54%	807,094	35	28
Central Support	0	0	0	0

Referencing figure 3.1 above, achieving COP19 targets will move Akwa Ibom and Rivers from the high impact zone to the epidemic control zone, while Lagos, Anambra, Delta and Enugu will move to the low impact zone with Lagos almost at saturation.

In addition, seven of the Yellow States (Kaduna, FCT, Plateau, Yobe, Jigawa, Cross-River and Kogi) will move to the epidemic control zone. This underscores the program growth envisioned in the Sustained Support SNUs.

These program outcomes are as depicted in figure 3.2 below.

Figure 3.2 – Treatment Saturation at the End of COP 19



3.2. - Population Prioritization

Population prioritization for COP19 is based on FY18 program gap analysis and considerations for KPs. Program analysis by age and sex shows significant gaps in treatment saturation for children, adolescents and young persons, as well as males aged 25 years and above (see Table 3.2 below).

Table 3.2 – ART Coverage by Age and Sex Disaggregation

Distribution by Age	Estimated PLHIV 2018			2018 PLHIV Currently on ART			2018 Current ART Coverage			Remaining PLHIV that Need ART		
	Estimated male PLHIV	Estimated Female PLHIV	Total PLHIV	Males on ART	Females on ART	Total PLHIV on ART	Males	Females	Overall	Males	Females	Overall
<1	6,744	6,299	13,043	193	209	402	3%	3%	3%	6,551	6,090	12,641
1-4	27,020	25,176	52,196	6,103	5,633	11,736	23%	22%	22%	20,917	19,543	40,460
5-9	26,076	23,984	50,060	6,103	5,634	11,737	23%	23%	23%	19,973	18,350	38,323
10-14	20,528	19,015	39,543	7,856	7,577	15,433	38%	40%	39%	12,672	11,438	24,110
15-19	32,254	48,690	80,944	4,850	8,910	13,760	15%	18%	17%	27,404	39,780	67,184
20-24	60,882	92,210	153,092	6,787	30,801	37,588	11%	33%	25%	54,095	61,409	115,504
25-29	82,891	111,927	194,818	13,533	70,074	83,607	16%	63%	43%	69,358	41,853	111,211
30-34	93,157	117,370	210,527	25,607	109,499	135,106	27%	93%	64%	67,550	7,871	75,421
35-39	95,118	114,956	210,074	36,633	108,642	145,275	39%	95%	69%	58,485	6,314	64,799
40-44	87,997	97,566	185,563	38,534	68,399	106,933	44%	70%	58%	49,463	29,167	78,630
45-49	63,461	63,340	126,801	38,535	68,400	106,935	61%	108%	84%	24,926	-5,060	19,866
50+	104,678	91,720	196,398	62,045	76,537	138,582	59%	83%	71%	42,633	15,183	57,816
All Ages	700,806	812,253	1,513,059	246,779	560,315	807,094	35%	69%	53%	454,027	251,938	705,965

What programs are effectively diagnosing these men and can be scaled?

Across the cascade, the program identified the challenges with children and young adolescents to be linked to dependence on caregivers for access to services, while among older adolescents and young persons, the challenges have more to do with health system barriers that impede their ability to access sexual and reproductive health services. For men, the challenges have to do with their poor health seeking behavior.

The gaps identified in the PMTCT program in Nigeria relate to:

a) low ANC attendance, with about 40% of pregnant women in the country not accessing ANC at facilities;
b) non-integration of reproductive, maternal, neonatal, and child health programs and PMTCT services, such that the majority of ANC service delivery points do not offer PMTCT services; and

c) low facility delivery among ANC attendees (only 35% of ANC attendees deliver in facilities).

The last point above (c) has a direct impact on PMTCT outcomes within the PEPFAR program. For instance, in FY19 Q1, 98% of pregnant women attending ANC got to know their HIV status and 98% of those who tested positive for HIV were placed on treatment. However, only 77% of HIV-exposed infants had received early infant diagnosis (EID) in the first two months of life and only 84% of the HIV-infected infants were linked to treatment.

FSWs, MSM, and PWIDs in Nigeria face significant risk for HIV, as evidenced by the much higher prevalence among these populations (refer to section 2). Their ability to access health services is limited by the high stigma and discrimination they face and criminalization of their behavior. The program has also included targets for incarcerated persons, a population for which there is now significant evidence in the country context of their increased vulnerability to HIV.

3.3 – Minimum program requirements

The COP19 guidance and the Planning Level Letter from the Office of the Global AIDS Coordinator to the Nigeria program both have a list of minimum program requirements, essentially summarizing expectations regarding global policy and program-level standards for PEPFAR-supported countries going forward. These standards were developed from WHO guidance as well as from emerging scientific evidence about optimizing program outcomes for PLHIV.

A summary of these minimum requirements is presented in the table below, along with an update of the status of implementation of these activities within the PEPFAR Nigeria program.

Table 3.3 – Status of Implementation of Minimum Requirements

Minimum Requirements	OU Status
1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups.	Nigeria has adopted a Test & Start policy at all PEPFAR sites which has led to 50% of all new positives initiated on treatment same day.
2. Adoption and implementation of differentiated service delivery models, including six month multi-month scripting (MMS) and delivery models to improve identification and ARV coverage of men and adolescents.	The OU has had fairly good success transitioning clients on ART to differentiated models of care, especially 3- months scripting/dispensing. Less than 5% of patients on treatment are currently receiving 6 months' worth of drugs.
3. Completion of TLD transition, including consideration for women of childbearing potential and adolescents, and removal of Nevirapine based regimens.	Between FY19 Q1 and Q2, the OU has scaled up TLD transition from 18% to 27% but there remains significant lag in transition among women. While TLD transition has been scaled up from 37% to 56% amongst men, among women the OU has only recorded an improvement from 7% to 14% with major challenges related to guidelines requirement for transition of women of reproductive age to TLD.

Minimum Requirements	OU Status
4. Scale up of Index testing and self-testing, and enhanced pediatric and adolescent case finding, ensuring consent procedures and confidentiality are protected and monitoring of intimate partner violence (IPV) is established.	At FY19 Q1, Index-testing only accounted for 7% of HTS_TST_POS and self-testing is yet to be deployed in the country.
5. TB preventive treatment (TPT) for all PLHIVs must be scaled-up as an integral and routine part of the HIV clinical care package.	TPT is currently around 50% of expected targets.
6. Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	The OU is currently at 82% but there remaining significant variation in age and sex disaggregation and linkage is particularly worrisome among children, adolescents and men.
7. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and related services, such as ANC and TB services, affecting access to HIV testing and treatment and prevention.	A significant number of facilities charge users fees especially for lab services that are not covered by the PEPFAR program (blood Chemistry and Hematology). There are also reports of fraudulent charges related to Viral load and EID services which are provided by the program.
8. Completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups.	Viral load and EID service optimization activities are on-going but Viral load testing numbers are still much lower that targets.
9. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	This is yet to be instituted in the OU monitoring and evaluation reporting systems.
10. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17.	The team has made deliberate plans to align OVC services with pediatric care and treatment outcomes. The impact of these changes will be tracked and reported on a quarterly basis.
11. Evidence of resource commitments by host governments with year after year increases.	The team is working with NACA and the FMOH to better document host government funding commitments.
12. Clear evidence of USG progress toward local, indigenous partner prime funding.	The 2018 PEPFAR Expenditure Report shows that the portion of the local partners reduced from 34% to 25%, in 2017 and 2018 respectively.
13. Scale up of unique identifier for patients across all sites.	As at January 2019, the OU has only deployed patient biometric solution to about 80,000 but 82% of PEPFAR clients on treatment are captured in the National Data Repository and can be tracked longitudinally.

Addressing gaps in the implementation of the minimum requirements above is one of the focal points for program implementation in COP19, especially in the scale-up SNUs with high unmet need and low treatment saturation (Red States). To this end, the program will maintain high-level engagement with public health decision-makers and other stakeholders at the state level and in the highest volume health facilities to ensure the removal of policy barriers and the optimization of these key program interventions to maximize outcomes. The program will also engage civil society stakeholders to develop and disseminate patient education materials to empower PLHIV to demand appropriate services as appropriate and to seek support to address any issues inhibiting their ability to access services.

4.0 Program Activities for Epidemic Control in Scale-Up Locations and Populations

As described in Section 3, the program will only be actively scaling-up efforts in the high burden, low ART coverage identified as "Red States". About 280,881 newly diagnosed PLHIV will be placed on treatment in these six states, with about 76% of them expected to come from Akwa Ibom and Rivers to bring the two states to >81% treatment saturation.

The sections below describe, across age and sex disaggregation, the expected program interventions to be deployed to achieve these targets in Akwa Ibom and Rivers mainly, but also in the other scale-up Red States.

4.1. First 95 - Case-Finding Approaches

A major priority in COP19 for PEPFAR Nigeria will be increasing testing yields through the use of smarter testing strategies, including index testing, focused testing based on HIV risk, eliminating testing from low yield modalities, and discontinuing support to underperforming facilities. In FY19Q1, the overall OU testing yield was 2.3%, up slightly from 2.2% in FY18. Index testing was scaled-up to the majority of high-volume (HTS_TST_POS ≥100) facilities throughout COP18. Scale-up will continue and, prior to COP19, all high-volume facilities will have active index testing with continued scale-up to medium-volume (HTS_TST_POS 50-99) facilities. By the end of FY20Q1, all sites will have active index testing.

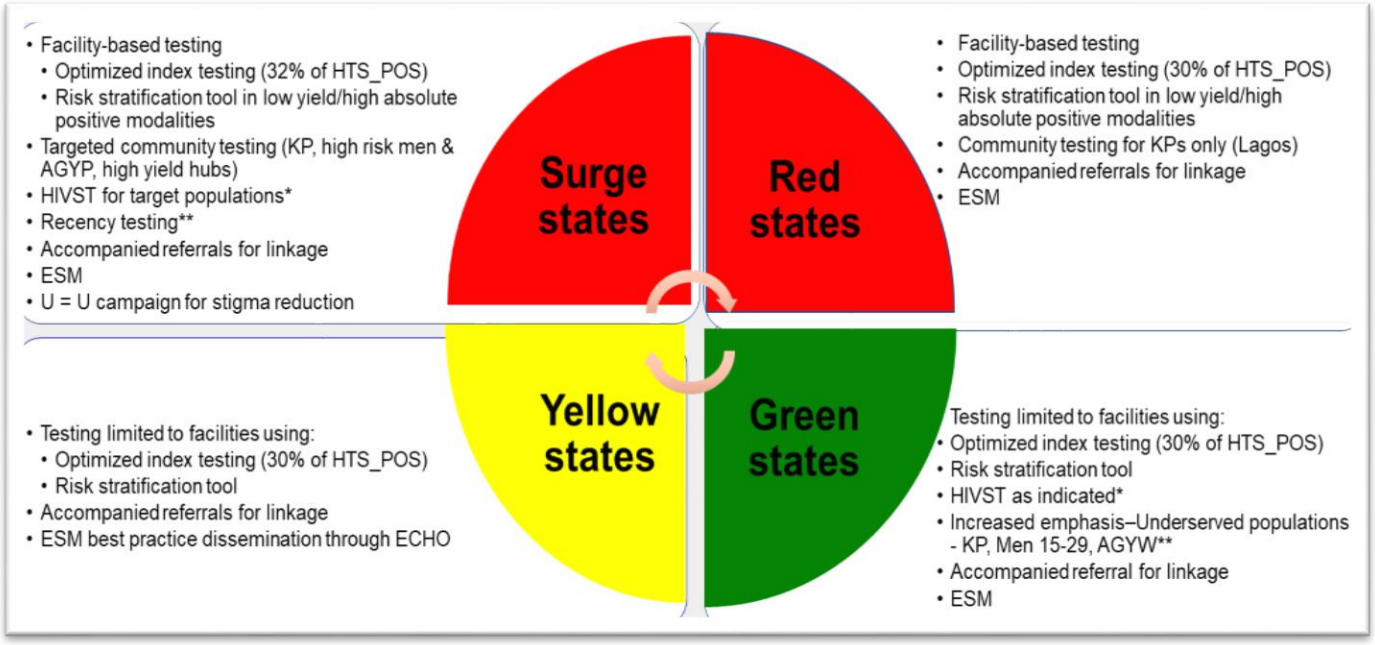
All PEPFAR IPs have been explicitly instructed to focus on achieving assigned HTS_TST_POS targets, with a target-based supply of rapid test kits. To assist in target achievement, partners were provided with a validated risk stratification/HIV screening tool in FY19Q2, with full roll out expected prior to COP19. During initial piloting, the tool increased yield by approximately 30%. HIV testing in low yield/low volume TST_POS modalities (i.e. via among populations with malnutrition, via community-based voluntary testing and counseling [VCT] , etc.) will be fully discontinued prior to COP19. IPs were instructed to discontinue support to 932 low-performing sites (defined as TST_POS/TX_CURR <20 at APR18), beginning from FY19Q3, with a full transition by September 30, 2019.

