Nigeria

Country Operational Plan (COP) 2020

Strategic Direction Summary

March 18, 2020

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Acronyms

ARV	Antiretroviral Drug
ASC	AIDS Spending Category
ART	Antiretroviral Therapy
CALHIV	Children Living with HIV
CSFW	Children of Commercial Sex Workers
CSO	Civil Society Organization
DTG	Dolutegravir
ECHO	Extension for Community Healthcare Outcomes
ESM	Enhanced Site Management
FBO	Faith-Based Organization
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HEI	HIV-Exposed Infants
HIV	Human Immunodeficiency Virus
LTFU	**L**oss-to-Follow-up
MSM	Men who have Sex with Men
NASCP	National AIDS and STI Control Programme
NAIIS	Nigeria AIDS Indicator and Impact Survey
NASA	National AIDS Spending Assessment
NCAPS	Nigeria Comprehensive AIDS Program in States
NDR	National Data Repository
NGO	Non-Governmental Organization

NISRN National Integrated Sample Referral Network

OI Opportunistic Infection

OVC Orphans and Vulnerable Children

PEP Post-Exposure Prophylaxis

PEPFAR US President's Emergency Plan for AIDS Relief

PLHIV People Living with HIV

PMTCT Prevention of Mother to Child Transmission

STI Sexually Transmitted Infections

SNU Sub-National Units

SVAC Sexual Violence Against Children

TLD Tenofovir, Lamivudine, and Dolutegravir (HIV Drug Regimen)

UNAIDS Joint United Nations Programme on HIV

VIA Visual Inspection (of the Cervix) with Acetic Acid

PEPFAR Indicator Description/Definition

Indicator	Description/Definition
TX_CURR	Number of adults and children currently receiving antiretroviral therapy (ART)
TX_NEW	Number of adults and children newly enrolled on antiretroviral therapy (ART)
TX_PVLS (D)	Number of ART patients with a VL result documented in the medical or laboratory records/LIS within the past 12 months.
PMTCT_STAT (newly tested)	Number of pregnant women attending antenatal clinics (ANC) and/or had a facility-based delivery and were newly tested for HIV during pregnancy to know their status
TB_STAT (newly tested)	Number of new and relapsed TB cases newly tested and have documented HIV status during the reporting period
HTS_SELF	Number of individual HIV self-test kits distributed.
OVC_SERV	Number of beneficiaries served by PEPFAR OVC programs for children and families affected by HIV
OVC_HIVSTAT	Number of orphans and vulnerable children (<18 years old) with HIV status reported
KP_PREV	Number of key populations reached with individual and/or small group-level HIV prevention interventions designed for the target population
PMTCT_STAT (Denom)	Number of new ante natal care clients in reporting period
PMTCT_STAT (Num)	Number of pregnant women with known HIV status at first antenatal care visit (ANC1) (includes those who already knew their HIV status prior to ANC1)
PMTCT_STAT (newly tested)	Number of pregnant women attending antenatal clinics (ANC) and/or had a facility-based delivery and were newly tested for HIV during pregnancy to know their status
PMTCT_STAT POS	Number of pregnant women attending ANC for a new pregnancy who were tested and confirmed HIV-positive for the first time during this pregnancy or have known her HIV status and have been on ART to the current pregnancy.
PMTCT_ART	Number of HIV-positive pregnant women who delivered and received ARV to reduce the risk of mother-to- child transmission during pregnancy and delivery.
PMTCT_EID	Number of infants who had a first virologic HIV test (sample collected) by 12 months of age during the reporting period.
TB_STAT (Denom.)	Total number of new and relapsed TB cases, during the reporting period
TB_STAT (Num.)	Number of new and relapsed TB cases with documented HIV status, during the reporting period

Indicator	Description/Definition
TB_STAT (newly tested)	Number of new and relapsed TB cases newly tested and have documented HIV status during the reporting period
TB_STAT POS	Number of new and relapsed TB cases with documented HIV positive status (both new and known at entry), during the reporting period
TB_ART	Number of registered TB cases with documented HIV-positive status during the reporting period. (TB_STAT_POS)
TX_TB (Denom.)	Number of ART patients who were screened for TB at least once during the semiannual reporting period.
TB_PREV (Denom.)	Number of ART patients who were initiated on any course of TPT during the previous reporting period
TB_PREV (Num.)	Among those who started a course of TPT in the previous reporting period, the number that completed a full course of therapy (for continuous IPT programs, this includes the patients who have completed the first 6 months of isoniazid preventive therapy (IPT), or any other standard course of TPT such as 3 months of weekly isoniazid and rifapentine, or 3-HP).

1.0 Goal Statement

The Nigeria PEPFAR Country Operation Plan for 2019 (COP 19) utilized results from the Nigeria AIDS Indicator and Impact Survey (NAIIS)[1] to geographically prioritize states in Nigeria based on unmet treatment needs and treatment coverage into four categories: the "surge" states of Akwa Ibom and Rivers, which accounted for 30% of unmet treatment needs, the "red" states with low saturation and high unmet need (Delta, Enugu, Anambra, Imo, and Lagos), the "green" states with high saturation and low unmet need (Benue, Nassarawa, and Gombe), and all remaining ("yellow') states, with low saturation and low unmet need. The surge states of Akwa Ibom and Rivers were prioritized as Scale-up to Saturation SNUs with the aim of achieving 81% treatment coverage by the end of the Fiscal Year 2020 (FY20). The red states were prioritized as Scale-up Aggressive SNUs with the aim of moving them closer to saturation. The green states were prioritized as Attained SNUs, with the aim of achieving treatment saturation by age and sex groups. The remaining 25 yellow states were prioritized as Sustained Support SNUs with the aim of improving retention while sustaining passive enrolment of patients to treatment at the facility level.

In COP 20, in addition to achieving at least 81% treatment coverage in Akwa Ibom and Rivers, the Nigeria PEPFAR program will aim to achieve 81% treatment coverage in two red states, Lagos and Delta states. Additionally, eight yellow states (FCT, Niger, Kaduna, Bauchi, Sokoto, Jigawa, Adamawa and Ebonyi) that are close to 81% treatment coverage at quarter one of FY 20, will be supported to achieve at least 81% treatment coverage by end of FY 2021. Furthermore, three states with over 81% treatment coverage, Benue, Gombe, and Nasarawa will be further saturated by age and sex groups to achieve at least 90% treatment coverage by end of FY 2021. At the OU level, the PEPFAR Nigeria program will aim to increase percentage of people living with HIV (PLHIV) who know their status from the current 67%[2] to 81%, increase percentage of PLHIV on treatment from current 53%[3] to 76% and increase percentage of PLHIV viral suppressed from 43%[4] to 72%. Thus, moving the country closer to achieving the UNAIDS goal of 90-90-90 by 2023 and 95-95-95 by 2030.

The Nigeria PEPFAR program will adopt three broad strategies for achieving the program objectives in COP 20. These include client-centered care, improved patient tracking and retention, and alignment of the National Treatment Program. To improve client care and retention, PEPFAR will scale-up recently available program innovations from enhanced site management (ESM), real-time data monitoring using electronic medical record systems (with data pooling in the National Data Repository for real time data analysis), and facilitating

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[1] Nigeria AIDS Indicator and Impact Survey (2018)
[2] UNAIDS 2020, Nigeria Country profile, overview of country epidemic. Available at: https://www.unaids.org/en/regionscountries/countries/nigeria
[3] Nigeria AIDS Indicator and Impact Survey (2018)
[4] Nigeria AIDS Indicator and Impact Survey (2018)

knowledge sharing and learning with support from "Project ECHO" (a collaborative across communities of service providers and medical experts facilitated through telemedicine technology which is currently being deployed across HIV service delivery points in Nigeria).
PEPFAR will also increase collaboration with stakeholders including the global fund, civil society, and the government of Nigeria to create an aligned National Treatment Program. The new alignment plan will focus on improving program synergies and resource efficiency by preventing duplication of efforts and achieve improvement in program outcomes through shared learning and harmonization of program standards.

The Nigeria PEPFAR program will continue to utilize the data from the Nigeria AIDS Indicator and Impact Survey (NAIIS) to modify interventions for case finding, linkage to care with immediate treatment initiation, and increasing access to viral load testing, improving viral suppression across all sites and SNUs. While all states will continue to implement the COP 2020 minimum program 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, 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 improvements in linkage and retention on treatment across all ages and sexes.

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[5]) with a current population estimate of 219,243,344 (population demographics: 49 percent female and 51 percent male[6]).

The HIV epidemic in Nigeria affects populations of all age groups and geographic locations. The 2018 Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS) reported HIV prevalence was 1.3% among adults 15 – 49 years, with a higher prevalence among women 1.7% compared to males 0.8%. Also, NAIIS reported 8 new infections per 10,000 population. The estimated 1,832,266 people are living with HIV in 2020.

Regarding, progress towards achieving the 90-90-90 goals, 67% of all PLHIVs know their status, 63% are on HIV treatment and 54% are virally suppressed. The main programmatic gaps are achieving the first and second 90s. In terms of gaps HIV treatment coverage, the states with the largest ART unmet needs are Rivers 142,394 and Akwa Ibom 111,193.

5 World Bank, 2017 data https://data.worldbank.org/country/Nigeria
6 2020 Spectrum data, 2019

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.

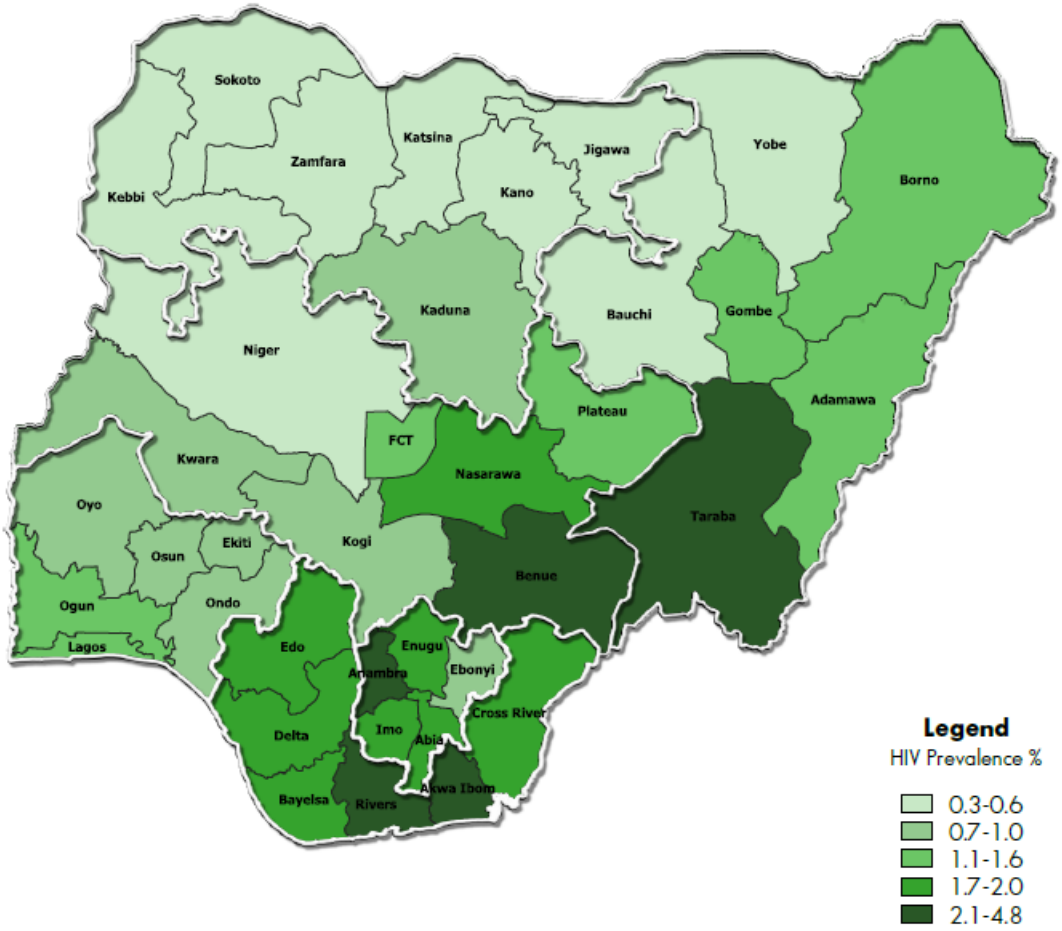


Figure 2.1.1: HIV Prevalence in Nigeria by States source: NAIIS 2018

The states with the highest burdens are Akwa Ibom prevalence 4.8% burden 188,562, Benue prevalence 4.3% with PLHIV burden of 197,000 and Rivers 3.6% with estimated PLHIV of 188,852. While the states with the lowest prevalence are Jigawa prevalence of 0.3% and Katsina prevalence of 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[7].