4.1.1. Testing Strategies by Geographic Prioritization

Testing approaches will also be tailored to the different geographic prioritization zones in Nigeria. In Akwa Ibom and Rivers (Scale-up to Saturation SNUs), PEPFAR Nigeria will identify **214,126** new PLHIV and link at least 95% of them to treatment. To achieve this, the program will deploy a premium package of testing services to strengthen facility-based testing with a focus on optimizing index testing with the expectation that at least 31% of newly identified PLHIV (HTS_TST_POS) will be found through the index testing modality. The application of a risk assessment tool for persons accessing HIV testing services via known high volume but low yield modalities like facility VCT, other provider-initiated testing and counseling (PITC) and targeted community based testing will help to ensure improvements in yields. Community testing

activities will not only target members of key population groups, but in addition, priority populations like high-risk men and at-risk and vulnerable adolescent girls and young women. Communities with observed high positivity rates amongst communities members will be targeted for testing campaigns; including the deployment of HIV self-testing (HIVST) for target groups; and recency testing. Community testing activities will be supported through accompanied referrals to treatment for those who test positive and the facilities in these states will be covered in the Enhanced Site Management program. Figures 4.1 and 4.2 below summarizes the expectation of varying level of effort and testing interventions across the four program tiers.

Figure 4.1: Case-finding strategies by geographic prioritization.



*KP, men, and AGYP prioritized for HIVST through index modality; **determined using NAIIS data, program data, IBBS

A component of PEEP will include treatment literacy campaign based on the U=U (undetectable = un-transmittable) concept which will incentivize early treatment uptake, fidelity to treatment adherence, routine viral load testing and viral suppression among patient community. This will in turn reduce stigma and promote uptake of testing services.

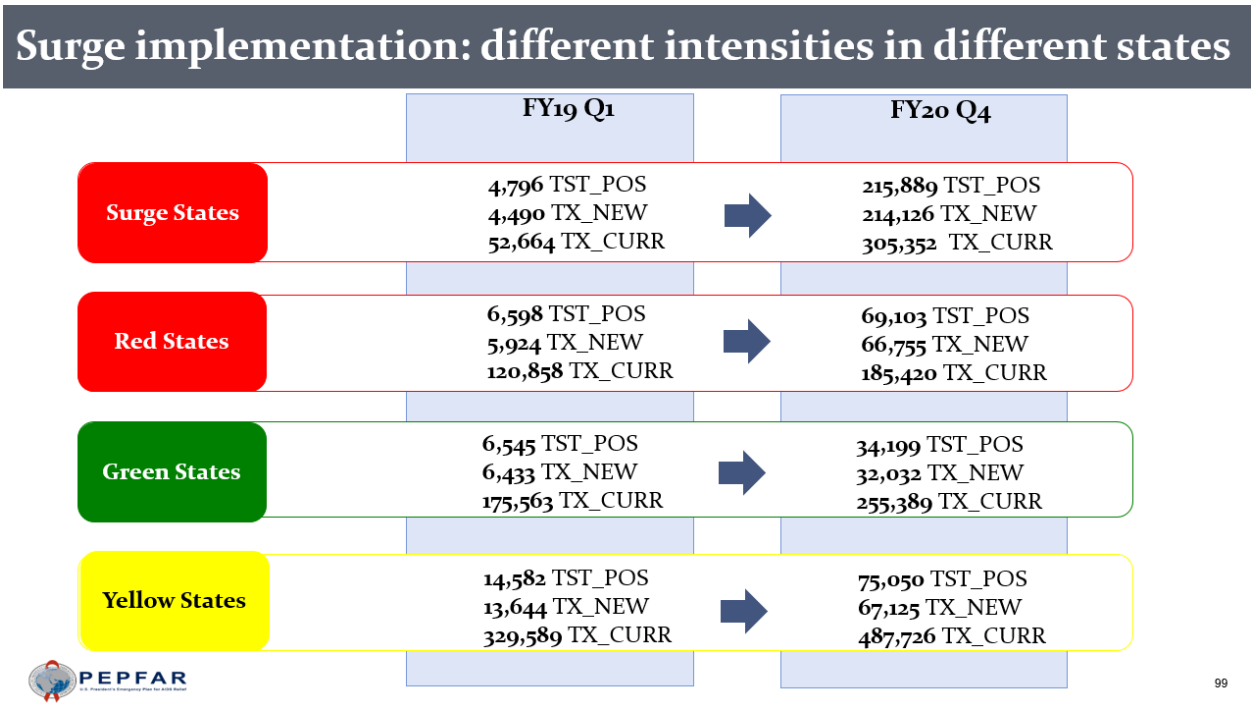
In other Red States (Scale-up Aggressive SNUs), the program will identify **66,755** new PLHIV and link at least 95% of them to treatment. To achieve this, the program will deploy facility-based testing using the risk stratification tool and optimized index testing (with 30% of TST_POS expected from index testing). Community testing will only target KPs and will be supported by accompanied referrals to maximize opportunities for linkage to treatment services. Sites in these states will also be covered in the ESM program and will receive increased supportive supervision to track program progress and maximize expected outcomes.

4.2 Second 95 - Treatment and Retention

In Akwa Ibom and Rivers States (Scale-up to Saturation SNUs), PEPFAR Nigeria will intensify efforts using innovative strategies such as same-day ART initiation (on every work day), flexible clinic hours and differentiated service delivery models to place **214,126**newly identified PLHIV on treatment and retain at least 90% of them to achieve a current on treatment (TX_CURR) target of **305,352** by the end of FY20. Achieving this ambitious treatment target will ensure a treatment coverage of 81% in these states by the end of FY20.

In the other Red States (Scale-up Aggressive SNUs), the program will place **66,755** newly identified PLHIV on treatment and retain at least 90% of them to achieve a TX_CURR target of **185,420** by the end of FY20 effectively moving these states closer to treatment saturation. Figure 4.2 below summarizes the amount effort (targets) required in the geographic prioritizations in COP19.

Figure 4.2 Clinical Cascade Target Distribution by Geographic Prioritization



In COP 19, PEPFAR will support an equitable treatment program that leaves no population behind, by identifying gaps in service delivery across finer age and sex disaggregation. The will be done by consolidating lessons learned in COP 18 and instituting continuous quality improvement initiatives to improve outcomes. PEPFAR will continue to implement and consolidate the "test and treat" approach across all supported health facilities in Nigeria, ensuring quality of care and

improved treatment outcomes. In addition to the provision of ARVs, the treatment service delivery package will include facility-based adherence monitoring, retention in care, and viral load assay to monitor treatment efficacy.

Strategies that will improve the linkage and retention of PLHIV on treatment will be strengthened as well. These include accompanied referral, documentation of repeat testers, same day ART initiation, improved client education and differentiated care approaches, such as fast-track adherence counseling and multi-month dispensing.

Client-level efficiencies will also be achieved through accelerated transition to the fixed dose combination of Tenofovir-Lamivudine-Dolutegravir (TLD) as a first line regimen, and the program will work with stakeholders to remove the requirement for women of childbearing age to be on long-acting contraceptives in order to access TLD. This transition will result in improved linkage and retention of clients due to significantly reduced side effects and adverse drug reactions.

PEPFAR Nigeria will continue to prioritize TB/HIV activities to combat the dual infection of HIV and TB. The core activities will include TB screening; timely TB diagnosis and treatment completion; scale up of TPT, with full procurement of isoniazid, to prevent stock-outs experienced in FY18; and sustained joint TB/HIV programming and monitoring. Furthermore, TB intensified case-finding will be strengthened in PLHIVs, using chest x-rays for TB screening and diagnostic evaluation. In addition, PEPFAR will continue to support co-trimoxazole 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.

To ensure and sustain VLS in children and adolescents, there will be full implementation of the optimized pediatric ART. This will entail the roll out of the use of LPV/r pellets/granules for children and Dolutegravir (DTG)-based regimens in line with revised recommendations to children weighing above 20kg, as they had been previously limited to those patients weighing above 30kg.

The treatment program will also leverage the OVC program to strengthen linkage, ART initiation and retention in children. 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. Other client-friendly services known to improve retention will also be scaled up across all facilities, but prioritized in high volume facilities. These include differentiated care, for example, using community pharmacies to support refills of ART for stable patients on treatment, multi-month dispensing, flexible clinic hours targeting males, continuous quality improvement, and scale up of adolescent-friendly clinics. Differentiated models of care for children will focus on age –band specific clinic days, Parent-Child Paired Care, family based approach to differentiated care, harmonization of clinic days for parents/caregivers, children and

scale up asset-based programming for adolescents and young people for optimal clinical outcomes – Operation Triple Zero (OTZ) initiative. OTZ is geared towards motivating and supporting adolescents and young people living with HIV (AYPLHIV) to take responsibility for their own health and commit to achieving the "triple zero outcomes" – zero missed appointments, zero missed drugs and zero viral load. It promotes a responsive service delivery model and engages AYPLHIV as active partners and stakeholders in improving their health and overall well-being.

4.3 Third 95 - Viral Load and EID Optimization

The country program will prioritize the expansion of VL and EID for all PLHIV and HIV Exposed infants (HEI) in the two states of Akwa Ibom and Rivers which have the highest treatment unmet needs, as well as in all the scale-up aggressive, and scale-up saturation states (the Red and Green States). To meet the needs of the aggressive treatment scale-up required in these prioritized geographic regions, the viral load testing targets for COP19 has been set to ensure that at least 95% of all eligible patients on treatment are tested and their results documented in their folders.

In order to achieve this, the program will take full advantage of the investments made in FY18/19 in standing-up six mega PCR laboratories in strategically selected geographic locations as part of the optimization of the streamlined lab network. This investment will be fully leveraged to expand VL testing to meet the COP19 target of 95% viral load coverage for all populations in these priority states. To ensure that COP19 95-95-95 targets are met in these priority states, the following approaches have been prioritized for implementation:

1. Empowering the community of PLHIV and civil society to own and lead viral load demand creations and services uptake;
2. To decentralize the ordering of viral load for patients so that nurses and other health workers could take on this responsibility for increased service uptake;
3. Full implementation of 24-hrs testing in all supported mega PCR laboratories – this will fully address the challenge of sample backlogs;
4. Full implementation of the bar-coding system for sample log-in in all the PEPFAR supported PCR labs, to reduce the time it takes to manually log-in the thousands of viral load samples received in the labs on a daily basis;
5. Enhancement of the laboratory information management system (LIMS) to enable remote log-in of viral load and EID samples and downloading of results at facility levels; as well as the full implementation of the LIMS-EMR interface for direct transmission of viral load and EID results from PCR labs to the patients electronic medical records;
6. The sustained use and strengthening of the NiSRN for efficient viral load and EID sample referral systems across all supported facilities; and
7. Strengthening the laboratory-clinic interface for enhanced two-way communication between the testing labs and the clinics to ensure well-coordinated and joint efforts for increased viral load services uptake and use of results to inform clinical care.

To optimize EID testing and ensure unlimited access to all HEI across the program, in Akwa Ibom, Rivers states, and all the prioritized scale-up states, the PEPFAR program is coordinating with stakeholders to roll-out the use of Point-of-Care (POC) for EID testing in FY19. This will be further scaled-out in FY20 to expand the coverage of EID testing using POC for the diagnosis of HIV in HEI and early linkage to treatment. With the current deployment of more than 400 GeneXpert Instruments in the country, and the significant un-utilized GeneXpert equipment capacity, the PEPFAR program is leveraging this investments and working with key stakeholders such as CHAI, UNICEF, and UNITAID, to integrate EID into the GeneXpert testing menu for multiple disease diagnosis using this platform. This will significantly reduce the turnaround time for EID testing. To further ensure expedited testing of EID samples, low through-put instruments in the mega PCR labs will be dedicated to providing daily EID testing and return of results through the LIMS-EMR linkage.

The country program is currently prioritizing viral load testing for pregnant and breast feeding women (PBFW). This will be sustained in COP19, in addition to expediting the lab processing using systems alert, and out-of-cycle fast-tracking of viral load samples from PBFW in order to identify high risk HEI who may require intensified postnatal prophylaxis, as part of the strategies to optimize HEI testing, prophylaxis and follow-up. The program will also support national efforts towards improving mother-infant pair retention throughout pregnancy and breastfeeding periods to ensure maximal coverage of testing by two months of age and optimal outcomes after weaning through proactive identification and tracking of known HEIs not enrolled in care after birth. Other strategies will include systematic screening of infant HIV exposure at routine MCH visits, optimized ANC counselling messaging, enhanced support/case management approaches and enrollment of all HEIs in OVC programs and peer support for mothers

A detailed review of the country viral load program indicates children <15 years, key population, and pregnant women currently have the least VL coverage. These populations will be prioritized for viral load testing in all supported health facilities across all geographic prioritization. To achieve this, the implementation of the “Rapid Coverage of Viral Load Testing” initiative will be implemented in all supported ART sites with less than 50% viral load testing coverage. This will be specially targeted at children<15, pregnant women, and KPs.

To ensure that viral load EID testing is consistently meeting the required minimum quality standard, all supported PCR labs will be enrolled into the National External Quality Assurance program. In addition, the country team will implement ESM for all the PCR in the network, with special priority placed on the Mega-labs. This will ensure that the labs are implementing continuous quality improvement for performance and for quality testing, and that they are getting the required routine oversight from the inter-agency Lab technical working group.

Critical to the optimization of viral load testing is the identification of patients with un-suppressed viral load results and linking these to the viremia clinics for enhanced adherence

counseling and longitudinal follow up and monitoring for viral suppression and linkage to ART switch committee for switch to second-line determination using clinical and laboratory evidence.

The country program will further use the U=U concept to incentivize ART services uptake including early initiation into treatment, fidelity to ART adherence, and routine testing for viral load, and achieving viral suppression. The laboratory program will further disaggregate the viral load test results to provide monitoring trends of undetectable viral load on a routine basis.

4.4 Population Specific Interventions

A review of FY19Q1 program performance revealed challenges in finding men and adolescents. Strategies for improved case finding amongst, children, adolescents and men and have been prioritized.

4.4.1 Specific Interventions for Children

In addition to clinic-based interventions, PEPFAR aims to better align the OVC program to support the treatment needs of children living with HIV. To achieve this in COP19, the program will expand the OVC program footprint from in six States (Benue, Nassarawa, Cross Rivers, Lagos, Rivers, Akwa Ibom) and the FCT Abuja to 14 States (Adamawa, Akwa Ibom, Bauchi, Benue, Cross River, Delta, Enugu, Gombe, Imo, Kaduna, Lagos, Kano, Nassarawa) and the FCT Abuja. By doing this, the program will now cover a significant enough proportion of children on treatment (a target of 82,185) to ensure country level improvements in the 95-95-95 cascade for these HIV+ children on treatment.

Implementing partners will deploy pediatric screening tools to identify children in HIV and/or OVC services. Linkage coordinators will facilitate and track bi-directional linkages between community and health service providers. In additional, case managers will support clients to keep their clinic appointments and assist with medication adherence counselling. They will also ensure that eligible children receive viral load services and that their caregivers are knowledgeable about expected health outcomes and the progress of their wards.

The OVC program will scale-up training of caseworkers to support HIV testing services for households enrolled on the program and will also support the follow-up of individual HIV+ clients to ensure they are retained on treatment, have access to viral load monitoring and are receiving appropriately optimized drug options (ritonavir granules/pellets for children and TLD for eligible adults).

More broadly, OVC service providers will continue to deliver need-based, age-appropriate interventions consistent with the integrated case management package and the National OVC Service Standards. They will also ensure improved access to HIV/AIDS and OVC services especially to prioritized sub-population; including children living with HIV, children of PLHIV, children of key populations, high risk adolescents, children who experience violence, abuse and exploitation, and other children affected by HIV.

4.4.2 Specific Interventions for Adolescents

In COP19, PEPFAR will build on efforts towards identifying HIV positive adolescents, promptly linking them to treatment, retaining them on treatment and ensuring optimal clinical outcomes.

To increase HIV case finding among adolescents, the program will train healthcare workers and OVC program staff to provide adolescent friendly services. Health facilities will provide designated/extended/weekend clinic hours centered on adolescents' needs. Risk stratification and HIV testing for adolescents will be scaled up at facility service delivery points (in-patient medical wards, TB units and out patients units). Adolescents who are biological children of HIV positive mothers or siblings of HIV positive individuals will receive risk stratified HIV testing. Sexual network testing and partner notification services will be scaled up for sexually active adolescents. In addition, the program will introduce HIVST among high-risk adolescent networks especially for adolescent girls and young women (AGYW).

To strengthen linkage to treatment, newly identified adolescents and their caregivers will receive intensified post-test counselling on the importance of early ART initiation and adherence. They will also receive peer support and escort services for prompt linkage to treatment, at the point of diagnosis.

An analysis of PEPFAR Nigeria program data showed worsened treatment outcomes for adolescents compared to adults, with adolescents having lower retention rates and suboptimal viral load suppression rates. To address this, PEPFAR will adapt, implement and scale up the" OTZ initiative - an asset- based approach of programming for adolescents. OTZ is geared towards motivating and supporting AYPLHIV to take responsibility for their own health and commit to achieving the "triple zero outcomes" – zero missed appointment, zero missed drugs and zero viral load. A critical aspect of OTZ is creating safe spaces and platforms for adolescents to participate constructively in their own care and that of their peers. OTZ will also simultaneously target AYPLHIV caregivers and healthcare workers with core intervention packages to build their skills in offering adolescent friendly services and treatment support. Clinic organization will entail separate adolescent clinic spaces or days, where feasible, and at the least, age-band based clinic appointment booking system. OTZ will focus on adherence to clinic visits, adherence to ARVs and viral suppression as primary outcomes of interest. The needs of pregnant and breastfeeding AGYW will be addressed through OTZ-plus.

HIV prevention activities for adolescents will be driven mainly through the OVC program using a DREAMS[20]-like approach to decrease HIV infection risk particularly among AGYW. Through education and empowerment community programs such as "Families Matter Program (FMP)" and

[20] DREAMS is an initiative geared towards help girls develop into **Determined, Resilient, Empowered, AIDS-Free, Mentored,** and **Safe** women. It consists of a core package of evidence-informed approaches that go beyond the health sector, addressing the structural drivers that directly or indirectly increase girls' HIV risk, including poverty, gender inequality, sexual violence, and lack of education

"Better Parenting", adolescents and their parents will receive information and support for HIV prevention, sexual risk reduction, and sexual violence awareness/reduction. FMP is an evidence-based group level intervention for adolescents and their parents or caregivers, which promotes positive parenting practices and assists parents to communicate messages about HIV, sexually transmitted infections (STIs), pregnancy prevention and gender based violence. Better Parenting builds parents' and caregivers' confidence in their parenting skills and improves the relationships between them and their children.

Through the OVC program, PEPFAR will continue to implement household economic strengthening activities through which AGYW and their families will receive vocational skills building and financial support. Educational support will be provided through educational subsidies such as block granting. During COP 19, PEPFAR will provide technical assistance for strengthening national systems for child protection and violence prevention. All adolescents enrolled in the OVC program will be screened for HIV using appropriate risk stratification tools and testing offered to eligible individuals.

4.4.3 Specific Interventions for Adult Men

In order to identify more men living with HIV, optimized index testing will be offered to all new PLHIVs and virally unsuppressed women in PMTCT settings and partners of FSWs using the peer approach. Within the scale-up saturation and scale-up aggressive states, targeted community testing will be carried out at high yield hubs for high-risk men who will in addition be reached through index testing. Here recency testing will be offered to newly identified HIV infected men to determine those who are recently infected so they can be prioritized for treatment initiation and index testing.

HIV testing will be offered at workplaces to at-risk men 15 – 39 years of age as well as to men in known KP settings. Also, targeted facility-based PITC in high yield modalities (such as TB, In-patient, etc.) and the use of the risk assessment tool in high volume/low yield modalities (e.g. facility VCT, other PITC, and targeted community based testing) will be implemented to identify high-risk men for HIV testing.

At blood banks, high-risk blood donors (mostly males) screened out from blood donation, and male donors who test HIV positive by RTKs or ELISA, will be directly linked to HTS and treatment initiation.

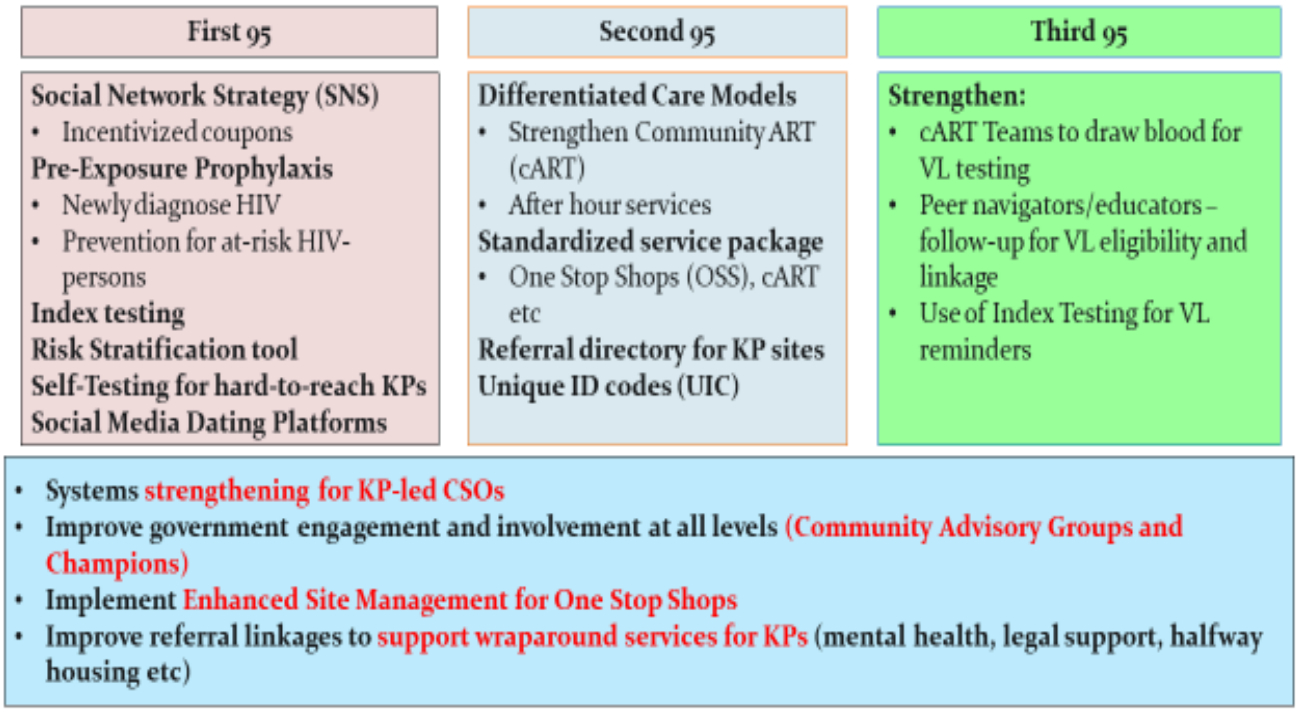
PEPFAR supported facilities will provide male-friendly services such as fast track services, extended evening and weekend hours in order to increase access to care for men. In health facilities, HIVST will be offered to partners of women identified from all testing modalities, sexual partners of FSWs, partners of PMTCT women and MSM using peer model with snow-ball. To reduce testing among men with little or low risk for HIV, the risk stratification tool will be applied to all men before being tested.

4.4.4 Specific Interventions for Key Populations

The KP program strategy for COP19 is focused on achieving 95-95-95 among key populations. The use of evidence-informed prevention-based peer-led networks will form the fulcrum for the 95-95-95 service delivery. In COP 19, 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 PEPFAR Nigeria KP program will include FSW, MSM, PWID, and incarcerated populations. A KP size estimation has been conducted in the current KP implementation geographic locations. The reports from this size estimation exercise will inform the KP program strategic implementation for COP19. IPs will continue to engage key stakeholders, including security agencies and the National Human Rights Commission, to address issues of the harassment, discrimination and criminalization of KPs.

Figure 4.3 Strategies for KP program optimization



Direct service provision will include elements of the nationally approved Minimum Prevention Package of Interventions. Combination prevention to be provided to KP shall include targeted HTS, PrEP, total market approach to condom/lubricant programming, social media engagement, sexually transmitted infections (STI) management, community level system strengthening and appropriate structural level interventions.

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, partner notification services (PNS), and HIVST, especially for sexual partners of KPs, will be prioritized in active case finding. KP PLHIVs will be actively linked to ART services using a same day initiation approach.

ART services will be available at the OSS and through mobile community ART 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. The treatment algorithms for first and second line drugs will be in line with national standards.

4.5 – Enhanced Site Management

ESM provides an overall strategy to improve implementation of the PEPFAR 2019 COP Guidance on crosscutting approaches to achieving 95-95-95 targets. ESM aims to improve the quality, fidelity, and outcomes of PEPFAR programs through effective partner and site oversight. In particular, ESM focuses on using in-depth analysis of site-level data to obtain a deeper understanding of health facility and patient-level factors affecting performance and apply the information through an intensified continuous quality improvement (CQI) approach to improve program performance.

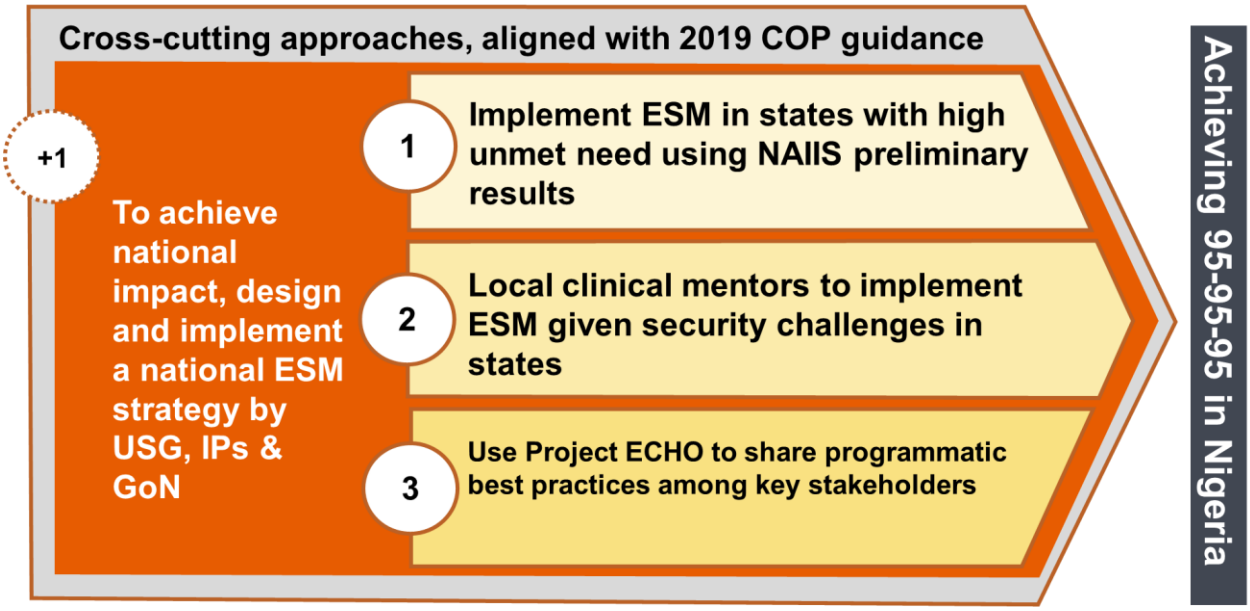
Program efficiency is improved by increasing testing yield (i.e., fewer tests conducted with an increased number of PLHIV identified), improvement in linkage and improvement in retention. Knowledge of effective strategies that improve yield, linkage and retention are obtained through the test of small change, which is an important component of CQI process implemented at ESM sites. In COP19, PEPFAR Nigeria will implement ESM in high volume sites in states with high unmet needs (Red States), especially in the two surge states of Rivers and Akwa Ibom, and high volume sites in states close to epidemic control (Green States) where PEPFAR will be trying to achieve excellence. However, information about what works and lessons learned from ESM implementation will be shared with other sites and states using a low bandwidth video conferencing technology (Project ECHO), creating a "domino effect" that leads to improvements across the entire PEPFAR Nigeria program.