[7] NACA (2015) 'Nigeria GARPR 2015'[pdf]

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 1.8% and 1.0%. The prevalence among children 0-14 years old was 0.1%. 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 old, 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 (3.1%) and 50-54 year old males (2.2%).

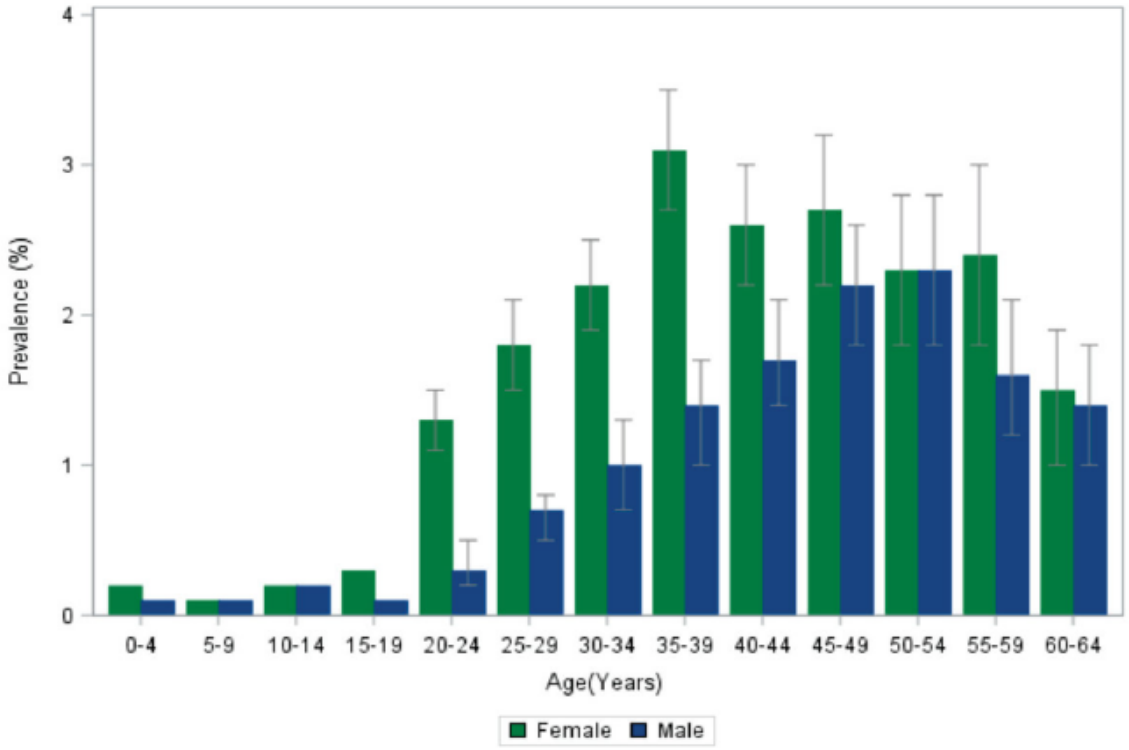


Figure 2.1.2 - HIV Prevalence by Age and Sex

The new survey results were used to update the UNAIDS Spectrum data for the country, which subsequently estimated that approximately 1,832,266 people are living with HIV in Nigeria in 2019, and approximately 1,146,643 of those were reportedly on treatment at the end of 2019. This suggests that about 63% of the estimated number of PLHIV in the country are on treatment. Based on the COP20 target projections and the Global Fund targets for the year, the country is

expected to have about 1,801,359 people on treatment by the end of 2022, raising the national treatment coverage to about 84%.

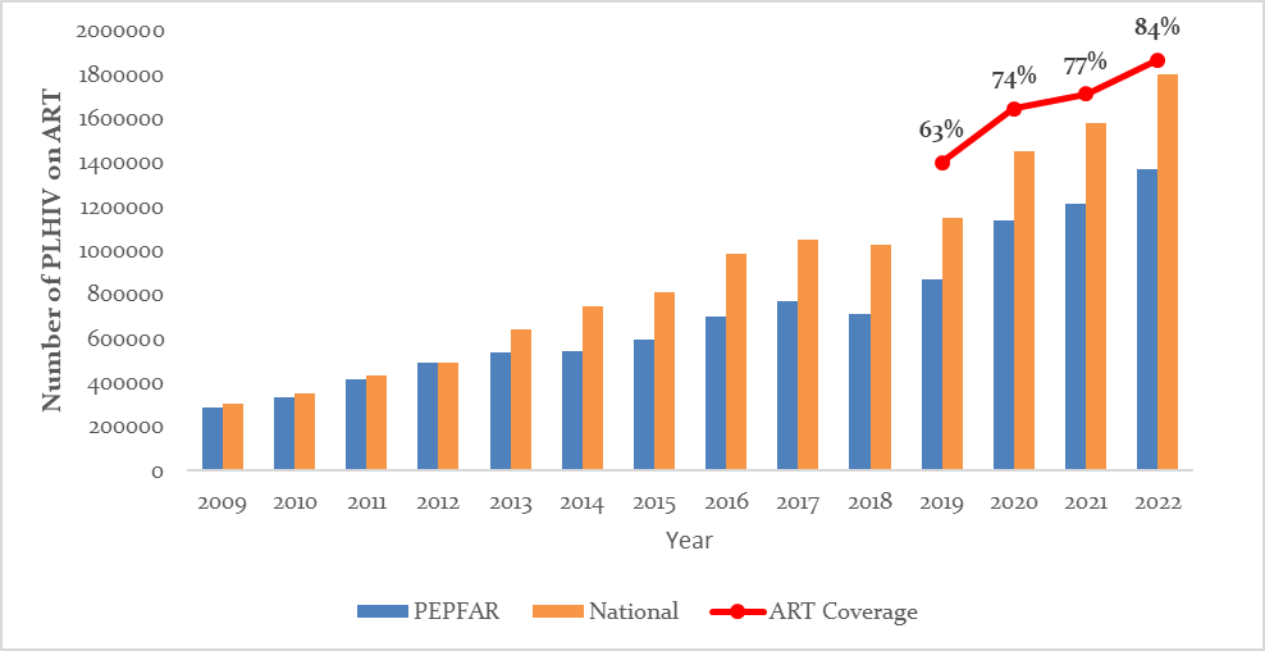


Figure 2.1.3 National and PEPFAR Current on Treatment Numbers

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, which 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 150,000, 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,[8] with just 10-20% of ANC sites offering PMTCT services[9]. It also reflects the gap in the uptake of ANC services, with just

8 FHI360 (2014), 'Rapid Health Facility Assessments in Eight Nigerian States'. https://www.fhi360.org/resource/rapid-health-facility-assessments-eight-nigerian-states

9 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

76.5% of pregnant women attending ANC services at least once during their pregnancy[10]. These findings highlight the need for a more integrated approach to the delivery of reproductive health services in the country.

The NAIIS estimated that 29.2% of PLHIV aged 15-64 years were aware of their status nationally. 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 are adherent to ART at the population level. The PVLS among all PLHIV aged 15-64 years was estimated nationally at 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.[11] 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 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 sexual and gender-based violence affecting the lesbian, gay, bisexual, transgender, and queer communities.

Other barriers which may impact health-seeking behaviors among PLHIV include: the persistence of user fees, stigma and discrimination, as well as operational issues such as patient flow challenges resulting 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, including PEPFAR Nigeria, are mobilizing to address these issues head on.

[10] Nigeria AIDS Indicator and Impact Survey (2018)
[11] NACA (2017)

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	219,243,344	100%	46,507,774	21%	48,760,493	22%	20,920,515	10%	21,623,615	10%	40,610,814	19%	40,820,138	19%	Spectrum, 2020
HIV Prevalence (%)		1.30%													NAIIS, 2018
AIDS Deaths (per year)	44,478	100%	18,461			42%	26,017							58%	Spectrum, 2020
# PLHIV	1,832,266	100%	102,240	6%	108,769	6%	110,090	6%	77,329	4%	850,586	46%	583,251	32%	Spectrum, 2020
Incidence Rate (Yr)		8%													NAIIS, 2018 (Preliminary)
New Infections (Yr)	94,648	100%	26,716			28%	67,931							72%	Spectrum 2020
Annual births	8,071,509														Spectrum, 2020
% of Pregnant Women with at least one ANC visit		76.50%													NAIIS, 2018
Pregnant women needing ARVs	147,492														Spectrum, 2020
Orphans (maternal, paternal, double)	2,150,821														Spectrum, 2020
AIDS Orphans (maternal, paternal, double)	227,345														Spectrum, 2020
Notified TB cases (Yr)	104,904														FMoH Report 2018
% of TB cases that are HIV infected	14,082	14%													FMoH Report 2018
[12]% of Males Circumcised		98.90%													Morris et. al (2016)
[13]Size & Prevalence Estimates of MSM	238,522	22.90%													1. Nigeria KP Size Estimates Studies
Size & Prevalence Estimates of FSW	621,219	19.40% (BBFSW) 8.6% (NBBFSW)													2. IBBSS 2014
Size & Prevalence Estimates of PWID	227,068	8.6%													

Table 2.1.2 90-90-90 Cascade: HIV Diagnosis, Treatment and Viral Suppression										
Epidemiologic Data					HIV Treatment and Viral Suppression			[12]HIV Testing and Linkage to ART Within the Last Year		
	[13]Total Population Size Estimate (#)	[14]HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	219,243,344	1.30%	1,832,266	1,229,185	1,161,881	63.4%	54%	4,753,772	166,537	161,953
Population less than 15 years	95,268,267	0.10%	211,009	59,073	68,206	32.3%	17%	444,559	8,186	7,997
15-24 year olds	42,544,130	0.50%	187,419	1,170,112	99,280	53%	59%	1,161,533	24,676	23,399
25+ year olds	81,430,952	1.80%	1,433,837		994,395	69%		3,147,680	133,675	130,557
MSM		22.90%								
FSW		19.4% (BBFSW)								
		8.6% (NBBFSW)								
PWID		3.40%								

2.2 New Activities and Areas of Focus for COP20, including Client Retention

In COP20, PEPFAR Nigeria will continue to deepen the program by applying a client-centered, program quality approach within the key domains of prevention, case finding, treatment, optimized retention, and viral suppression. The drive to enhance retention will be coupled around a client centric case management approach that tailors support for care and treatment service to meet the specific needs of individual clients by dedicated case managers from initiation on ART through continued care and treatment services aimed at ensuring optimal retention and virologic suppression.

Epidemic control will only be attained if new, stable, unstable and long-term clients remain on continuous care and treatment, which is tailored to be responsive to individual needs, preferences, and changing life circumstances. Robust evidence generated in Q3 and Q4 of COP19 from program data indicated 30-40% of program leakage were from patients newly enrolled on ART within the first 6 months of treatment with the greatest lost within the first month compared to treatment experienced clients. Through an iterative process, a deep dive analysis was conducted for clients who were Loss to Follow-Up (LTFU) and defaulters, with determinants driving attrition shown in figure 2.2.1. The significant reasons for attrition include unexpected travel, long distance to health facility, self-transfer to another facility, stopped medication, forgot, socio-economic factors and medication side effects. 10% of the losses were due to death.