Project ECHO is a cost-effective, interactive, low-bandwidth video-conferencing technology, currently used or planned for in over 20 PEPFAR-supported African countries. PEPFAR Nigeria successfully piloted Project ECHO during FY2018, focused on HIV clinical care. Based on this experience, the communication platform can be usefully expanded to share best practices for patient care and programmatic implementation. Project ECHO sessions will be held both within selected states (i.e., "state-based sessions"), as well as between selected states (i.e., "national

sessions"). The key participating stakeholders will be sites, implementing partners, state Ministry of Health staff, and PEPFAR Nigeria.

Furthermore, ESM will involve a more intensive routine biweekly monitoring of site performance against targets and prompt feedback on key MER indicators, biweekly leadership/partner meetings, regular communication with partner staff and weekly video conferencing to share programmatic progress and lessons learned. Furthermore, given security concerns and travel restrictions in the two surge states, clinical mentors will serve as proxies for PEPFAR staff. Clinical mentors will support continuous quality improvement, including identifying the top challenges per site; developing an action plan to solve challenges; and, in-depth analysis and reporting of site-level data. In addition, clinical mentors will spread site-level best practices to other sites. Figure 4.3 provides a schematic overview of three key ESM activities within the context of PEPFAR guidance.

Figure 4.4 - Schematic of ESM Activities in Nigeria.



4.5.1 – Site differentiation for ESM

In red and green states where ESM will be implemented, sites will be differentiated using a three-tiered system. Tier 1 sites are high volume treatment sites and among the less than 20% of the total number of sites that contribute to 80% of total PLHIV currently receiving antiretroviral treatment (TX_CURR) in the state. However, Tier 1 sites are also sites performing below expectations on key MER indicators. In contrast, Tier 2 sites are high volume sites contributing 80% of TX_CURR that are achieving targets or on track on key MER indicators. Tier 3 sites are the rest of the sites accounting for 20% of TX_CURR achievements for the state. In the states with relatively low-unmet treatment needs (yellow states), the sites will be differentiated using a two-tiered system. The total number of sites contributing to 80% of TX_CURR achievements for the state are classified as Tier A sites. Whereas the rest of the sites contributing to 20% of TX_CURR

are Tier B Sites. Table 4.1 provides a summary of the intensity of support and technical assistance to the different tiers of sites in COP 19.

Table 4.5.1 - Summary of Activities by Site Tier

Activities	Green and Red States			Yellow States	
	Tier 1 Sites	Tier 2 Sites	Tier 3 Sites	Tier A	Tier B
Monitoring Technical Assistance (TA)					
Enhanced monitoring and site visits	✓				
Virtual monitoring and TA		✓	✓	✓	✓
Additional Support					
Clinical Mentor Support	✓				
Videoconferencing Support (ECHO Project)					
State-based sessions	✓	✓			
National sessions	✓			✓	

4.6 Targets for scale-up locations and populations

Table 4.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts			
Entry Streams for ART Enrollment	**Tested for HIV (APR FY20) HTS_TST**	**Newly Identified Positive (APR FY20) HTS_TST_POS**	**Newly Initiated on ART (APR FY 20) TX_NEW**
Total Men	1,919,345	118,885	119,317
Total Women	2,592,102	137,195	137,276
Total Children (<15)	505,986	24,192	24,288
Total from Index Testing	454,624	85,283	81,019
Adults			
TB Patients	11,049	1,078	1,024
Pregnant Women	485,717	11,872	11,278
VMMC clients			
Key populations	224,256	17,985	17,086
Pediatrics (<15)			
HIV Exposed Infants	14021	264	248
Other pediatric testing	505,986	24,192	22,982
Previously diagnosed and/or in care (Pediatrics)			

Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	**Population Size Estimate** (scale-up **SNUs**)	**Coverage Goal (in FY20)**	**FY20 Target**
[Specify target populations for focus, e.g. AGYW] Indicator Codes include PP_PREV and KP_PREV	**951,437**	**49%**	**461,571**
TOTAL	**951,437**	**49%**	**461,571**

Table 4.6.4 Targets for OVC and Linkages to HIV Services			
SNU	**Estimated # of Orphans and Vulnerable Children**	**Target # of active OVC (FY20Target) OVC_SERV**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY20 Target) OVC***
Adamawa	**99,680**	**36,696**	**27,428**
Akwa Ibom	**191,831**	**142,111**	**106,585**
Bauchi	**108,413**	**38,314**	**28,736**
Benue	**317,201**	**131,765**	**98,833**
Cross River	**136,529**	**53,125**	**39841**
Delta	**116,988**	**49,262**	**36,931**
Enugu	**91,277**	**34,752**	**26,064**
FCT	**117,993**	**47,911**	**35,926**
Gombe	**62,629**	**24,597**	**18,447**
Imo	**94,941**	**24,649**	**18,447**
Kaduna	**194,340**	**68,972**	**51,729**
Kano		**118,994**	**89,242**
Lagos	**408,098**	**155,226**	**116,456**
Nassarawa	**123,710**	**51,558**	**38,685**
Rivers	**189,544**	**120,685**	**90,512**
TOTAL	**2,341,313**	**1,098,617**	**823,862**

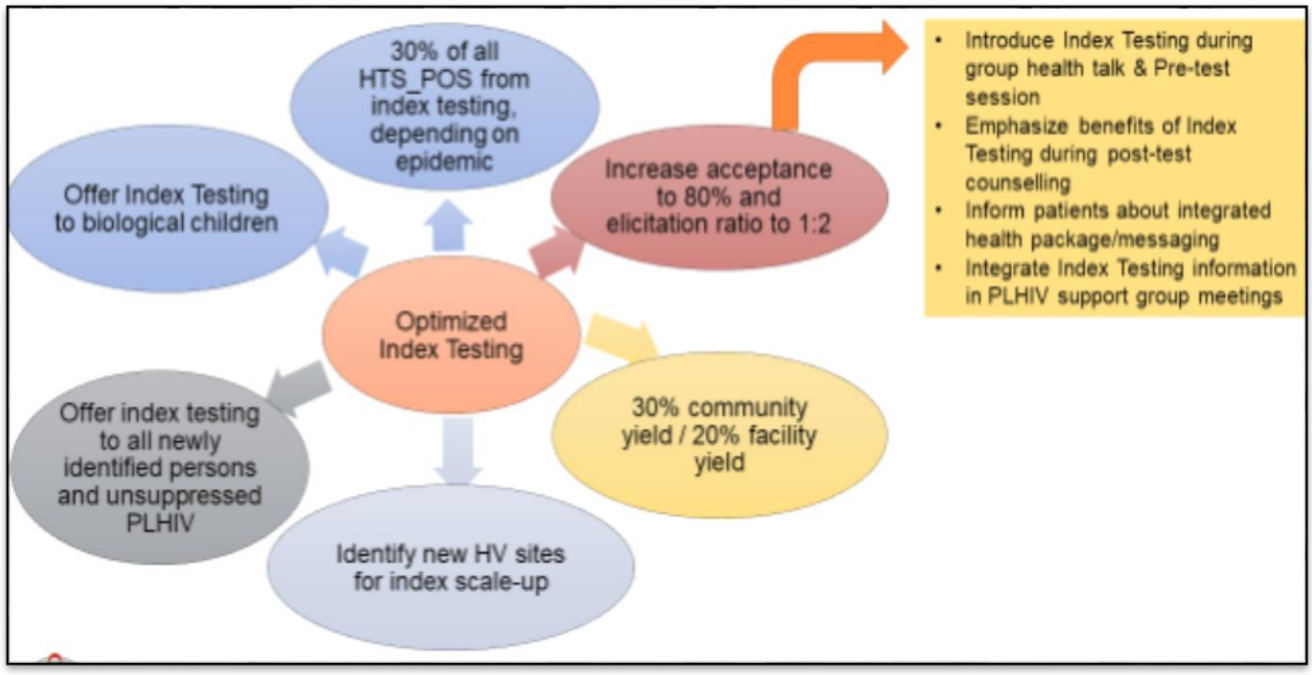
4.7 Additional Country-Specific Priorities Listed in the Planning Level Letter

The Federal Ministry of Health (FMOH) will finalize and disseminate HIVST operational guidelines and tools by the fourth quarter of the current fiscal year (FY19). To support HIVST in COP19, PEPFAR will procure approved HIV self-test kits and leverage test kits procured through the unified procurement and supply chain by other stakeholders (like Global Fund) and the GoN's Total Market Approach.

In COP19, PEPFAR will fully scale-up index testing by,

(1) offering index testing to all newly identified PLHIV, virally unsuppressed PLHIV and biological children (≤15 years) of female PLHIVs;
(2) increase acceptance rate of index testing to minimum 80% from the current 76% as of FY19Q2;
(3) increase elicitation ratio to minimum 1:2; and
(4) Ensure index testing yield in community is minimum 30% and in facility minimum 20%. (See figure 4.4 below for summary on index testing optimization).

Figure 4.5 Strategies for Optimizing Index Testing

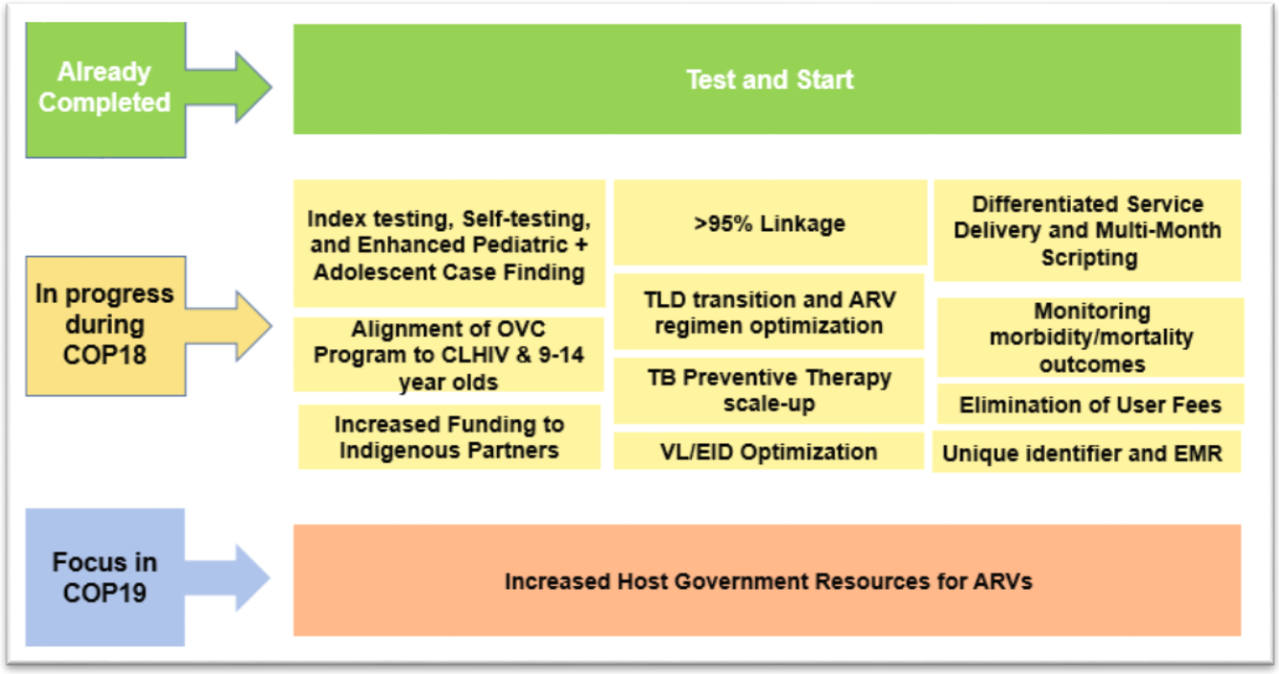


In all sites, index testing will be introduced during the group health talk, in PLHIV support group meetings and pre-test counselling session. The benefits of index testing will also be emphasized in post-test counselling where clients will be informed about integrated health messaging and free integrated health service package with the aim of further increasing acceptance.

In COP19, PEPFAR will deepen the implementation of "test and start" (focusing especially on same day ART initiation) to reach country treatment saturation targets. All newly diagnosed and previously diagnosed, unlinked PLHIV will be commenced on optimized same-day ART regimens as prescribed in the National Rapid Advice Recommendations for first line ART. Enhanced site management will be implemented to support the scale-up of these services with specific focus on missed populations.

Concerning the 13 minimum program requirements highlighted in the COP19 guidance, the country is currently focusing on eliminating user fees which serve as a barrier to accessing HIV prevention, care and treatment services. PEPFAR will consolidate 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 National Treatment Program launched in 2018.

Figure: 4.6 COP 19 minimum program requirements



Differentiated service delivery models will focus on delivering patient centered services using the backbone of the TLD transition for stable clients receiving treatment, and includes multi-month dispensing (between 3 and 6 months) and flexible drug pick-up options at community pharmacies and lower level health facilities. PEPFAR will support the GoN to reach a minimum equitable saturation of 81% TLD for pediatrics >20kg, men and women of reproductive age group, while ensuring access to contraceptives for those accessing services in the facilities. PEPFAR IPs will, through ESM, optimize service delivery in supported health facilities, eliminating all 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 high volume facilities, faith-based organizations and private for-profit sites to provide weekend and after-hours clinic services.

4.8 Cervical Cancer Program Plans

Cervical cancer continues to claim the lives of thousands of women who could have been saved through relatively simple screening for and treatment of pre-cancerous lesions in Nigeria and other countries of the world. Generally cervical cancer screening and treatment services are available in many PEPFAR supported health facilities across Nigeria as part of the RMNCH services. Screening for cervical cancer and other forms of cancer is largely funded by clients directly or, more recently, indirectly through the National Health Insurance Scheme (NHIS). Current efforts are, however, poorly coordinated and the proportion of HIV positive women among beneficiaries cannot be ascertained due to weak reporting system.

Predominantly, a "pap smear" is the procedure of choice by health facilities in Nigeria compared to developed countries where other various cervical cancer screening, diagnostic and treatment methods are used. Cervical cancer was not part of Nigeria COP18 funded activity.

In COP19, selected high volume ART sites will be supported to provide cervical cancer screening using Visual Inspection with Acetic acid and facilitated referral for treatment of precancerous lesions to maximize opportunities for immediate cryotherapy or thermal ablation treatment for women living with HIV who are eligible without the need for diagnostic pathology confirmation. This will also assist in the reduction of loss to follow-up among PLHIVs. This service will be targeted at all HIV positive women aged 25 to 49 at time of diagnosis and every-other-year as part of care and support services. Scaling up this life saving intervention will require additional skills by the ART service providers and possibly additional manpower. PEPFAR Nigeria will intensify advocacy for implementation of task shifting and task sharing policy at the selected health facilities.

Facilitated referral system by redeemable coupon system will be put in place to ensure that all those requiring treatment are linked to the appropriate referral facilities. PEPFAR supported the Government of Nigeria to development of an electronic master facility list, which will be leveraged upon to facilitate linkage to treatment. A cervical cancer referral coordinator, whose main role of this coordinator will be to ensure that all referrals are completed and reported, will be identified for each site.

4.9 Commodities

PEPFAR continues to engage with stakeholders to transition patients on Nevirapine-based regimens and Tenofovir-Lamivudine-Efavirenz (TLE) regimens to the new Dolutegravir-based, TLD regimen. This transition is led by the Federal Ministry of Health, in conjunction with the PEPFAR IPs and Global Fund Principal and Sub-recipients. The IPs provide weekly reports on their progress with the transition to the PEPFAR agency teams. TLD rollout started with the initiation of new patients on TLD in October 2018. Despite initial slow uptake in the rollout of TLD – which may have being caused by lack of proper communication on eligibility – the plan is to reach at least 80% of stable patients in Nigeria by the end of the current fiscal year. No shortages of TLD are envisioned through FY20.

While waiting for updates to earlier guidelines requiring women of child bearing desiring to receive TLD to first be put on long acting contraception, PEPFAR is engaging the Family Planning division of the Federal Ministry of Health to improve access to contraceptives for women living with HIV. This effort will include providing technical assistance to quantify family planning commodities for HIV/AIDS patients, particularly women of childbearing age with the aim to improve access to contraception and eligibility for transition to TLD.

In addition, nevirapine-based regimens have been largely phased out and will no longer be delivered to health facilities; TLE 600 will also be phased out and replaced by TLE 400 for the

patients that are unable to transition to TLD. PEPFAR will also introduce 90-day packs of TLE 400 for these patients thus encouraging 3 to 6 months of MMD.

To meet the COP19 targets, PEPFAR proposes a total budget of $168,874,552 for commodities of which $10,037,617 is budgeted for test kits (about 8.36 million units of the screening test Determine™; 836,000 units of the confirmatory tests Uni-Gold™ and about 83,500 units of the tiebreaker kit STAT-PAK®). The program also plans to procure about 8,950 units of self-testing kits and some recency testing kits.

The program has budgeted $111,064,196 for adult ARVs (making sure to reflect the planned transition of majority of adults on treatment to the Dolutegravir-based regimen) and $10,352,879 on Peadiatric ARVs. $26,794, 069 has been budgeted for viral load reagents and consumables, while $1,934,000 will be spent on CD4 reagents and about $745,000 on EID reagents.

About $3.3 million was budgeted for TPT with isoniazid, while $2.8 million was budgeted for treatment and prevention of other HIV-related opportunistic infections. The program will also procure about 140,000 units of the GenXpert cartridge for TB diagnosis amongst PLHIVs.

As with previous years, all procurements will be and sequenced with other stakeholder investments to mitigate any risk of excess and waste. This is particularly important as the conversations about planned commodities procurement by state and national government and other potential investors (like the soon to be launched, HIV Trust Fund) come onboard.

4.10 Collaboration, Integration and Monitoring

PEPFAR collaborates with the GoN, Global Fund and other stakeholders through several platforms to achieve joint planning and implementation in the commodity procurement and supply chain, laboratory systems, strategic information management and have help to address potential sources of duplication with investments aligned to optimize outcomes.

The NAIIS is the most recent of such collaborations. PEPFAR and the Global Fund contributed $70.80 million and $20 million respectively to the fund of the project, which was led by the GoN through, the NACA and the FMOH. Other stakeholders like the UNAIDS, WHO, the Network of PLHIV and the Civil Society for HIV/AIDS in Nigeria were also represented in coordination and implementation of the survey. State governments and multiple other state level actors, including traditional and religious leaders, were also engaged in the implementation of the survey.

Another area of collaboration in the national response is the national laboratory systems. A national network of PCR labs has been set up 16 labs, 11 of which are supported directly by the PEPFAR program, four by the Global Fund and one by the GoN. In COP19, these 16 PCR labs will be responsible for the over 1.5million viral load test need for the country. A linked NiSRN system became operational in FY18, and serves to jointly managed samples logging from health facilities (using 3rd-party logistics systems) to the PCR labs and other referral labs in the network and in turn, pick-up results from the labs back to the clinics. The NiSRN system is currently being expanded for TB and CD4 samples as well.

Nigeria has also integrated a LIMS into the Lab Network with a common repository for all viral load and EID testing data from all of 16 PCR labs. In COP19, this common LIMS system will be enhanced with features that would enable remote sample log-in and download of results at the facilities level. The linkage of the LIMS system to the EMR systems in the health facilities will also be completed in FY19, to allow easy transmission of patients' data from Lab to clinics directly, to reduce the turn-around-time for viral load and EID services.

In supply chain management, PEPFAR engages the Global Fund, UNAIDS, CHAI and the FMOH in quantification and supply planning of HIV/AIDS commodities to ensure commodity availability. The biennial quantification and forecast meeting for HIV/AIDS commodities is co-funded by these stakeholders, using consumption data to forecast the national needs for the next two years.

The onboarding of the HIV/AIDS, Malaria and Family Planning Logistics data on the National Health Logistics Management Information System (NHLMIS) platform has provided greater visibility for facility-level stock data for those commodities. The backbone for the NHLMIS was established with funding from by UNICEF, Bill and Melinda Gates Foundation and Global AIDS Vaccine Initiative initially for the vaccine program. Since them, other it has been expanded to accommodate data from other health programs through funding from PEPFAR, Global Fund, UNFPA and USAID. The data on the platform is be used for commodities forecasting and supply planning going forward. HIV/AIDS commodity data is now 100% complete on the platform and henceforth, PEPFAR commitment to the platform will be limited to funding towards its annual maintenance. Efforts are currently underway to incorporate TB and MNCH commodity data onto the platform by Q4 FY19.

PEPFAR continues to collaborate with the Global Fund and UNFPA in providing support to state Logistics Management Coordination Units (LMCUs) in 36+1 states in Nigeria, a platform for ensuring state government ownership. The LMCUs are continually playing a major role in managing the supply chain of public health commodities at the state level by ensuring prompt bi-monthly ordering of commodities by health facilities, tracking utilization, inputting logistics data onto the NHLMIS and ensuring commodity availability in the health facilities.

For HIV service delivery, the Global Fund and PEPFAR have worked closely to rationalize states in an effort to reduce program overlap and duplication of results and targets. During COP planning, the two parties agreed PEPFAR will cede Anambra and the number of patients currently on treatment to the Global Fund while continuing to support the reference lab in the state. In return, the Global Fund will cede Akwa Ibom and Rivers, including its treatment current patients, to the PEPFAR program. In Kaduna state, PEPFAR and Global Fund agree to co-locate with PEPFAR providing services to the patients currently on treatment while the Global Fund find and support treatment new patients. A transition plan is being developed for the transitioning of the states to the relevant programs by June 2019. In COP19, CDC will be supporting Rivers state while Akwa Ibom will remain under USAID support. The two agencies are in the process transition planning.

The need for unique identifiers for patients accessing HIV-related services in Nigeria has long be established to potentially be a strategy for addressing de-duplication issues in testing

and treatment data arising from the undeclared movement of clients between service delivery points. In the instances where PLHIV would seek to access testing and treatment services from multiple health facilities, there was no way to de-duplicate these clients in the database until PEPFAR started to introduce EMRs optimized with unique identifier systems. The recent adoption of PBS at the Fifth National Council of AIDS meeting in April 2019 is an opportunity for the program to address these issues and fully account for all persons receiving HIV/AIDS services in the program at any point in time. This will facilitate the longitudinal monitoring of individual clients progress with antiretroviral care and empower clients and their service providers to engage more decisively to ensure optimal treatment outcomes.

5.0 Program Activities for Epidemic Control in Attained and Sustained Locations and Populations

5.1 COP19 Programmatic Priorities and Targets

Three States; Benue, Gombe and Nassarawa come closest to meeting the requirements for "attained sub-national units (SNUs)". Despite significant coverage gaps with age and sex disaggregation especially amongst the younger population, the three states currently >81% treatment coverage and will received targets support in COP19 to address the remaining gaps. They are described as "Green States" in the Nigeria PEPFAR four-quadrant prioritization matrix (see Figure 3.1 above).

Twenty-two states (categorized as Yellow States in the matrix) remain with relatively lower coverage rates and similarly low unmet needs for treatment because of their lower prevalence rates and population sizes. These states fit the description of the "sustained SNU" categorization and the program plans for them in COP19 align with that description. These states account for about 40% of the total PLHIV in Nigeria so there is an interest to see the states not only retain those that are currently receiving HIV/AIDS treatment but also to keeping diagnosing and adding new people on treatment. Expectedly, the program aims to reach about 62,585 newly diagnosed PLHIVs with treatment services. All of these people will be reached mainly through facility-based testing services except in situations where index testing follow-up lead to community follow-up of contacts and among key populations.

The proposed testing strategies for the Green and Yellow states are captured in detail in subsequent sections.

5.2 Targets for Attained and Sustained Locations and Populations

Table 5.2.2 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Support States

Sustained Support Volume by Group		Expected result APR 19	Expected result APR 20
HIV testing in PMTCT sites	PMTCT_STAT	**1,521,926**	**1,089,175**
HTS (only sustained ART sites in FY18)	HTS_TST/HTS_TST_POS	**5,265,681/167,080**	**2,628,279/113,969**
Current on ART	TX_CURR	**966,087**	**777,764**
OVC	OVC_SERV	**940,068**	**1,098,617**

5.2. Establishing Service Packages to Meet Targets in Sustained Districts

The Sustained service package has been divided into three components - facility-based programs (including HTS, treatment and viral load), KP programming, and programs for OVC.

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

For descriptive purposes, facility-based programs to be supported are categorized in line with the UNAIDS 95-95-95 target framework. A separate section on pediatric (similarly categorized) can be found in section 4.1 above.

5.2.1.1 First 90 - HTS

In the Green States (Attained zone), HIV testing will be limited to facilities and with the risk stratification tool applied across all testing modalities. A strong focus will be placed on optimized index testing (30% of TST_POS), reaching underserved populations (KP, men 15-29, AGYP), offering of HIVST (prioritized for KP, men and AGYP through index modality), accompanied referral for linkage and Enhanced Site Management (ESM).

The Yellow States (Sustained zone) will have testing limited to facilities with strict application of the risk assessment tool across all testing modalities. All eligible patients will be offered optimized index testing (30% of TST_POS), accompanied referrals for linkage and ESM best practice will be disseminated through ECHO platform.