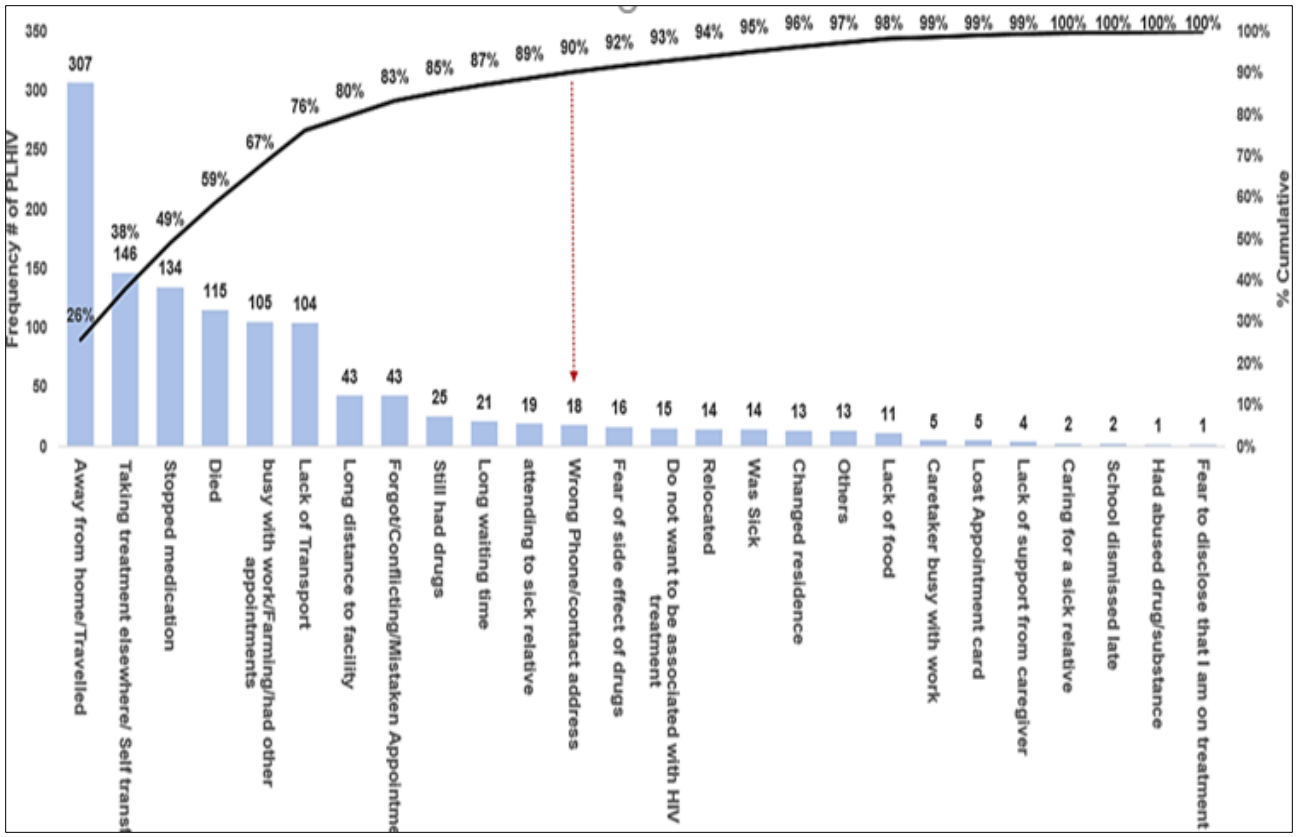


Figure 2.2.1 Client-centric, Back-to-care feedback from Akwa-Ibom

Optimizing retention at a 98% benchmark or more will be a core focus for PEPFAR Nigeria building off pockets of success established in COP19. Preventing losses as well as tracking and

accounting for the losses will be key. Leveraging off of the widespread adoption of electronic medical records (EMRs) at supported ART facilities, the ability of the program to de-identify and de-duplicate patient data into the National Data Repository (NDR) has provided greater visibility of patient level data for better program monitoring, detecting losses efficiently and predicting losses through predictive analysis in contrast to paper based and aggregate data that often mask true losses. The performance of program growth will be assessed weekly on the NDR as a proxy to track complete and up to date patient encounters on EMR. Also, a line list of inactive patients i.e. patients without clinic encounters greater than 28 days following scheduled appointments will be generated weekly from the NDR, sent to partners to track patients back to care and accounting for each patient as shown in table 2.2.1. These will help achieve the following (MER 2.4, 2019):

- Improved understanding of fluctuations or steady growth in TX_CURR
- Tracking of patients when a patient has had no clinical contact for greater than 28 days since their last expected contact
- Promote timely identification of patient outcomes among patients known to have missed clinical visits or drug pickups

Week 43

A	B	C		D	E		F					G	H	I		J	
State	Total # of patients LTFU (from previous week) received from ND	No of LTFU Cases attempted (subset of B)	% attempted	No of LTFU Cases successfully reached (subset of C)	no of LTFU cases tracked and returned back to care (subset of D)	% reached and returned to care	No of LTFU Tracked and confirmed to still be active (Subset of D)	% still active	Total Active	% active among reached	% active among total lost	No Died (Subset of D)	No transferred out with Records (subset of D)	No of LTFU reached but refused to return to treatment (subset of D)	% refusing to come back	No unable to reach due to inaccurate contact information (subset of D)	% unable to reach
FCT	1,220	1,191	98%	883	310	35%	681	77%	991	112%	81%	11	28	12	1%	64	5%
Benue	7,405	6,845	92%	5,843	1,838	31%	3,771	65%	5,609	96%	76%	13	52	169	3%	1,002	15%
Nasarawa	710	688	97%	570	42	7%	418	73%	460	81%	65%	9	20	2	0%	183	27%
Rivers	1,251	1,215	97%	934	223	24%	416	45%	639	68%	51%	6	15	125	13%	225	19%
Enugu	203	203	100%	123	29	24%	67	54%	96	78%	47%	4	6	17	14%	80	39%
Imo	336	336	100%	177	29	16%	100	56%	129	73%	38%	5	8	5	3%	159	47%
Total	11,125	10,478	94%	8,530	2,471	29%	5,453	64%	7,924	93%	71%	48	129	330	4%	1,713	16%
							?EMR backlog or data quality										

Table 2.2.1 Weekly NDR, LTFU dashboard

Preventing Losses

Use of a case management approach will leverage the use of trained expert clients and case managers who are mostly PLHIVs as peer supporters for all clients enrolled into care and treatment services. Active management of client retention will be implemented by centering preventive measures and taking these to scale in COP20. The cohort of newly diagnosed clients will be assigned to experienced case managers, and a 28-day case management calendar will be applied with intensive follow through interventions within the first 6 months of enrolment (figure 2.2.2). A prevention package of pre-appointment calls and 2-week, 2-days and 24 hours' pre-appointment check-ins will be provided with early defaulters identified and a list-serve generated

list to tracking within 24-48hrs of missed appointment. Other measures to be implemented include MMD-6 for patients requiring temporary relocation, travelers, expansion of community models of ART delivery (CARGs) and family centered approaches targeted at patients that can't afford transportation to health facilities, linkage to community resources for household economic strengthening activities, fast track of patients to reduce waiting time within the facilities and routine collection of patient satisfaction surveys during visits.

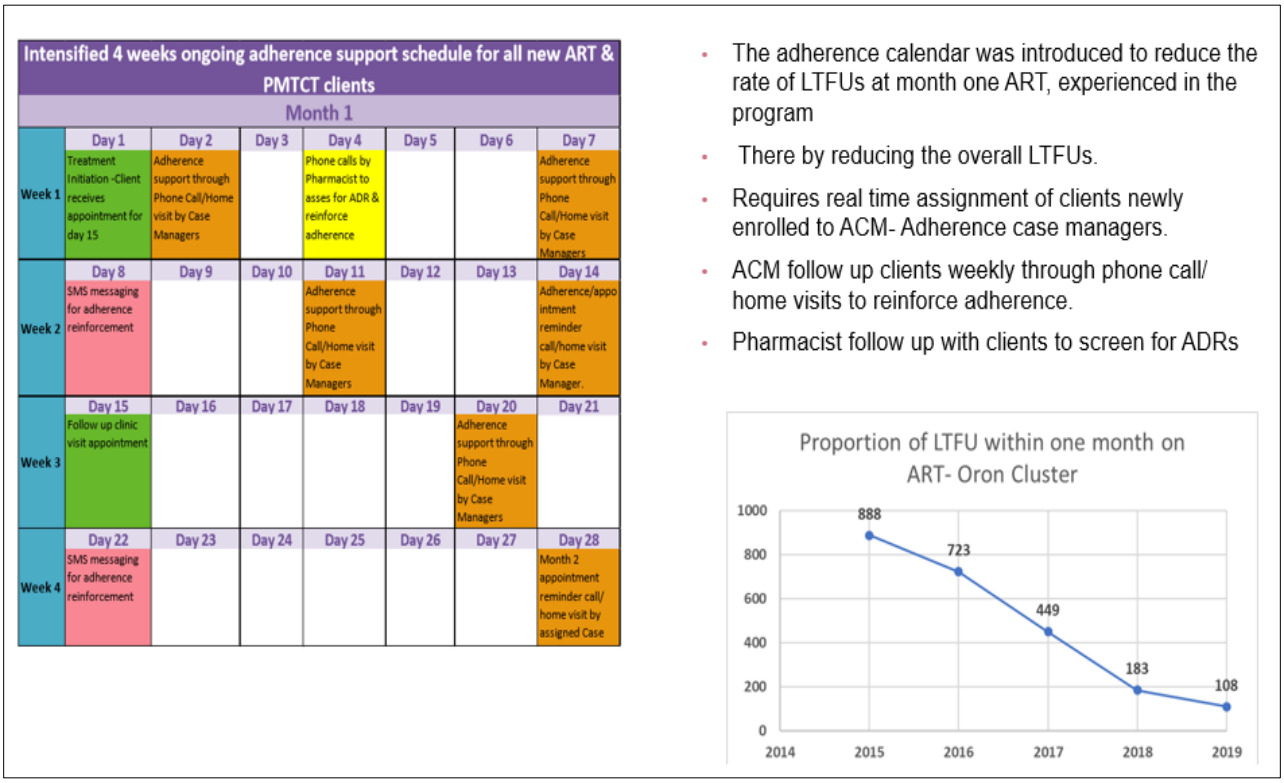


Figure 2.2.2 client-centric 28-day case management calendar for newly linked clients

2.3 Investment Profile

HIV response efforts in Nigeria continue to be almost fully dependent on international donors, mainly PEPFAR and the Global Fund, accounting for 67% and 15% respectively of the $532.4m reported HIV spending in 2018[12]. Of this amount, $238.4m (45%) was reported to have been spent on Care and Treatment, $162.5m (31%) was spent on Program Management and Administration, and $35.6m (7%) was spent on the delivery of HIV testing services. PEPFAR and the Global Fund accounted for 87% and 18% respectively of the investments in Testing, Care and Treatment, and 60% and 17% respectively of Program Management costs.

The Government of Nigeria was responsible for 89% of human resources costs for the HIV program while PEPFAR and the GF did not report any investments in these areas even though both programs cover the stipend payment for almost all of the lay workers (data clerks, peer educators, lay

[12] National Agency for the Control of AIDS, '2019 National AIDS Spending Assessment Report'. (Unpublished Draft).

counsellors and case managers) in the program. At present, the current investment tracking process is unable to account for the investment in these lay workers, who make up more than 60 -70% of the HIV service workforce in the country[13].

The investments for the support of Orphans and Vulnerable Children (OVCs) is 100% from the PEPFAR program, but it is noted that the program currently only supports OVCs in 15 states (see OVC section below) while no similar support is available in the rest of the other states.