5.2.1.2 Second 90 – HIV and AIDS treatment

In COP 19, PEPFAR will support an equitable treatment program that leaves no population behind by identifying gaps in service delivery across regions, age and sex disaggregation, consolidating lessons learned in COP 18 and instituting The ESM approach, which is expected to improve program quality and fidelity, with proper operations management, for better outcomes. PEPFAR will continue to implement and consolidate "test and start" across all supported facilities in Nigeria, ensuring quality of care and improved treatment outcomes. The treatment service 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-track 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. Other client-friendly services known to improve retention will also be scaled up across all facilities, but prioritized in facilities in the "surge" states. These include differentiated care, for example, using community pharmacies to support refills of ART for stable patients on treatment, multi-month dispensing, flexible clinic hours targeting males, continuous quality improvement, and scale up of adolescent-friendly clinics.

PEPFAR will continue to prioritize TB/HIV activities to combat the dual infection of HIV and TB. The core activities will include TB screening: timely TB diagnosis and treatment completion; scale up TPT, with full procurement of isoniazid, to prevent stock outs experienced in FY18 and sustain joint TB/HIV programming and monitoring. In addition, PEPFAR will continue to support co-trimoxazole prophylaxis, nutritional assessment and counselling, and 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.

PEPFAR will work closely with IPs to leverage best practices, CQI initiatives targeting high volume ART sites, and innovative approaches to service delivery. The program aims to achieve efficiency through the NiSRN to improve viral load coverage, deepen EID penetration, and strengthen TB/HIV collaboration and achieve optimal turnaround times. 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 TLD.

5.2.1.3 Third 90 - Viral Load (VL)

Given the overall low viral load coverage (45%), and Community viral suppression rate of 80% in Nigeria, viral load scale-up approaches described above will be implemented in all the sustained states. However, aggressive viral load scale-up efforts in these states will be primarily targeted at the priority populations which currently have the least viral coverage - children, pregnant and breastfeeding women, as well as KPs through the OSS. Aggressive transition to TLD will also be implemented amongst these priority populations in these states starting from FY19.
In COP19, the routine program implementation oversight and site monitoring for viral load testing by the USG technical teams and implementing partners would however be less frequent in these states. Priority would be given to the transitioning of PCR laboratory ownership and leadership to the host facilities.

5.3 Pediatric Case-finding, Treatment and Viral Suppression

In COP19, PEPFAR will continue to implement strategies that will improve pediatric HIV case identification with effective linkage to ART. With HIV prevalence among children estimated at 0.2%, the program will continue to implement intensive pediatric HIV case finding at supported sites where children seen at pediatric inpatient wards, TB clinics, and nutrition clinic will be tested. Additionally, testing will be offered to biological children of index cases and use of appropriate HIV testing screening tool to maximize HTS yield and improve HTS efficiency. Through an effective mother-infant pair, HIV positive children identified through EID services will be promptly linked to care and ART services.

Enhanced site management approach will be implemented to improve viral suppression in children on ART, scale up use of the optimized pediatric ART regimen by placing treatment naïve children on LPV/r or DTG-based regimens as appropriate. Children on NNRTI-based regimens will be transitioned to LPV/r or DTG-based regimens. To further improve adherence, LPV/r granules will be prioritized over LPV/r pellets in children less than three years. PEPFAR will advocate for the inclusion of eligible weight for DTG from 30kg to 20kg, in the national guidelines. To improve viral load testing coverage, children on ART will be prioritized for viral load testing. The program will also optimize TB preventive therapy for children on ART.

PEPFAR will leverage the OVC program to strengthen facility-community bidirectional linkage and improve ART adherence and retention. Children on ART will be linked to mapped CBOs offering OVC services at contiguous communities.

PEPFAR will implement age appropriate differentiated model of care for children on ART such that they will be given age band specific clinic appointments. Using PCPC and family based approaches, we will harmonize clinic days for parents/care givers and young children. Structured age-appropriate disclosure for CLHIV will be strengthen to optimize full disclosure by age 10.

In COP19, sexual network testing and partner notification services will be optimized for older adolescents aged 15-19 years, as a case-finding strategy. Linkage to care among adolescents will be strengthened through intensified counselling and peer navigation. To achieve optimal retention and viral load suppression among AYPLHIV,, OTZ, will be implemented and scaled up.. Adolescents will be transitioned to optimal TLD regimen and a standardized package of care for adolescents will be implemented at supported facilities.

5.4. Establishing Service Packages to Meet Targets in Attained & Sustained LGAs

Service Packages		SNU Prioritization Category	
		Green/Attained SNUs	**Yellow/Sustained SNUs**
First 95	Targeted community based testing	Yes (KP only)	KP only (where applicable)
	Facility based testing (PITC)	Yes	Yes
	Optimized index testing to contribute at least 30% of HTS_TST_POS	Yes	Yes
	Deployment of risk stratification tool in modalities with high volume of positives but low testing yield	Yes	Yes
	Discontinue testing in low-volume, low-yield modalities	Yes	Yes
	Withdraw PEPFAR support from low volume/low yield sites (HTS_TST_POS/ TX_CURR < 20 at APR18)	Yes	Yes
	Targeted testing to reach underserved populations (KP, children and adolescents, men 25+)	Yes	No
	HIV Self-testing	Yes	No
	Recency Testing	No	No
	Accompanied referral for linkage	Yes	Yes
	Enhanced site manage implementation	Yes (whole package)	Only dissemination of ESM best practices/lessons learned through ECHO platform
	Targeted age-sex care & treatment services	Yes	No

Service Packages		SNU Prioritization Category	
		Green/Attained SNUs	Yellow/Sustained SNUs
Second & Third 95	Community ART services/DSDM for mobile population	Yes	Yes (where applicable)
	KP ART services	Yes	Yes (where applicable)
	Implementation of rapid viral load testing coverage	Yes	No
	Optimized viral load suppression by age and sex disaggregation	Yes	No
	Enhanced site manage implementation	Yes (whole package)	Only dissemination of ESM best practices/lessons learned through ECHO platform
	PLL Minimum Requirements	Yes	Yes

5.5. OVC Program in Attained and Sustained Support SNUs

The OVC program in Attained and Sustained support SNUs will be very much similar the other SNUs and most of the service package has to do with service quality which the program aims to maintain in all SNUs. Proportionately, the client targets in these SNUs are much less per state than in the scale-up SNUs.

The program 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, life skills training and economic strengthening activities. The program will also support the creation of safe spaces for socially marginalized adolescents such as children of commercial sex workers and teen mothers. Financial literacy programs will focus on how to translate skills into concrete economic opportunities. The program will also continue to support “norms” interventions, which identify and address gender issues predisposing especially adolescent girls and young women to HIV risk. Community and school based gender based violence prevention activities for children and adolescents will be expanded through existing clubs and school-based programs.

Lastly, implementing partners will continue to work with CBOs and the government to strengthen national OVC program data management and reporting systems including the National OVC Management Information System (NOMIS).

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

PEPFAR system-level ("above-site") investments are structured to address in whole or in part, health systems gaps which impact on the ability of the program to achieve desired targets and objectives. These investments are structured as time-bound projects with clear objectives and details summarized in Table 6 below.

The apart from the cost of commodity distribution to site using 3rd-party logistics agents, the program also support technical assistance to ensure that the GoN, at both the state and federal levels, has adequate visibility and oversight on commodity procurement and distribution activities. The technical assistance to the State Logistics Management Coordination Units in all states (expect Taraba and Abia) include payment for technical advisory support to each of the State Ministries of Health to monitor and report the procurement and supply of HIV and other commodities from the central pool to the health facilities and ensure timely reporting for re-supply purposes. In addition, PEPFAR contributes to funding for the twice-yearly quantification and procurement planning engagements with stakeholders in the National HIV/AIDS response and well as the maintenance of regional warehouses which were built by the program (in collaboration with the Global Fund) and handed over to the GoN in 2016. These investments have also supported the establishment of the NHLMIS, which in COP19 will add on features for real-time tracking of drug shipments as they move to the facilities.

The NiSRN is the common system for all viral load and EID sample referral in the country. The system is currently being expanded for TB and CD4 samples as well. Since its launch in 2017, the NiSRN has helped to improve the timeliness and volumes of sample shipment from clinics to hub laboratories all over the country. In the current fiscal year, the project is focused on improving turnaround time for sample shipment, processing and results retrieval. In COP19 the project will sync with the LIMS and will automate processes for sample logging to further improve turnaround time.

Similarly, over the past five years, PEPFAR above-site investments have funded the set-up of a data warehouse for the HIV/AIDS program in Nigeria, the NDR. In COP18, PEPFAR will capture at least 70% of its patient-level data on the NDR. In COP 19, PEPFAR will increase the coverage of patient-level data captured on the NDR to include 100% of patients from the Global Fund and GoN treatment programs. The program will use the NDR data analytics and visualizations to monitor the surge activities in Akwa Ibom and Rivers, the country's overall achievement towards the UNAIDS 95:95:95 targets, and for HIV case-based surveillance.

To improve data quality for patients receiving HIV/AIDS treatment services, PEPFAR will incorporate PBS to cover at least 60% of PEPFAR-supported patients and will work with GF stakeholders to achieve similar objectives.

To improve overall use of program data for timely decision-making, PEPFAR will integrate data from the LIMS at all PEPFAR-supported PCR labs and use this to ensure the improve and timely availability of patients lab results for clinical decision making. Similarly, the planned linkage with the NHLMIS Logistics will help improve program accountability for commodity utilization in the facilities.

A new activity in Table 6 in COP19 is PEEP, which was proposed partly in response to the recommendation from civil society stakeholders on the need for targeted interventions to improve patient literacy on current program objectives. These include mobilizing demand for viral load services, TLD transition, multi-month scripting and other differentiated care service options. It is designed as collaborative with local CSO leaders and the patient community to facilitate improved engaged and institute mechanisms to address patient barriers in access services such as user fees and stigma. The project also aims to disseminate knowledge on patient's rights and privileges in hospitals in line with the Patient's Bill of Rights (PBoR), launched in 2018 by the Vice-President of the Country in collaboration with the Federal Ministry of Health and the Consumer Protection Council of Nigeria. The project help to establish communication channels to address any patient grievance that might arise in the course of accessing HIV-related services.

Like the PEEP, the Ambassador's Small Grants program is focused on addressing community and individual vulnerabilities to HIV-related risks and over the years has proven to be a major community engagement activity of the US Mission in Nigeria.

Another new project focused on resource tracking and advocacy for increased budget allocation and release for HIV/AIDS will also provide technical assistance to expanded health insurance benefits package to include HIV/AIDS services. This activity will build on priori investments in support of State Health Insurance Schemes in Kano and Rivers States, but it is expected that the knowledge gained will be applied in support of the scale-up states to achieve similar objectives.

The rest of the activities in Table 6 are Survey, Research and Surveillance type activities. Some like the AFRICOS Study and the NAIIS have continued from previous years.

AFRICOS is a multi-country, multi-year cohort study managed by DOD. It is in the sixth year of implementation across Kenya, Tanzania, Uganda and Nigeria. Study outputs have resulted in more than 50 publications and presentations since inception, and informed programming decisions to improve the quality of patient care. A prospective cohort study, it has enrolled approximately 3,400 patients, and every 6 months collects 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. A secondary goal of AFRICOS is to facilitate investigation into the pathogenesis of HIV infection and HIV disease progression. Finally, an amendment to the

protocol was submitted late 2018 to include a youth cohort of adolescents aged 15 years and above to study HIV dynamics specific to this population.

The NAIIS investments proposed in COP19 will support additional data analyses for two key biomarker tests – ARV Drug Resistance Test and serum ARV detection test.

OVC program investments in Table 6 include a study to understand the impact of household economic strengthening activities on HIV outcomes for AGYW, with the intention to inform future investments to mitigate the vulnerability of this population to the negative impacts of HIV. In addition, PEPFAR will build on previous investments in the NOMIS and will pay for system upgrades for data reporting to the new PEPFAR MER 1.5 reporting system. PEPFAR will also build the capacity of the Ministry of Women Affairs and Social Development (at State and Federal level) to use the NOMIS data for program decision-making and will conduct an end line survey of MER1.5 outcome indicators to see how these new reporting framework has impact on program implementation.

7.0 Staffing Plan

For COP18 planning, the PEPFAR Nigeria's team's staffing analysis resulted in the repurposing of several positions currently being implemented across the agencies to close identified gaps, and strengthen the agencies' ability to successfully implement the PEPFAR business model. As part of COP19 staffing analysis, the assessment covered routine and emergency interagency business processes, partner management, and technical leadership. With the surge strategy, and enhanced site management (ESM), there is need for increased resources. The OU is repurposing three positions (DOD 2, CDC 1), and adding seven new positions (USAID 5, CDC 2).

USAID identified gaps in technical leadership, strategic information, testing, local partner management, retention, viral load suppression, and care and treatment. The surge strategy has further necessitated the need to increase support to technical and program management through procurement, human resource and financial management to allow USAID to efficiently manage the program going forward. Thus, several positions were repurposed in FY19 to better respond to these gaps. In COP19, the team proposes to increase the overall staffing structure to further support the management burden.