Table 2.3.1a Investment Profile by Program Areas (Amounts in USD) *

AIDS Spending Categories	Government of Nigeria	Private Funds	PEPFAR	GF	Others	Totals
Prevention	$ 21,525,222	$ 81,754	$ 7,415,680	$ 3,191,677	$-	$ 32,214,333
HIV testing	$ 1,003,702	$ 4,148	$ 28,088,586	$ 6,498,372	$-	$ 35,594,808
Care and treatment	$ 7,877,771	$ -	$ 187,840,854	$ 42,728,815	$ -	$ 238,447,440
Orphans and vulnerable children	$ -	$ -	$ 33,754,442	$ -	$ -	$ 33,754,442
Programme management & admin. (including Above Site)	$ 34,782,609	$ 111,371	$ 98,197,237	$ 27,951,621	$ 1,473,580	$ 162,516,418
Systems Strengthening & Programme Coordination	$ -	$ -	$ -	$ -	$ 311,939	$ 311,939
Human resources	$ 26,094,707	$ -	$ -	$ -	$ 3,232,645	$ 29,327,352
Social protection and social services (excluding OVC)	$ 185,557	$ -	$ -	$ -	$ -	$ 185,557
Enabling environment	$ 8,214	$ -	$ -	$ -	$ 10,996	$ 19,210
HIV & AIDS-related research	$ -	$ -	$ -	$ -	$ -	$ -
Total	**$ 91,477,782**	**$ 197,273**	**$ 355,296,799**	**$ 80,370,485**	**$ 5,029,160**	**$532,371,499**

[13] PEPFAR facility HRH assessment 2014.

Table 2.3.b Investment Profile by Program Areas (Percentages) *						
AIDS Spending Categories (ASC)	**Government of Nigeria**	**Private Funds**	**PEPFAR**	**GF**	**Others**	**Proportion of Total By ASC**
Prevention	67%	0%	23%	10%	0%	6%
HIV testing	3%	0%	79%	18%	0%	7%
Care and treatment	3%	0%	79%	18%	0%	45%
Orphans and vulnerable children	0%	0%	100%	0%	0%	6%
Programme management and administration (including Above Site)	21%	0%	60%	17%	1%	31%
Systems Strengthening & Programme Coordination	0%	0%	0%	0%	100%	0%
Human resources	89%	0%	0%	0%	11%	6%
Social protection and social services (excluding OVC)	100%	0%	0%	0%	0%	0%
Enabling environment	43%	0%	0%	0%	57%	0%
HIV and AIDS-related research (excluding operations research)	Nil	Nil	Nil	Nil	Nil	0%
Total	**17%**	**0%**	**67%**	**15%**	**1%**	100%

Information gathered from the National Supply Chain System by the collaborating PEPFAR Technical Working Group reflects a total investment in HIV commodities of $126M compared to the $181.6M reported spent in the previous year. This reduction is largely due to the reduction in the holding stock available across commodities line stored at the central level in Nigeria. Where previously the central warehousing held a maximum stock level at 6 months of stock, it is now down to 2 months.

Donor investments account for almost all of the commodities expenditure (98%), with PEPFAR 82% while the Global Fund accounts for 16%. Only 2% of commodities investments are funded domestically. Investments in antiretroviral drugs accounted for 77.7% of commodity expenditures, while Viral Load commodities account for 11.5% and Rapid test kits (RTKs) 5.7%. No condoms were reported to have been procured in 2019. In support of the Nigeria Comprehensive AIDS Program in States (NCAPS) program being directly funded by the National Agency for the Control of AIDS (NACA) in Abia and Taraba states, the Government of Nigeria reportedly spent $2.3m on antiretroviral drugs and $300,000 on drugs for the treatment of opportunistic infections (OIs) but no funds on RTKs and Viral load commodities. PEPFAR procured 83.3% of ARVs, 79.5% of RTKS, 78.6% of Viral Load commodities and 100% of the GeneXpert Cartridges bought in the country in 2019.

Even though Nigeria implements a pooled procurement system, the major contributors (PEPFAR, Global Fund and the Government) essentially budget and provide funds to cover the needs of patient volumes supported by their programs, especially with respect to ARV procurements. The evolving program dynamics which reflect differential levels of patient growth in facilities and states as well as the need to ensure that all PLHIVs in the country receive a minimum agreed

standard package of services, this year's COP discussions have reflected a need to plan for greater alignment of all funding efforts in support of the national pooled procurement system and the need to tie individual donor contribution to the commodities pool to the number of patients they support in the national HIV program. What is expected in future investment profiles is that while program expenditure will still reflect to a large degree the level of effort of funders in the HIV program, their contribution to the commodities pool will depend on a pre-negotiated funding agreement which will ensure transparency and accountability for these investments.

The need for continued advocacy to improve domestic financing for HIV services has been stressed by all stakeholders, and the National Agency for the Control of AIDS (NACA) has given reassurances for the Government's renewed commitment as reflected in the 2020 budget documents.

Table 2.2.2a Annual Procurement Profile for Key Commodities (Amounts in USD) **

Commodity Category	Government of Nigeria	Private Funds	PEPFAR	GF	Others	Totals
ARVs	$2,284,128	$-	$81,498,382	$14,039,287	$-	$97,821,797
Rapid test kits	$-	$-	$5,745,607	$1,485,763	$-	$7,231,370
Other drugs (OIs)	$299,469	$-	$1,936,770	$1,123,167	$-	$3,359,406
Lab reagents (CD4 commodities)	$-	$-	$1,800,216	$212,898	$-	$2,013,114
Condoms	$-	$-	$-	$-	$-	$-
Viral Load commodities	$-	$-	$11,373,874	$3,091,318	$-	$14,465,192
EID commodities	$-	$-	$509,130	$308,282	$-	$817,412
Other commodities (GeneXpert Cartridges)	$-	$-	$349,880	$-	$-	$349,880
Total	**$2,583,597**	**$-**	**$103,213,859**	**$20,260,715**	**$-**	**$126,058,171**

Table 2.3.2b Annual Procurement Profile for Key Commodities (Percentages) **

Commodity Category (CC)	Government of Nigeria	Private Funds	PEPFAR	GF	Others	Proportion by CC
ARVs	2.3%	0.0%	83.3%	14.4%	0.0%	77.6%
Rapid test kits	0.0%	0.0%	79.5%	20.5%	0.0%	5.7%
Other drugs (OIs)	8.9%	0.0%	57.7%	33.4%	0.0%	2.7%
Lab reagents (CD4 commodities)	0.0%	0.0%	89.4%	10.6%	0.0%	1.6%
Condoms	Nil	Nil	Nil	Nil	Nil	0.0%
Viral Load commodities	0.0%	0.0%	78.6%	21.4%	0.0%	11.5%
EID commodities	0.0%	0.0%	62.3%	37.7%	0.0%	0.6%
Other commodities (GeneXpert Cartridges)	0.0%	0.0%	100.0%	0.0%	0.0%	0.3%
Total	**2.0%**	**0.0%**	**81.9%**	**16.1%**	**0.0%**	100.0%

Aside from HIV/AIDS program investments, the US Government PEPFAR implementing agencies have also reported other health-sector related investments in 2019 amounting to a total of $197,115,101. The US Agency for International Development (USAID) invested $13.5 million in support of the National TB and Leprosy Control Program, $70 million in the National Malaria

Control Program and $38 million in Maternal and Child Program. USAID also invested about $35 million investment in support of Family Planning and Reproductive Health services, $6 million in Nutrition and $6.7 million in Water and Sanitation.

The US Centers for Disease Control (CDC) similarly invested $15.5 million in Polio Eradication efforts as well as Immunization and disease surveillance in collaboration with the Federal Ministry of Health, while the US Department of Defense (DoD) invested about $2 million to support other health collaborations with the Nigerian Ministry of Defense and the Federal Ministry of Health.

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	$13,500,000				Accelerate case-finding and increase national case detection rate.
USAID Malaria	$70,000,000				Reduce malaria burden under the PMI.
USAID Maternal & Child Health	$48,000,000				End preventable child and maternal deaths.
USAID Family Planning & Rep. Health	$35,000,000				Improve access to and use of quality and voluntary Family Planning services including long-acting and permanent methods to reduce unwanted pregnancies.
USAID NUT	$6,000,000				Reduce malnutrition among women and children.
USAID WASH	$6,700,000				Improve water supply and sanitation.
CDC GID	$14,010,588				Work towards: • Polio eradication and certification through coordination and collaboration with global polio partners and the Government of Nigeria • Strengthened polio SIA campaigns and outbreak responses efforts in response to circulating

2.4 National Sustainability Profile Update

As with previous years, the 2019 Sustainability Index and Dashboard (SID) was developed through a rigorous stakeholder process led by an Expert Panel with membership drawn from Stakeholder groups – NACA, NASCP, UNAIDS, WHO, Civil Society Organizations, Implementing Partners and the PEPFAR team. The group met over a 5-days period to complete the first draft of the SID questionnaire as well as the newly introduced Responsibility Matrix; an accompanying tool which aimed to assess the functional responsibilities (by contributing to that element and being accountable for its level of success or failure) of the three major funding components of the HIV response: PEPFAR, the Global Fund, and Host Government. The draft report of the Expert Panel was reviewed by a Stakeholder group in November where additional inputs were gathered and incorporated. A final draft of the SID documents was subsequently disseminated in January before it was finalized and disseminated.

As seen from the dashboard (Figure 2.4 below), the Country has sustained the achievements recorded in the previous iteration of the SID in most of the SID elements by continuing to sustained most of the structures and systems which had supported the previous assessments, though there has been some slight reversals observed in a few areas.

Sustainability Analysis for Epidemic Control: Nigeria

Epidemic Type: Generalized
Income Level: Lower middle income
PEPFAR Categorization: Long-term Strategy (Co-finance)
PEPFAR COP 19 Planning Level: $392,154,669

SUSTAINABILITY DOMAINS and ELEMENTS	2015 (SID 2.0)	2017 (SID 3.0)	2019	2021
Governance, Leadership, and Accountability				
1. Planning and Coordination	8.17	9.67	9.67	
2. Policies and Governance	5.44	6.57	5.55	
3. Civil Society Engagement	6.33	8.33	7.71	
4. Private Sector Engagement	4.93	7.42	5.81	
5. Public Access to Information	7.00	5.00	6.56	
National Health System and Service Delivery				
6. Service Delivery	2.50	6.06	4.90	
7. Human Resources for Health	4.92	6.09	6.09	
8. Commodity Security and Supply Chain	5.73	6.18	4.72	
9. Quality Management	6.24	7.38	3.86	
10. Laboratory	4.44	5.83	5.94	
Strategic Financing and Market Openness				
11. Domestic Resource Mobilization	3.06	5.71	5.56	
12. Technical and Allocative Efficiencies	4.51	8.00	7.58	
13. Market Openness	N/A	N/A	9.20	
Strategic Information				
14. Epidemiological and Health Data	3.75	5.71	5.99	
15. Financial/Expenditure Data	5.00	8.33	7.50	
16. Performance Data	3.74	6.23	5.84	
17. Data for Decision-Making Ecosystem	N/A	N/A	0.67	

Figure 2.4.1 – The Nigeria 2019 SID Dashboard

Recent improvements in the political engagement on HIV financing evidenced by the open pronouncement of the Federal Government of Nigeria of its commitment to provide domestic funding for the treatment of an increasing number of People Living with HIV in the Country has helped, despite the lack concrete evidence of these investments at the time of the assessment. As it stands, the Government has promised to support 100,000 persons on treatment annually in 2020 with plans to see that number increase by 50,000 on annual basis henceforth.

The progress in the efforts to introduced optimized drug regimens and improve program coordination through regular engagements with stakeholders and the reintroduction of Joint Annual Program Review process contributed to these sustained positive reviews, while the continued lack of growing domestic commitments and service provider's inability to eliminate all user fees related to HIV was flagged. Despite commitments from several State Government and some open pronouncements on these issues, a majority of the States had yet to make any concrete steps in this regard. One State (Rivers State) does appear to have identified and deployed an effective model of reimbursing public hospitals for their losses on user fees and in doing so, guaranteed that PLHIV in their state could indeed access services with no user fees.

The reemergence of the Nigeria Business Coalition and its renewed conversations with NACA for the set-up of a Private Sector-led HIV Trust Fund may prove to be a game-changer in subsequent SID assessments. Despite improvements in the operations and program outcomes of key health systems investments supporting the treatment program, stakeholders had a negative perception of the absence of easily accessible data tracking the National Pooled Procurement and Integrated Commodity Supply Chain as well as the National Integrated Sample Referral System which had in particular led to the ability to account for the Turnaround Time of results for Viral Load and EID samples sent to the reference labs for processing. Stakeholders have, however, received reassurance that both projects are currently working to develop easily accessible data dashboard that will address these visibility issues.