CDC will utilize the available skills set to fill gaps, for greater efficiency and effectiveness, and has transitioned Program office roles and responsibilities previously handled by U.S. direct hire (USDH) to appointed locally employed (LE) staff. These changes transfer responsibility for extramural processes (i.e. budget approval, expenditure tracking and monitoring cooperative agreement execution) from the USDH Public Health Advisors to the technical Branch Chiefs. As a result, in addition to their current responsibilities, they will ensure that Implementing Partners' (IPs) activities are in line with COP programs plans and budget, recommend changes in the scope of activities, approve IPs' key personnel, and ensure appropriate use of funds. The four branch chiefs (Prevention, Continuum of Care & Treatment (CoCT), Laboratory Systems, Epidemiology & Strategic Information (ESI)) have assumed the Project Officers' roles for CDC's six awards.

Reprogramming/reclassification requests approved in COP18 for CDC positions have been finalized. Two Surveillance Specialist positions, the Data Analysis and Visualization (DAV) position, and the Key Population (KP) Program Specialist positions have been filled. Processes are ongoing to fill the HMIS Specialist position, and the USDH Laboratory Scientist, both positions are expected to be filled by Q4 of FY19. CDC is changing a vacant administrative assistant position to a chauffeur position.

Two CDC USDH positions (Senior Advisor for CoCT and Deputy for Financial and Partner Management) will arrive post by Q3 of FY19. The program Assistant CoAg position with the Partner Management Team (PMT) which has been vacant for more than six months has been abolished and moved to another CDC program as the staffing current complement of the PMT is adequate to provide effective administrative oversight of CDC awards. The CDC Deputy Director for programs position has received all required approvals, CDC is currently scheduling interviews for this position, and expects to fill position by Q3 of FY 19.

CDC is adding two new chauffeur positions. With this plan, CDC will have increased motor pool resources to further support its travel needs and the expanded ESM. Also, current changes to post RSO policies on number of vehicles/chauffeurs required for travel to various locations has changed, and Embassy motor pool support (when needed) is limited.

USAID continues to push recruitment actions for all vacant positions (currently, 2 FSO, 2 USPSC, and 7 FSN). Two FSN positions (Project Management Specialists, Strategic Information and Testing/Linkages) have been advertised while the others are at various stages of reclassification by HR and will soon be advertised. All vacant positions are expected to be filled by Q4 of FY19.

USAID proposes five new local staff positions (Senior Partner Management Team Lead, Strategic Information Advisor, one Program Management Assistant, one Senior Acquisition and Assistance Specialist and one Financial Analyst). This is in response to renewed focus on enhanced site/partner management and the local partner initiative. One of those positions, Senior Partner Management Team Lead has received the approval of the DCM and USAID/W and the full procurement package will soon be submitted to HR for classification. In addition, the position of Senior Strategic Information Advisor was re-purposed from Care & Treatment Advisor's position for locally resident American position to locally employed position.

Within the DOD team, the overall staffing pattern will not change significantly. Four vacancies still exist due to previous headcount limitations established via headquarters, however, conversations are ongoing to secure approval for hiring.

Two DOD positions will be repurposed to support the surge and the increased targets to be achieved in COP19. One position will be for HIV Testing Services, in order to better scale up index testing, and the other for Commodities/Logistics for supporting additional logistics needs and TLD scale up.

All CDC's technical staff are included in SIMS activities and follow quarterly SIMS schedules. Each SIMS team consists of a mix of technical staff to ensure programmatic balance during the visits. CDC 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 most SIMS travel and works closely with the Regional Security Office (RSO) to ensure that the necessary approvals are received for SIMS travels. CDC will utilize Enhanced Site Management (ESM) which is monitoring high volume sites intensely with site visits, weekly updates from the IP at site level and through the Extension for Community Healthcare Outcomes (ECHO) project which mentors site staff through video conferencing – this ESM will coordinate with the SIMS activities not to duplicate efforts.

USAID continues to rely on a third party contractor to accomplish its SIMS required assessments and continues to meet its commitment to joint SIMS assessments as well as its commitment to reassessing sites that had red or Yellow or both "score" in FY18. USAID reviews the third party contractor quarterly planned schedules, prioritizing sites and states that are high volume, need

focused quality improvement and/or coincide with other PEPFAR related activities. In FY19, the third party contractor continued to reinforce its strategies in communicating and presenting SIMS results to the USAID Implementing Partners through written responses and corrective actions to address SIMS findings. Beginning FY19 Q3, USAID will prioritize SIMS assessment in Akwa-Ibom state in response to the surge activities and to ensure quality within the system.

In FY20, USAID will focus SIMS visits to sites with much higher volume of clients to align with new guidance from the Office of the Global AIDS Coordinator (OGAC) and USAID/W Office of HIV/AIDS (OHA). The third party contractor will continue to 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. All checks through SIMS activities will be reinforced in USAID surge state and also within the yellow and red states.

Given the budgetary constraints of COP19, the OU explored ways to efficiently apply the cost of doing business (CODB) across the agencies, to support the planning level letter activities level as well as the surge in Akwa-Ibom and Rivers. Overall, the OU CODB budget increased by 3%. This is a result of a 2% increase in overall CDC CODB budget and 6% increase in overall USAID CODB budget.

The 6% increase in overall USAID's CODB in COP19 is mainly due to the new positions. USAID proposes five new local staff positions (Senior Partner Management Team Lead, Strategic Information Advisor (repurposed from Care & Treatment Advisor), Program Management Assistant, Senior Acquisition and Assistance Specialist and a Financial Analyst). This is in response to renewed focus on ESM. USAID also plans to utilize the institutional contractor's for SIMS and enhanced partner management activities in COP19.

For DOD, with the shift in focus in COP19 for the surge in Akwa-Ibom and Rivers, as well as increased partner management and the OU operational goal of ESM, there will be need to increase the travel costs. Thus, if the CODB request is not fully funded, available travel for site establishment and partner management, as well as key hiring actions, will be impacted, thus impacting the quality and rapidity of responding to the rapid scale up and support of additional patients on treatment.

To prepare adequately for increased travel needs, CDC will purchase additional vehicles to replace older vehicles to support its motor pool operations. Travel and ICASS costs increased, but the team found efficiencies in some other object class areas to reduce the financial implications of the demands of the surge. CDC anticipates filling all positions that are vacant in FY19 and made full year budget for these positions in COP19.

APPENDIX A - PRIORITIZATION

Continuous Nature of SNU Prioritization to Reach Epidemic Control

Table A.1

SNU	COP	Prioritization	Results Reported	National Treatment Coverage at APR by Age and Sex					
				<15		15+		Overall TX Coverage	
				F	M	F	M	F	M
Akwa Ibom (Surge)	COP15	Scale-Up: Saturation	2016	20%	10%	43%	30%	41%	27%
	COP16	Scale-Up: Saturation	2017	13%	7%	32%	22%	30%	20%
	COP17	Sustained	2018	13%	7%	31%	22%	29%	20%
	COP18	Sustained	2019	13%	7%	53%	38%	49%	34%
	COP19	Scale-Up: Saturation	2020	107%	56%	92%	66%	93%	65%
Rivers (Surge)	COP15	Scale-Up: Aggressive	2016	16%	8%	31%	16%	29%	15%
	COP16	Scale-Up: Aggressive	2017	13%	7%	30%	16%	29%	15%
	COP17	Sustained	2018	15%	8%	27%	14%	26%	14%
	COP18	Sustained	2019	22%	11%	37%	20%	36%	19%
	COP19	Scale-Up: Saturation	2020	153%	79%	105%	57%	108%	58%
Red States (4)	COP15	Scale-Up: Aggressive	2016	20%	10%	49%	43%	46%	37%
	COP16	Scale-Up: Aggressive	2017	20%	11%	50%	44%	47%	38%
	COP17	Sustained	2018	16%	8%	43%	38%	40%	32%
	COP18	Sustained	2019	24%	13%	57%	50%	53%	43%
	COP19	Scale-Up: Aggressive	2020	33%	17%	51%	45%	49%	40%
Green States (3)	COP15	Sustained	2016	119%	61%	122%	78%	122%	76%
	COP16	Sustained	2017	125%	64%	139%	89%	138%	87%
	COP17	Sustained	2018	87%	45%	125%	80%	122%	77%
	COP18	Sustained	2019	105%	54%	131%	84%	129%	82%
	COP19	Sustained	2020	117%	60%	135%	87%	134%	84%
Yellow States (25)	COP15	Sustained	2016	46%	24%	79%	46%	76%	44%
	COP16	Sustained	2017	50%	26%	82%	49%	79%	47%
	COP17	Sustained	2018	43%	22%	77%	46%	74%	44%
	COP18	Sustained	2019	55%	29%	92%	56%	89%	53%
	COP19	Sustained	2020	65%	34%	97%	59%	95%	57%

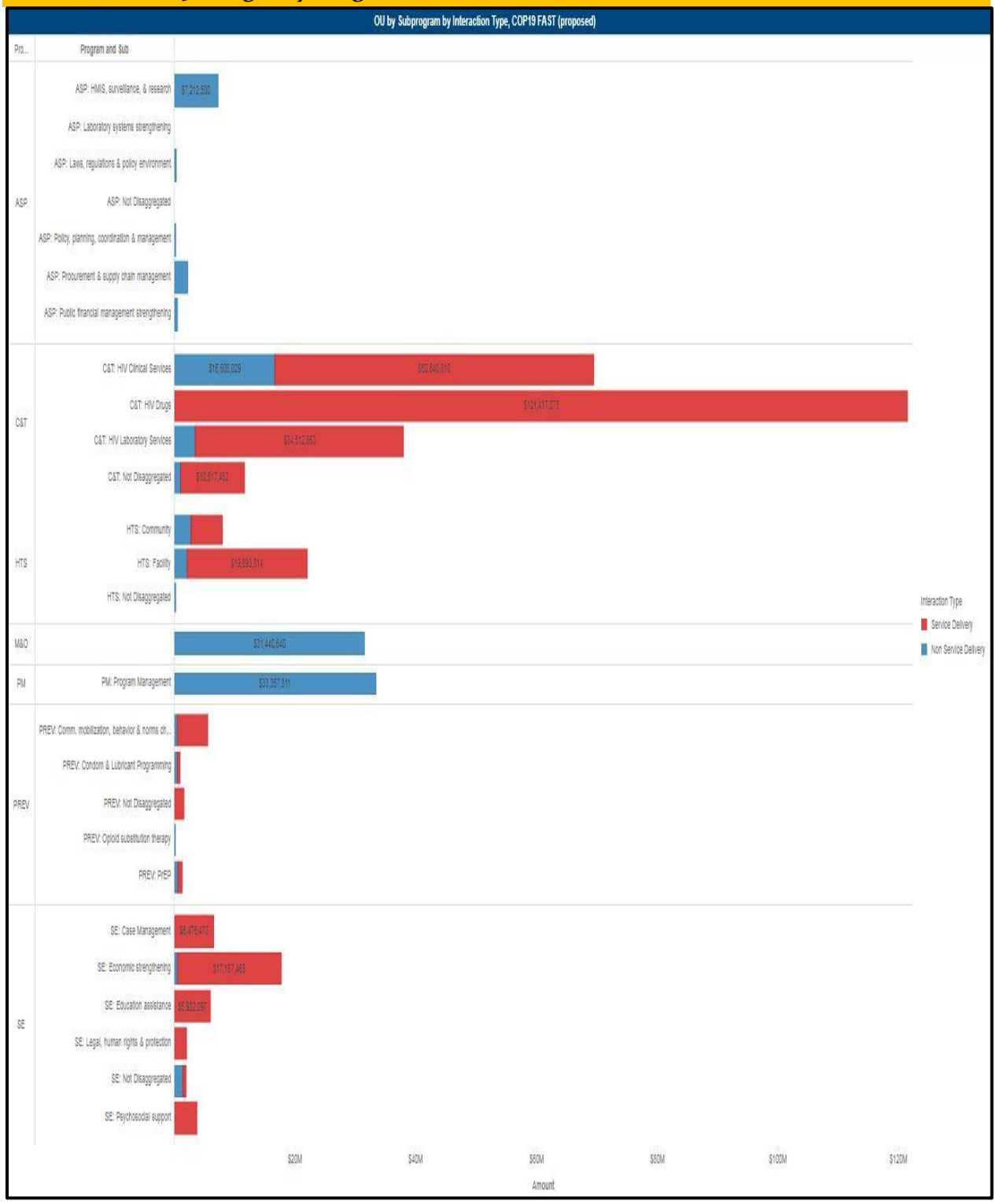
Table A.2 ART Targets by Prioritization for Epidemic Control

Prioritization Area	Total PLHIV	Expected current on ART (APR FY19)	Additional patients required for 80% ART coverage	Target current on ART (APR FY20) TX_CURR	Newly initiated (APR FY20) TX_NEW
Attained					
Scale-Up Saturation	397,673	100,268	10,873	305,352	214,126
Scale-Up Aggressive	321,144	131,968	75,600	182,370	66,755
Sustained	1,086,025	706,181	87,736	777,764	103,714
Central Support	N/A	N/A	N/A	N/A	N/A
Commodities (if not included in previous categories)	N/A	N/A	N/A	N/A	N/A
Total	1,804,842	966,087	174,209	1,268,486	384,595