For the two new elements introduced in the SID, the findings were mixed. On Market Openness, or the extent to which the country's policies impact on the ability of stakeholders to contribute effectively to the national HIV/AIDS response, Nigeria was positively assessed because of the availability of ample opportunities for stakeholders to operate and compete transparently in the allocation of investments within the national HIV response effort.

On the other element, Data for Decision-Making Ecosystem, the country scored poorly because of the sub-optimal status of the Civic Registration and Vital Statistics system and the absence of formal unique identification systems for de-duplicating individual service delivery experiences and related health outcomes. Also flagged was lack of accurate and updated national population estimates and the fact that there has not been a Census in the country since 2006.

The recent ratification of the use of biometric apparatus and Electronic Medical Records (EMR) systems for optimized biometric data capturing and linkage to the National Data Repository (NDR) by the fifth National Council on AIDS presents an opportunity to begin to make

improvements on this sustainability element. In addition, PEPFAR partners are currently rolling out biometric patient data identification systems for the facilities they support. Recent agreement between the three major donors as outlined in the Country Alignment Plan, ensures that for 2020-2023, the country will be resourced to implement a standard package of program services, a common national target framework and review process, as well as a common national financing framework for the HIV response. It is expected that the outcome of this new approach to supporting the Nigeria HIV response will yield improved results in future SID assessments.

2.5 Alignment of PEPFAR investments geographically to disease burden

Nigeria has made significant progress in achieving the UNAIDS goals of 90-90-90 by 2023. At the end of December 2019, there were about 1.9 million PLHIV in Nigeria. Due to concerted efforts by several stakeholders, the country had 1,114,064 PLHIV currently receiving antiretroviral therapy across all SNUs, with PEPFAR alone responsible for 78% of PLHIV on ART, bring the country's treatment coverage to 57%. Figure 2.5.1 shows the maps of Nigeria by SNU for PLHIV burden and unmet treatment needs. PEPFAR's investment has been aligned over the past six years to provide more support to SNUs with the highest unmet needs. The progress in Nigeria in the past few years suggests major success has been achieved. For example, Benue state, the SNU with the highest PLHIV burden, now has a relatively low unmet treatment need due to significant scale-up efforts in the past few years to improve access to treatment. A similar effort is currently in progress in Akwa Ibom and Rivers states to increase access to treatment and achieve epidemic control. The two states account for 30% of the unmet treatment needs in Nigeria. Figure 2.5.2 shows the ranking of the HIV unmet treatment burden by state. Eight states (Rivers, Akwa Ibom, Anambra, Lagos, Imo, Delta, Enugu, and Abia) are responsible for 56% of the unmet treatment need in Nigeria. Figure 2.5.3 depicts the SNUs in Nigeria by treatment coverage and contribution to unmet need. In COP20, PEPFAR will be scaling up treatment services in six of the eight high burden states: Rivers, Akwa Ibom, Lagos, Imo, Delta, and Enugu. Concurrently, the Global Fund will scale up in Anambra and the Government of Nigeria will scale up ART services in Abia and Taraba.

The COP20 geographical prioritization strategy addresses unmet treatment need in six PEPFAR-supported states responsible for the majority of unmet need in Nigeria. PEPFAR will work with other stakeholders to prioritize scale up in these states with the aim of achieving at least 81% ART coverage in four (Akwa Ibom, Rivers, Lagos, and Delta) of the six states supported by PEPFAR by the end of FY 2021. Additionally, eight yellow states (FCT, Niger, Kaduna, Bauchi, Sokoto, Jigawa, Adamawa and Ebonyi) that are close to 81% treatment coverage will be supported to achieve 81% treatment coverage by end of FY 2021. Three states with over 81% treatment coverage, Benue, Gombe, and Nasarawa will be further saturated by age and sex groups to achieve at least 90% treatment coverage by end of FY 2021. The six states with the highest unmet treatment needs will be classified as scale-up aggressive. The effort anticipated to achieve these objectives is captured in the "Nigeria National Alignment Plan," which recognizes the need for national resource alignment for program efficiency, cross-agency collaboration within the PEPFAR country team, deploying program innovations for enhanced site management, near-time data monitoring using electronic

medical record systems, and facilitating knowledge sharing and learning platforms supported through the ECHO project.

The key aspects of the national alignment are the focus on program synergies, resource efficiency by preventing duplication of efforts, improvement in program outcomes through shared learning, and harmonization of program standards. Another key aspect will include joint 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 eight scale up states. These sites will form the learning hubs for the ESM strategy. The goal of the current implementation period is first to engage with the 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.

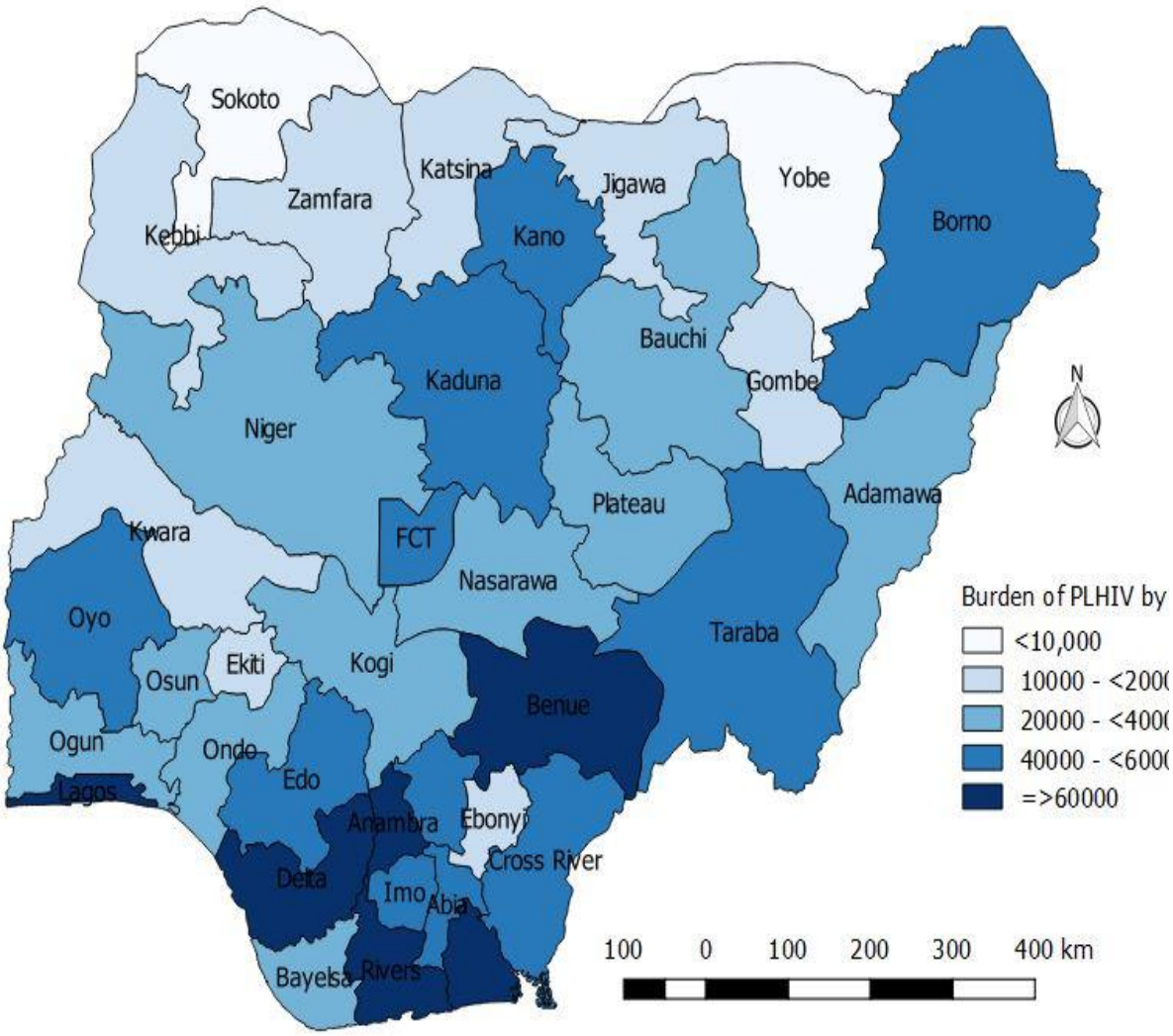


Figure 2.5.1: Nigeria's PLHIV burden by SNU

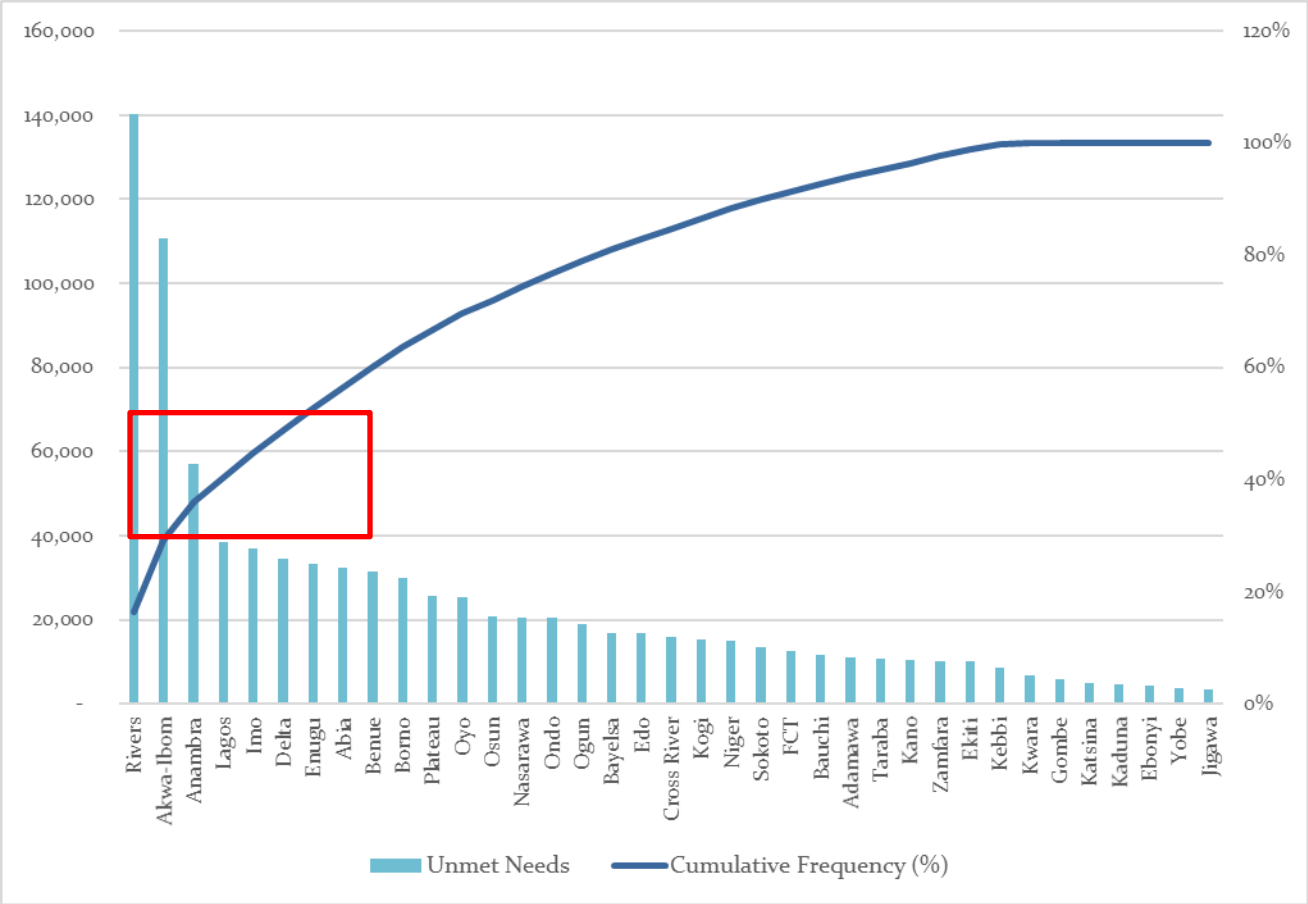


Figure 2.5.2: State Ranking by Unmet Treatment Needs

2.6 Stakeholder Engagement

Building on the momentum of the CSO collaboration funds in COP19, the PEPFAR country team plans to dramatically expand the scope of the PEPFAR CSO platforms in COP20 by strategically mobilizing a broad array of CSO leaders representing the different communities in Nigeria HIV response efforts. Emerging voices within the Key Population community have played an increasingly active role in the space while efforts continue to progress towards a more meaningful and productive engagement. In the last half of 2019, three successive meetings where held with CSO leaders to establish a framework for future engagement and gradually bring those who were new on the platform up to speed with PEPFAR priorities and the annual program cycle. The outcome of these engagement in the COP20 CSO engagement plan is the consensus to engage around six broad areas of collaboration summarized in Figure 2.6.1 below.