APPENDIX B – Budget Profile and Resource Projections

B.1 COP19 Planning Spending

Table B.1.1 COP19 Budget by Program Area



B.1.2 Total Funding Level

B.1.1 Total Funding Level				
Applied Pipeline	**New Funding**	**Total Spend**		
$52,206,272	**$339,948,397**	**$392,154,669**		
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	$6,803,115	$ 3,570,639	$10,373,754
HVAB	Abstinence/Be Faithful Prevention	-	-	-
HVOP	Other Sexual Prevention	$3,780,307	$2,633,124	$6,413,431
IDUP	Injecting and Non-Injecting Drug Use	-	-	-
HMBL	Blood Safety	-	-	-
HMIN	Injection Safety	-	-	-
CIRC	Male Circumcision	-	-	-
HVCT	Counseling and Testing	$29,020,372	$3,857,124	$32,877,496
HBHC	Adult Care and Support	$10,813,776	$120,149	$10,933,925
PDCS	Pediatric Care and Support	$4,553,703	$120,296	$4,673,999
HKID	Orphans and Vulnerable Children	$25,707,315	$20,093,435	$45,800,750
HTXS	Adult Treatment	$92,863,896	$3,800,178	$96,664,074
HTXD	ARV Drugs	$123,255,688	-	$123,255,688
PDTX	Pediatric Treatment	$3,922,927	$115,906	$4,038,833
HVTB	TB/HIV Care	$7,334,837	$1,318,655	$8,653,492
HLAB	Lab	$919,965	$313,056	$1,233,021
HVSI	Strategic Information	$5,187,504	$7,539,130	$12,726,634
OHSS	Health Systems Strengthening	$6,226,289	$2,543,077	$8,769,366
HVMS	Management and Operations	$19,558,703	$6,181,504	$25,740,207
TOTAL		**$339,948,397**	**$52,206,272**	**$392,154,669**
***Central Funding - $0.00**				

B.2 Resource Projections

The resource projections for COP19 were made using a program-based incremental budgeting approach with consideration for partner program needs. This focused on the scope and intensity of activities to be implemented across the different geographic prioritizations (surge states, other red states, green states and yellow states) which were in turn determined by distribution of EPP spectrum PLHIV burden, NAIIS population level viral load suppression, and unmet treatment need by state as described in previous sections of this document (sections 3-5). Partner level COP19 budgets were then determined based on the states each partner would be implementing in and the associated estimated program cost for activities to be implemented within sites in the specific states including HRH and program management costs. Commodities' budget was based on fully loaded cost per unit of ARVs and other commodities needed to reach projected targets by state. The fully loaded cost includes proportion for quality assurance, freight, in-country logistics, program management and data management costs. Program budget was developed using the COP18 work plans of implementing partners to determine the items they would need after COP18 implementation. Items of equipment and renovations costs that will be incurred in FY19 where considered as still usable for FY20 at the sites where they were incurred and not budgeted for in COP19.

D– Minimum Program Requirements

Minimum Requirements	Targets/Expectations
1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups (required in COP16).	*Nigeria has adopted a Test & Start policy at all PEPFAR sites which has led to 50% of all new positives initiated on treatment same day. The team will scale up the immediate initiation of ART for all persons newly diagnosed with HIV infection.*
2. Adoption and implementation of differentiated service delivery models, including six-month multi-month scripting (MMS) and delivery models to improve identification and ARV coverage of men and adolescents (required in COP16).	*The team will implement DSD approaches in all sites that include, by the end of the year, a minimum of 6-month ART delivery for stable patients, as well as other strategies to ensure ART coverage and utilization by men and persons 25 or younger.*
3. Completion of TLD transition, including consideration for women of childbearing potential and adolescents, and removal of Nevirapine-based regimens (required in COP18).	*The team will phase out the use of the remaining TLE stock and complete its TLD transition in COP19.*
4. Scale up of index testing and self-testing, and enhanced pediatric and adolescent case finding, ensuring consent procedures and confidentiality are protected and monitoring of intimate partner violence (IPV) is established (required in COP18).	*The team has scale-up index testing into high volume (>100 TST_POS) sites in FY18 and first half of FY19 and will continue to scale up index partner testing (first across sites with 50-100 TST_POS and other supported sites) and self-testing to maximize case-finding and optimize the cost per positive.*
5. TB preventive treatment (TPT) for all PLHIV must be scaled-up as an integral and routine part of the HIV clinical care package (required in COP18).	*Team will continue to scale TB preventative therapy for all eligible PLHIV and TB_PREV targets should reflect TPT as routine part of clinical cascade.*
6. Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	*Team will continue to initiate clients same day and COP19 IP work plans need to reflect fidelity to this minimum requirement. Special attention should be paid to linkage in the 10-14 age bands and AGYW.*
7. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and related services, such as ANC, TB, and routine clinical services, affecting access to HIV testing and treatment and prevention (required in COP17 and COP18).	*Team will consolidate work with state and local governments as well as key stakeholders to extend HIV services to lower income residents through domestic resource mobilization and the social health insurance scheme, thus reimbursing the client for the operational costs associated with a clinic visit.*
8. Completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups.	*The team should maintain its scale-up of VL/EID coverage, particularly for those persons 20 years or younger.*
9. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity (required in COP18).	*PEPFAR/Nigeria team will strengthen its active public health surveillance system capable of identifying new outbreaks as they develop and accurately track quality of care and subpopulation morbidity and mortality indicators.*

Minimum Requirements	Targets/Expectations
10. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on adolescent girls in high HIV-burden areas, 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV, and children and adolescents living with HIV who require socioeconomic support, including integrated case management (required in COP17 and COP18).	*PEPFAR/Nigeria will maintain its year-on-year improvement of testing and linking eligible OVC (0-17) and continue to monitor its OVC transition.*
11. Evidence of resource commitments by host governments with year after year increases (required in COP14).	*The team will expand its work with GoN to increase domestic resources to eliminate user fees and increase access to HIV prevention and treatment services for all persons.*
12. Clear evidence of agency progress toward local, indigenous partner prime funding (required in COP18).	*The PEPFAR Nigeria team will align with the increase of local and indigenous partners in COP19 and work toward a timeline for progress in future FYs.*
13. Scale up of unique identifier for patients across all sites.	*The team will deepen its patient biometric solutions (PBS) at all PEPFAR sites where patients are enrolled on ART and encourage all comprehensive partners to utilize EMR and PBS.*

APPENDIX E – Feedback on CSO Input for COP19

CSO Priority Areas	Requests and Recommendations	PEPFAR Feedback on CSO Input
1. User Fees: CSOs note the positive discussions and planned action at country level but recognize the devil is in the details with regards to implementation. Policies must deal with the different dynamics related to FBO facilities delivering treatment services	CSOs must be involved in the quarterly meetings with state commissioners on user fees and follow up on progress MOUs with health facilities need to widely disseminated so patients can be aware of their rights and demand services and/or report facilities who are not complying Formal and informal user fees for Contraceptives should also be removed to support TLD roll-out	CSOs will be involved in all of the engagements and CSO inputs will form part of the agenda for these discussions and plans.
2. Community based Monitoring: CSOs note with appreciation the $150,000 included for CSO engagement in this COP. However, this amount is too small to support CSO facility level monitoring of COP19.	Commit resources to enable facility site level monitoring for local CSOs in the 7 priority states Involve CSO on PEPFAR's site level monitoring visits across all locations Support CSOs' implementation of their annual work plans	PEPFAR Implementing Partners will continue to work with local CSOs at State and LGA level. To the degree that it is logistically and strategically feasible, IPs will engage local CSOs and PLHIV support groups in site monitoring activities and provide technical assistance in support of CSO plans.
3. Index Testing: CSOs agree that index Testing is an important strategy. However, they note that implementation of this strategy must be done recognizing the risks of gender based violence, IPV, and stigma that may arise	Consent procedures need to be actively monitored and reported on. CSOs recommend that index testing should only be conducted where there can be referral to GBV services Active monitoring and follow up of adverse events must be conducted and reported back by all implementing partners	Context procedures for Index testing will be tracked and reported. Gender based violence mitigation and response actions have been integrated in the index testing service package.
4. TLD: CSOs note the continuing progress on the roll out of TLD but acknowledge that it could be faster. This rollout is threatened by the lack of clear policies that respect women's choice of treatment regardless of contraception use	Clear guidelines need to be developed, disseminated and enforced Ensure integration of HIV and Family planning services as well as access to FP commodities	PEPFAR will work with other stakeholders to revise and disseminate guideline for TLD, including patient education knowledge interventions and materials. PEPFAR will engage other stakeholders to improve the integration of HIV, family planning and other reproductive health services.

CSO Priority Areas	Requests and Recommendations	PEPFAR Feedback on CSO Input
5. Traditional Birth Attendants (TBAs): CSOs recognize that finding the missing cases of HIV positive pregnant women cannot be limited to existing health facilities alone. TBAs and Faith Based Attendants (FBAs) provide a significant proportion of services to pregnant women and these opportunities can be leveraged	In the 7 priority states, PEPFAR must set targets for training and supporting HIV testing, at TBAs and FBAs and work through existing/new partners to ensure linkage to care through mentor mothers/expert clients.	PEPFAR IPs will explore strategic opportunities to expand PMTCT services through orthodox and traditional community service delivery points that meet program standards for efficiency and effectiveness (yield and volume).

APPENDIX F – Summary of COP 19 Program Targets

Treatment			
Indicator	**Pediatric**	**Adult**	**Total**
TX_CURR	74,430	1,159,457	1,233,887
TX_NEW	29,661	350,377	380,038
TX_NET NEW	28,954	238,376	267,330
PVLS (Denom.)	63,740	1,070,392	1,134,132

OVC	
OVC_SERV (Active)	1,098,617
OVC_HIVSTAT	832,862

PMTCT	
PMTCT_STAT (Denom.)	1,601,078
PMTCT_STAT (Num.)	1,560,038
PMTCT_STAT (newly tested)	1,555,710
PMTCT_STAT POS	37,457
PMTCT_ART	35,677
PMTCT_EID	35,263
< 2 months	30,057
2-12 months	5,506

HTS	
PMTCT_STAT (newly tested)	1,555,710
TB_STAT (newly tested)	41,577
Pediatric HTS_TST	625,938
Adult HTS (excludes, EID, PMTCT, TB)	5,301,328
Key Population HTS	343,641
HTS_SELF	9,250

KP	
KP_PREV	283,295
KP_PREV MSM	129,070
KP_PREV FSW	253,710
KP_PREV PWID	97,460

TB	
TB_STAT (Denom.)	50,359
TB_STAT (Num.)	47,538
TB_STAT (newly tested)	41,577
TB_STAT POS	4,018
TB_ART	10,877
TX_TB (Denom.)	1,306,323
TB_PREV (Denom.)	1,269,160
TB_PREV (Num.)	1,093,294

Tables and Systems Investments for Section 6.0

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/CDC	UNIVERSITY OF MARYLAND	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Adults	4,125,000	Surveillance	Program Gap 1 (1st 90), Barrier One: Existing data, including national and sub-national surveys and statistics, may not reflect accurate population estimates, sero-prevalence and HIV burden.	COP17	COP19	- Secondary data analysis completed - Technical report completed and dessiminated - GoN capacity strenthen for handing over of sample repository
HHS/CDC	UNIVERSITY OF MARYLAND	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	1,875,000	Surveillance	Program Gap 2 (2nd 90), Barrier Five: Data systems are insufficient to accurately identify and track linkage and retention of HIV positive individuals to services.	COP16	COP20	- 100% of pepfar supported treatment facilities reporting HTS and PMTCT data in NDR - 100% of pepfar supported facilities having patients biometric solution - 80% of clients on treatment with their biometrics captured
USAID	Palladium International, LLC	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	150,000	Information and sensitization for public and government officials	Program Gap 2 (2nd 90) : Barrier Four - Facility-based patient fees for service negatively affect linkage and retention	COP19	COP21	(1) % increase in HIV related operational expenditures at facility level (2) HIV care and treatment services included in National and State level health insurance benefit package
DOD	Henry M. Jackson Foundation For The Advancement Of Military Medicine, Inc., The	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	450,000	Surveillance	Program Gap 1 (1st 90), Barrier One: Existing data, including national and sub-national surveys and statistics, may not reflect accurate population estimates, sero-prevalence and HIV burden.	COP16	COP21	% of target enrolled; Ongoing reporting on relevant indicators for PEPFAR
State/AF	DEPARTMENT OF STATE	ASP: Laws, regulations & policy environment	OVC: Orphans & vulnerable children	150,000	Information and sensitization for public and government officials	Other - Ambassador Small Grants for supports local community action to mitigate HIV-related risks amongst vulnerable populations.	COP16	COP21	Grants are being issued and implemented as planned.

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
DOD	Henry M. Jackson Foundation For The Advancement Of Military Medicine, Inc., The	ASP: Laws, regulations & policy environment	OVC & care givers: Not disaggregated	150,000	Information and sensitization for public and government officials	Program Gap 2 (2nd 90) : Barrier Four - Facility-based patient fees for service negatively affect linkage and retention	COP19	COP21	Collaborate with local CSO networks and treatment partners to develop and disseminate a PLHIV rights document based on Patients Rights Law of 2018. Empower PLHIV to demand services for improved health outcomes. Support CSOs to mobilize media attention for the HIV/AIDS services and the rights of PLHIVs within the program. Mobilize action of patient advocacy groups to mitigate the impact of users on PLHIV
USAID	Palladium International, LLC	ASP: Public financial management strengthening	Non-Targeted Pop: Not disaggregated	$ 450,000	Information and sensitization for public and government officials	Program Gap 2 (2nd 90) : Barrier Four - Facility-based patient fees for service negatively affect linkage and retention	COP19	COP21	(1) % increase in HIV related operational expenditures at facility level (2) HIV care and treatment services included in National and State level health insurance benefit package