Activity	Sub-activities
CSO monitoring & oversight of facilities	> Site reviews > Patient surveys > Retention, predictors of loss-to-follow up >Quantitative waiting time audit
U=U Campaign rollout	> Development & roll out of strategic behavior change campaign to jumpstart: - U=U information dissemination - Patient retention & adherence - Stimulate demand creation for VLT & EID - Anti-Stigma & discrimination messaging
Patient engagement, education & information dissemination	> Service package > Rights > Grievance communication & management systems
Resource tracking & government engagement for domestic financing	> User fees (commitment & operationalization of bans of same) > tracking of stakeholder resource commitment by government.
PEPFAR/CSO/stakeholder quarterly meeting	> Quarterly monitoring meetings > Production of briefs for dissemination and action
KP CSO capacity development	> KP advocacy actions for community needs

Figure 2.6.1: PEPFAR CSO Engagement Plan

Under the supervision of the CSO leaders, community members will be supported to conduct oversight activities (site reviews, patient surveys and rapid evaluations of the impact of facility operations on client satisfaction and retention in care).

CSOs will champion the nationwide rollout of the "UequalsU" campaign which was launched by the National Agency for the Control of AIDS and PEPFAR as part of the World AIDS Day events in 2019. Significant traction has already been established in disseminating general messages around this concept via a social media campaign (#NigeriaUequalsU) and competition won in the CSO category by the CSO network Civil Society for HIV/AIDS in Nigeria (CiSHAN). Efforts in COP20 will focus on developing specific messages appropriate to different communities and engagement with a much broader array of stakeholders, including medical professional bodies, service providers and community members at sub-national level.

Linked to these activities will be similar efforts to develop and disseminate updated self-care information to PLHIV to empower them to demand services for their health and information around stigma mitigation in communities and at service delivery points.

The CSOs also expressed an interest in seeing a more transparent process of monitoring and accounting for resources invested in the HIV/AIDS program and engaging more constructively with the various structures of Government to advocate for increased domestic investments in the Nigeria HIV/AIDS response. These interests align with agreements between the three major

stakeholders to work towards more efficient programmatic alignment. Taking advantage of the unique opportunity of the Global Fund's grant planning process happening at the same time as PEPFAR Country Operational Plan (COP) 20, the proposed Nigeria HIV Program Alignment Plan will see investments in the National HIV program deployed on the basis of consideration of comparative advantage of the funding partners and will allow for a unified process and common framework for target setting, program planning and review – inclusive of system level alignments for the monitoring and evaluation of program results, laboratory services (for Viral Load, Early Infant Diagnosis and GeneXpert), commodity pooling and distribution as well as the deployment of human resources in the community in support of efforts to address retention gaps flagged in program.

Overall, HIV program stakeholders are poised to reduce duplication and inefficient use of resources while improving coordination, transparency and accountability. This framework will also allow for the rapid deployment of new innovations that are found to be effective and the rapid dissemination of knowledge and learning.

3.0 Geographic and Population Prioritization

3.1. Geographic Prioritization

In COP20, PEPFAR Nigeria will expand on the HIV response gains of COP19 to demonstrate saturation and epidemic control through an efficient, galvanized, multi-sectoral approach across key geographies and target populations. This will be advanced by developing enhanced understanding of HIV determinants, drivers, patterns, and micro-epidemic hot spots, and achieved through equitable, client-centered mechanisms aligning with the UNAIDS 95-95-95 global goals for 2030. Leveraging the recalibrated epidemiology defined through 2018 NAIIS, the updated 2020 HIV spectrum projections, continuously generated program data, trends and analytic derivatives from NDR, the country program will align and consolidate the COP19 State, LGA, site and community level geographical prioritization that is categorized by the burden of HIV, unmet treatment need, treatment saturation, and clustered from four into five core epidemic zones based on the distribution across 36+1 states highlighted below:

A. ***High unmet need > 100,000 and low saturation < 81% - The high impact zone***
   - *Akwa Ibom & Rivers* ***(Surge States)***

B. ***Moderately high unmet need >30,000 & low saturation < 81% - The high impact zone***
   - *Abia, Delta, Enugu, Imo and Lagos* ***(Red States)***

C. ***Low unmet need and high saturation > 81%, termed the Epidemic control zone***
   - *Benue, Gombe and Nasarawa* ***(Green States)***

D. ***Low unmet need < 30,000 & low saturation < 81% -, termed the low impact zone***
   - *All other states* ***(Yellow States)***

E. ***States with >90% ART coverage across all age and sex disaggregation (in COP20)***
   - *Yellow & Green SNUs meeting the above criteria* ***(Attained Saturation States)***

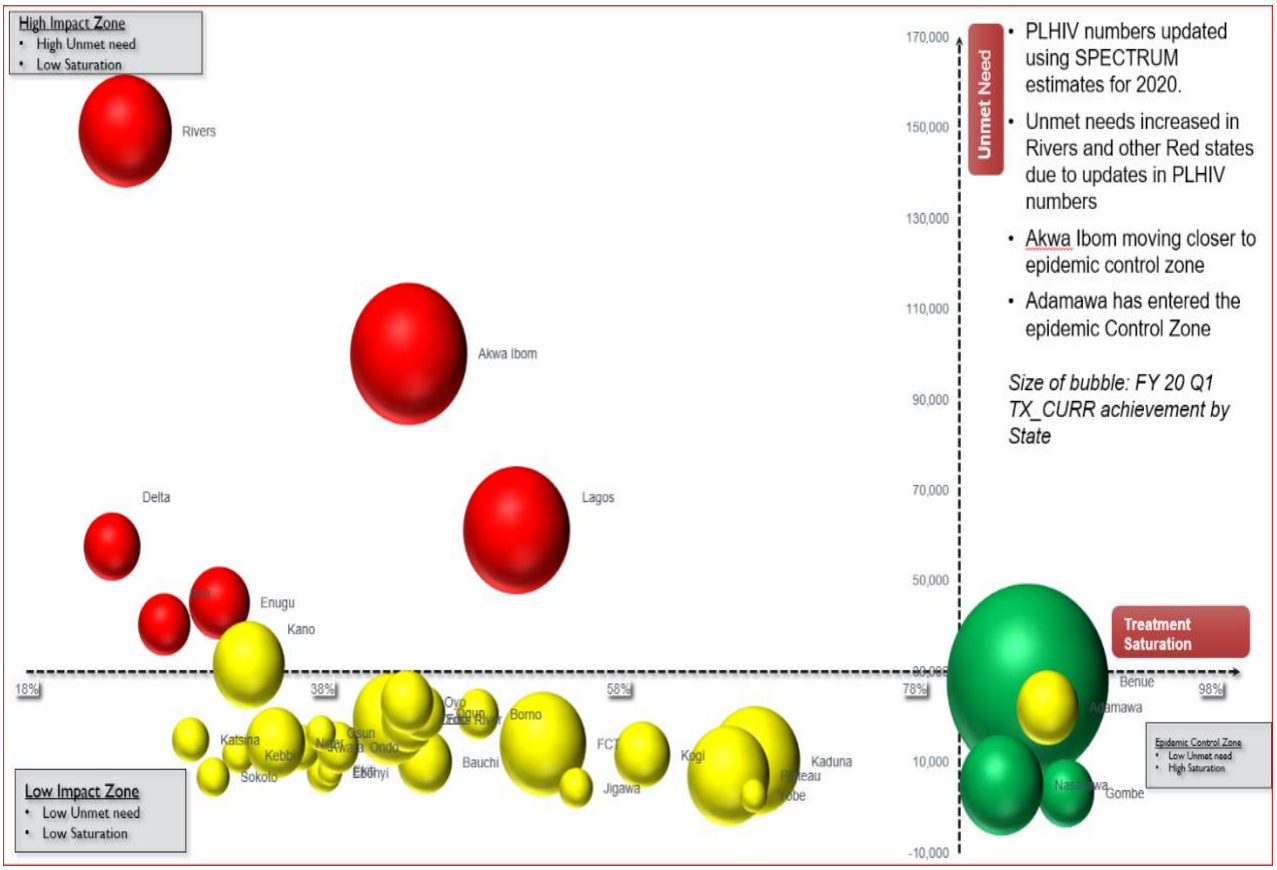


Figure.3.1.1: SNU Epidemic Status at FY 20 Q1

Nigeria has made significant progress across the Surge, Red and other target States. At the end of December 2019, the OU TX_CURR grew to 856,513. At the SNU level, early gains were made in Akwa Ibom which moved closer to epidemic control and in Adamawa which entered the epidemic control zone as highlighted in Figure 3.1.1 due to the updates in the SPECTRUM estimates for 2020, the estimated PLHIV numbers increased across the Surge, Red, and other states. As such, Akwa Ibom and Rivers states account for 30% of the country unmet treatment need. Eight states (Akwa Ibom, Rivers, Abia, Anambra, Imo, Enugu, Lagos, and Delta) contribute 56% of the total unmet need (PLHIV yet to be placed on treatment). The Green States (Benue, Nasarawa and Gombe) contribute 7% of the country's unmet need, while the remaining 25 states (Yellow States) together contribute 37% of the country's unmet need.

The historic COP20 National Alignment Plan aims to coordinate Government of Nigeria, PEPFAR, and Global Fund delivery of HIV services across all geographies through optimizing pooled resource allocation, standardizing programing, expanding best practices and deepening innovations and learning at all levels. With this alignment, Taraba and Abia states, which respectively contribute 6% of the unmet need and which are ranked 4th and 6th in terms of HIV prevalence will be on the way to saturation. In addition, the Global Fund will play a critical role in leading the surge efforts in the Red states of Anambra and a yellow state of Ebonyi.

3.1.1 – COP20 Target Setting

The overarching 95/95/95 goals across all SNUs will be to achieve saturation levels of all core critical interventions applicable to all populations within the SNU, reverse the transmission of HIV, and improve health outcomes for PLHIV. Even after achieving attained or saturated status, the SNU should continue to scale other core interventions and optimize resource allocation for maximum impact as dictated by epidemiologic need.

The COP20 geographical prioritization is intended to facilitate attainment of a PEPFAR new on treatment target of 123,532 and a current on treatment target of 1,316,286 by ensuring an optimal retention rate of 98%. This builds on the post-NAIIS OU treatment growth gains of COP19 in the Surge states of Akwa-Ibom and Rivers and applying a complementary set of prevention and treatment interventions. This will move the Nigerian program across the 36+1 supported states, from the current OU FY19 Q1 treatment coverage of 53% to 76% at end of FY21 (COP20). Additional contributions to this achievement are expected from the Global Fund and other stakeholders as part of the **National Alignment Plan**[14]**.**

The COP20 targets are distributed across the geographic prioritization in line with the COP realignment strategy to;

I. Achieve 81% treatment saturation in the Surge States of Akwa Ibom and Rivers, moving both from the high impact to the epidemic control zone
II. Achieve 81% treatment saturation in the Red States of Lagos and Delta moving them from the high impact to the epidemic control zone
III. Address age and sex saturation gaps in the 3 Green States of Benue, Gombe, and Nasarawa with over 81% treatment coverage, to achieve at least 90% treatment saturation by age and sex group
IV. Optimize retention services across the 25 Yellow States while advancing seven of these Yellow States (Kaduna, Adamawa, Cross River, Bauchi, Ebonyi, Niger and Sokoto) to the epidemic control zone.
V. Based on this common target framework, Abia and Taraba have been assigned a two-step saturation target of 12,327 TX_NEW and 75,049 TX_CURR commencing from FY21. The efforts in both states will continue to be led by the Government of Nigeria.

Further analysis of these high burdened Surge and Red States with LGAs to refine the geographic targeting, identify areas of new infections, localize "hotspots" within SNUs, and utilize available data to identify the population groups with the greatest burden of disease. Even in lower-prevalence yellow SNUs, if a hotspot meets criteria for a micro-epidemic with a high volume of new infections, yield or spike in the trajectory of cases identified, the SNU in which it is located should be a unique focus on these micro-epidemics and detail plans to achieve 90% ART coverage and accelerated coverage of combination prevention in the hotspot(s) within the SNU. In addition, a granular focus on underserved sub-populations especially children, adolescents, males under 40, and young girls under 35 will be institutionalized as depicted below in Figure 3.1.

[14] A Stakeholder Group has been set-up to develop the details of this plan and the document.

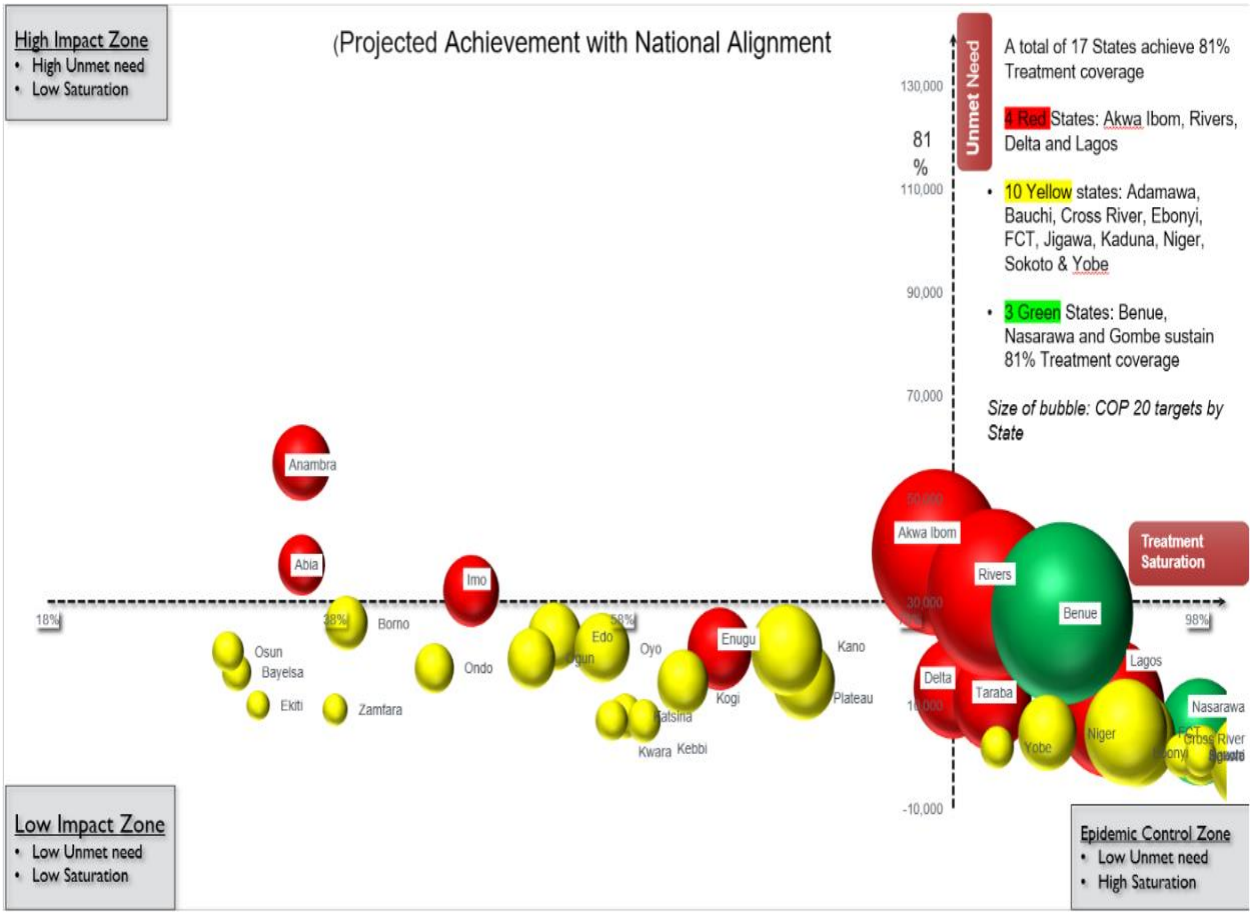


Figure.3.2.2: COP20 Geographical prioritization

3.2. Population Prioritization

Population prioritization for COP20 is grounded on a right's based, client centered, equitable treatment program access approach. Insights derived through the program gap analysis insights by age and sex to shows significant gaps in treatment saturation for children, adolescents and young persons, as well as males aged 25 years and above (see Table 3.1 below).

	State	<1		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
		Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
Surge	Akwa Ibom	79%	80%	193%	172%	195%	180%	98%	66%	119%	40%	180%	42%	75%	58%	102%	70%	72%	79%	77%	102%	89%	111%	79%	69%
	Rivers	17%	17%	112%	107%	98%	89%	111%	104%	44%	53%	109%	93%	94%	85%	121%	61%	78%	101%	88%	102%	76%	122%	63%	75%
Red States	Abia			32%	34%	76%	77%	38%	39%	14%	29%	20%	18%	35%	17%	51%	27%	63%	38%	73%	49%	79%	56%	82%	64%
	Delta	0%		56%	53%	58%	60%	72%	94%	42%	53%	51%	39%	85%	43%	142%	53%	155%	85%	216%	184%	103%	89%	107%	153%
	Enugu	16%	17%	59%	51%	121%	122%	82%	88%	37%	59%	37%	31%	58%	27%	82%	34%	98%	53%	125%	87%	107%	76%	110%	86%
	Imo	4%	4%	26%	25%	72%	74%	46%	52%	32%	39%	31%	26%	45%	30%	63%	39%	74%	50%	93%	70%	92%	73%	97%	104%
	Lagos	13%	13%	36%	33%	37%	38%	42%	42%	31%	49%	63%	58%	81%	88%	100%	85%	106%	96%	125%	129%	98%	99%	234%	106%
Green States	Benue	128%		232%	175%	190%	187%	153%	151%	85%	61%	154%	40%	201%	49%	231%	61%	185%	71%	119%	81%	172%	87%	122%	92%
	Gombe	0%		81%	70%	93%	94%	53%	55%	102%	81%	251%	88%	259%	117%	215%	154%	140%	149%	149%	233%	108%	100%	108%	101%
	Nasarawa	80%	81%	162%	132%	81%	82%	72%	73%	101%	106%	144%	102%	215%	105%	222%	107%	165%	109%	167%	143%	110%	110%	110%	110%
Yellow States	Adamawa	40%	40%	215%	193%	161%	145%	149%	130%	126%	93%	232%	69%	266%	157%	310%	144%	275%	160%	164%	139%	188%	152%	124%	119%
	Bauchi			86%	80%	111%	111%	87%	84%	106%	73%	198%	66%	190%	111%	213%	94%	181%	95%	115%	87%	116%	91%	116%	101%
	Bayelsa	26%	27%	29%	30%	30%	31%	22%	22%	56%	48%	71%	31%	83%	34%	91%	37%	98%	45%	103%	56%	107%	66%	108%	78%
	Borno	21%	21%	22%	`	23%	24%	23%	22%	11%	8%	30%	15%	54%	23%	71%	36%	82%	55%	90%	74%	94%	86%	89%	95%
	Cross River	50%	51%	65%	60%	82%	83%	94%	77%	145%	91%	209%	104%	193%	128%	168%	96%	162%	100%	116%	103%	165%	140%	118%	119%
	Edo	24%	25%	36%	37%	56%	58%	68%	66%	63%	62%	69%	40%	91%	39%	116%	51%	127%	70%	137%	91%	142%	109%	145%	122%
	Ekiti	29%	31%	34%	35%	45%	46%	36%	42%	24%	23%	25%	16%	39%	15%	52%	22%	64%	30%	74%	47%			82%	55%
	FCT	51%	51%	204%	192%	127%	119%	112%	126%	95%	99%	150%	104%	276%	108%	309%	121%	223%	131%	247%	225%	111%	111%	110%	164%
	Jigawa	96%	100%	95%	87%	73%	74%	80%	82%	130%	57%	200%	50%	149%	94%	166%	76%	149%	96%	115%	97%	118%	99%	121%	99%
	Kaduna			96%	96%	104%	105%	96%	96%	75%	32%	131%	16%	228%	33%	299%	59%	240%	75%	117%	85%	127%	103%	103%	152%
	Kano	94%	95%	74%	75%	84%	86%	75%	79%	58%	47%	109%	45%	132%	86%	143%	65%	121%	76%	109%	74%	114%	88%	117%	100%
	Katsina	100%	97%	77%	78%	119%	119%	62%	72%	91%	55%	106%	54%	124%	54%	121%	65%	128%	81%	133%	100%			136%	120%
	Kebbi	49%	46%	32%	31%	56%	58%	39%	41%	33%	49%	87%	48%	90%	61%	106%	75%	117%	95%	125%	112%	128%	123%	127%	129%
	Kogi	0%		93%	80%	76%	77%	71%	73%	59%	48%	90%	60%	100%	195%	115%	208%	114%	109%	168%	120%	101%		103%	48%
	Kwara	30%	30%	61%	56%	78%	78%	57%	60%	32%	39%	42%	49%	75%	100%	98%	46%	98%	38%	91%	31%	94%	37%	113%	53%
	Niger	64%	60%	168%	153%	129%	119%	79%	86%	75%	76%	78%	66%	187%	77%	190%	71%	163%	81%	114%	90%	119%	96%	162%	122%
	Ogun	35%	36%	86%	87%	74%	75%	71%	71%	43%	45%	47%	29%	67%	33%	87%	41%	103%	55%	133%	89%			129%	101%
	Ondo	27%	28%	37%	38%	56%	57%	39%	38%	31%	25%	32%	22%	53%	17%	79%	23%	83%	31%	113%	85%			76%	59%
	Osun	61%	62%	65%	66%	63%	65%	56%	57%	32%	35%	36%	27%	48%	30%	60%	34%	73%	41%	93%	49%			101%	68%
	Oyo	25%	27%	67%	65%	94%	96%	72%	78%	51%	23%	79%	21%	96%	28%	107%	42%	115%	56%	182%	84%	117%	71%	123%	211%
	Plateau	59%	59%	35%	35%	57%	58%	36%	37%	80%	95%	101%	99%	106%	104%	107%	106%	107%	106%	201%	257%	107%	106%	446%	380%
	Sokoto			65%	62%	119%	119%	145%	171%	32%	23%	77%	54%	108%	89%	147%	105%	146%	113%	112%	117%	117%	140%	111%	263%
	Taraba	126%	127%	90%	92%	101%	102%	70%	71%	156%	116%	153%	107%	161%	102%	165%	111%	167%	125%	168%	138%	168%	147%	169%	155%
	Yobe					106%	109%	57%	58%	73%	112%	118%	155%	92%	291%	117%	136%	128%	100%	124%	130%	127%	147%	128%	159%
	Zamfara	28%	28%	27%	28%	33%	34%	22%	18%	47%	55%	52%	109%	66%	154%	82%	161%	96%	137%	108%	90%	115%	78%	121%	93%

Legend
<70%
71%-79%
80%-89%
>90%

Table.3.1: COP20 Geographical prioritization

Table 3.1 Current Status of ART Saturation				
Prioritization Area	**Total PLHIV/% of all PLHIV for COP20*** **	**# Current on ART* (FY19)**	**# of States COP19 (FY20) ** **	**# of States COP20 (FY21)**
Attained (Green states)	15%	244,510	3	3
Scale-up Saturation (surge states)	23%	105,362	2	2
Scale-up Aggressive (red states)	18%	114,291	4	4
Sustained (yellow states)	49%	384,814	25	24

4.0 Client Centered Activities for Epidemic Control

4.1 Finding the missing and getting them on treatment

In COP20, PEPFAR Nigeria will continue to tailor testing approaches to the different geographic prioritization zones in Nigeria to improve case finding amongst populations that are being missed, especially men, adolescents, and children across all age groups. The situation varies by location; hence the program will continue to work with the partners to utilize data to determine who is being missed at all levels and follow transmission dynamics to improve case finding efforts.

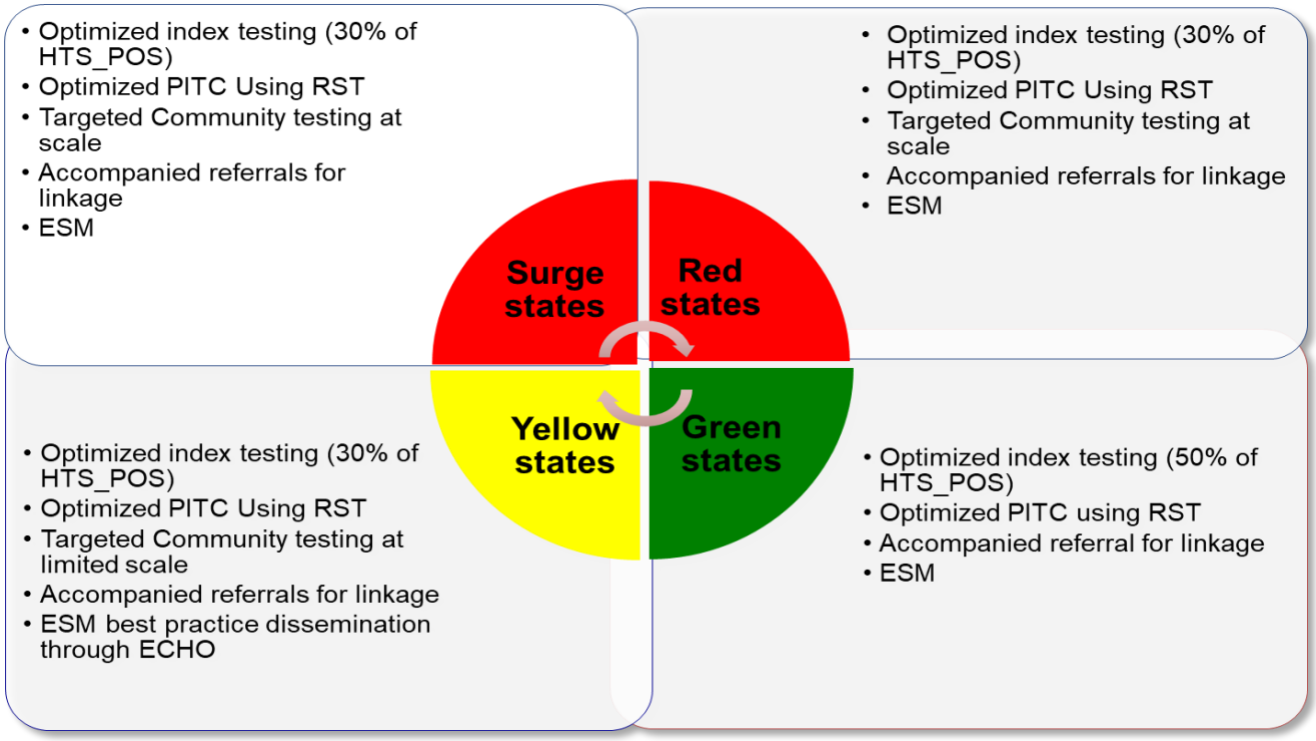


Fig 4.1.1 Case finding strategies by geographical prioritization

In the Surge SNUs (Akwa Ibom and Rivers), the red states and the yellow states, PEPFAR Nigeria will identify new PLHIV and link at least 95% of them to treatment. To achieve this, the program will deploy strategically tailored approaches for case-finding to identify difficult to reach persons in these high burden areas. Facility-based testing will focus on optimizing client risk stratification tools to best prioritize Provider-Initiated Testing and Counseling (PITC) modalities. Low yield modalities such as STI and malnutrition will be discontinued. Learning from COP19, providers' capacity to correctly administer the risk stratification tool will be improved through training, to ensure that there is a corresponding increase in the number of positives identified in relation to increased yield. PEPFAR Nigeria will also continue to scale up high-quality index testing with fidelity across all geographical areas of coverage as a critical case finding strategy with the expectation that at least 30% of newly identified PLHIV (HTS_TST_POS) will be found through the index testing modality, with a yield of 15-40%, and an acceptance rate of about 85%.

PEPFAR Nigeria will work in consultation with civil society to conduct assessment of partner facilities to ensure adherence with the WHO 5Cs (consent, confidentiality, counselling, correct results and connection[15]) using the tool developed by OGAC technical teams. Additionally, all minimum standards set by the OGAC team such as ensuring providers are trained on index testing procedures including human rights, ethics, gender issues especially IPV screening, provision of first line services for IPV etc., will be put in place as services are being scaled up. An actionable and time bound remediation plan will be set up for sites that do not meet the minimum standard for index testing.

The procedure of site certification will be instituted to ensure all sites/settings that provide index testing meet the minimum requirements and conform to the Standard Operating Procedures of index testing. Index testing concepts will be introduced during group health talks in the facilities and in support group meetings, and the benefits will be discussed during post-test counseling to improve informed consent. Adverse events will be monitored closely using monitoring tools and survivors linked to services. Similarly, integrated health messaging and services will be provided to address disclosure, stigma related issues and support anonymous testing of partners. The expert counselors will support poorly performing sites to scale up with fidelity without compromising quality. Index clients with hard to reach partners will be offered HIV Self-test kits after screening out for IPV. Assisted and unassisted approaches will be utilized with HIV Self testing targeting men, adolescent girls and young persons and Key populations who are currently being missed by the program. Also, PEPFAR Nigeria will build on lessons learned from the FY 20 Recency TRACE project and program implementation to scale up recency testing in FY 21. Locations with recent infections will be prioritized for community testing, prevention interventions and timely index testing services.

Using GIS hotspot mapping and data triangulation, strategic and integrated community testing activities will target key population groups, priority populations like high-risk men, at-risk adolescent girls and young women to guide case-finding in the community. Hot spots and communities with observed high positivity rates will be focused on for targeted testing and supported with accompanied referrals to treatment. Same day ART initiation for those who test positive will continue to be optimized. In the yellow states, targeted community testing will be at a limited scale using index testing partners identified and locations with recent infections to determine testing locations. Quality of interventions across all SNUs will be maintained and supported through the Enhanced Site Management program. Also, a risk stratification tool will be applied in the communities to improve testing efficiencies. Community Moonlight and sunrise testing in coastal regions that generated high yields in FY19 will be continued as well as OVC household testing to improve case finding amongst children.

[15] World Health Organization. (2015). Consolidated guidelines on HIV testing services: 5Cs: consent, confidentiality, counselling, correct results and connection 2015. World Health Organization. https://apps.who.int/iris/handle/10665/179870

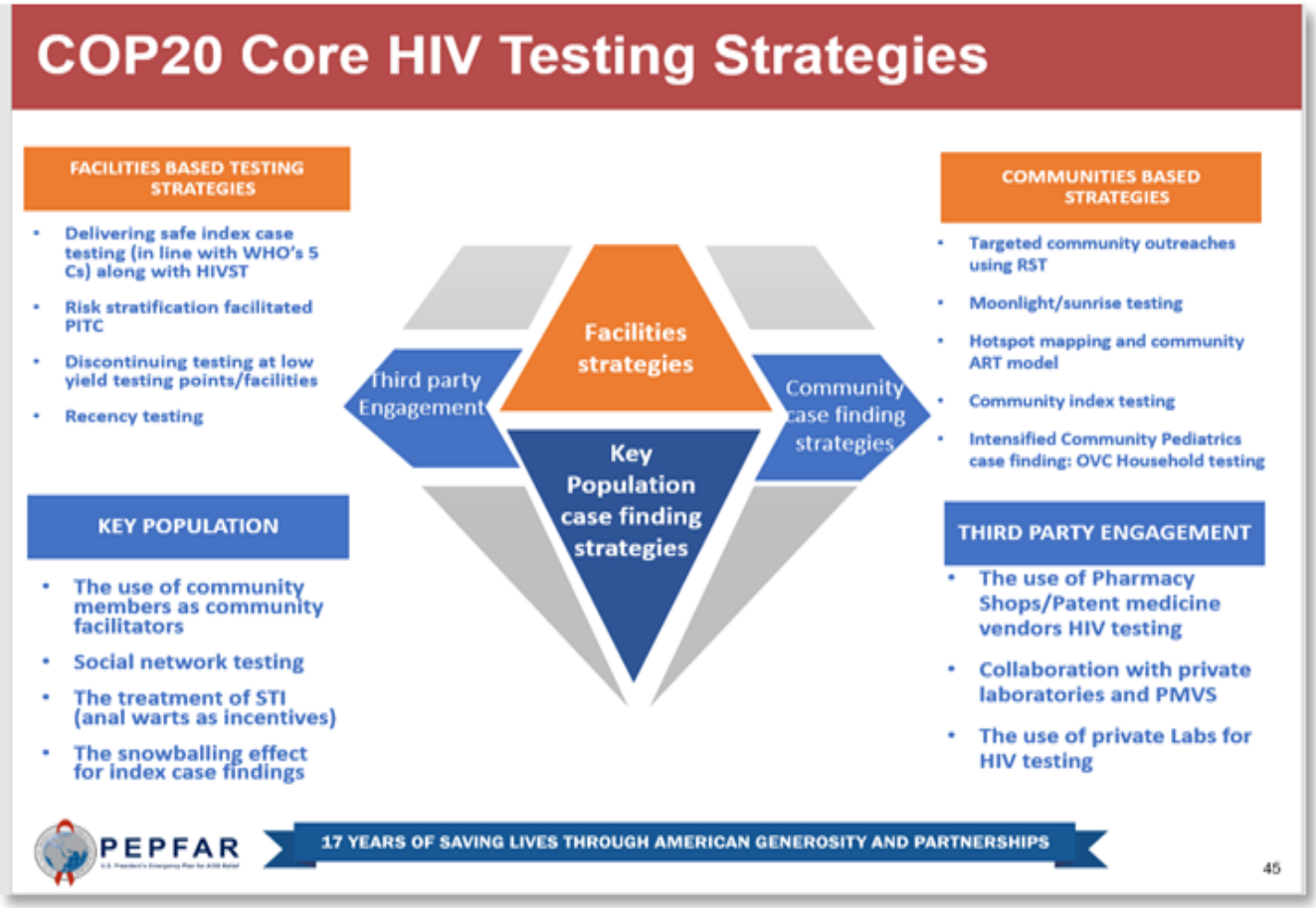


Fig 4.1.2 Case finding strategies by geographical prioritization

Figures 4.1.3 summarizes the expectation of varying level of effort and testing interventions across the four program tiers and within specific priority populations.

In the green states, strategic case finding strategies such as index testing, will be scaled up with fidelity, and 50% of positives are expected to come from index testing. As a result, more efforts will be channeled towards optimizing index testing services in these states that are near saturation. The risk stratification tool will be applied here as well to improve the yield. Community testing will be not implemented in the green states.

For pediatrics <15, in line with COP guidance, 100% of all biological children of adult index clients will be tested for HIV; hence family index testing will be scaled up as well as PITC in high yield modalities for all pediatrics. EID will be explored in non-PMTCT settings where children are being brought in such as nutrition/immunization, TB, and pediatric in-patient's clinics. In line with COP guidance, formal relationships between treatment partners and OVC IPs would be jointly developed (with MOUs), outlining the roles and responsibilities of each member of the

multi-disciplinary team and addressing key issues such as bi-directional referral protocols, case conferencing, shared confidentiality, and joint case identification.

For adolescents & young persons (15-24 years), other strategies that will be continued include HIV Self testing, social network testing using their social peers as well as targeted community-based testing in high burden locations where young people congregate. Also, AYP survivors of gender-based violence will be prioritized for HIV testing and positives actively linked to treatment.

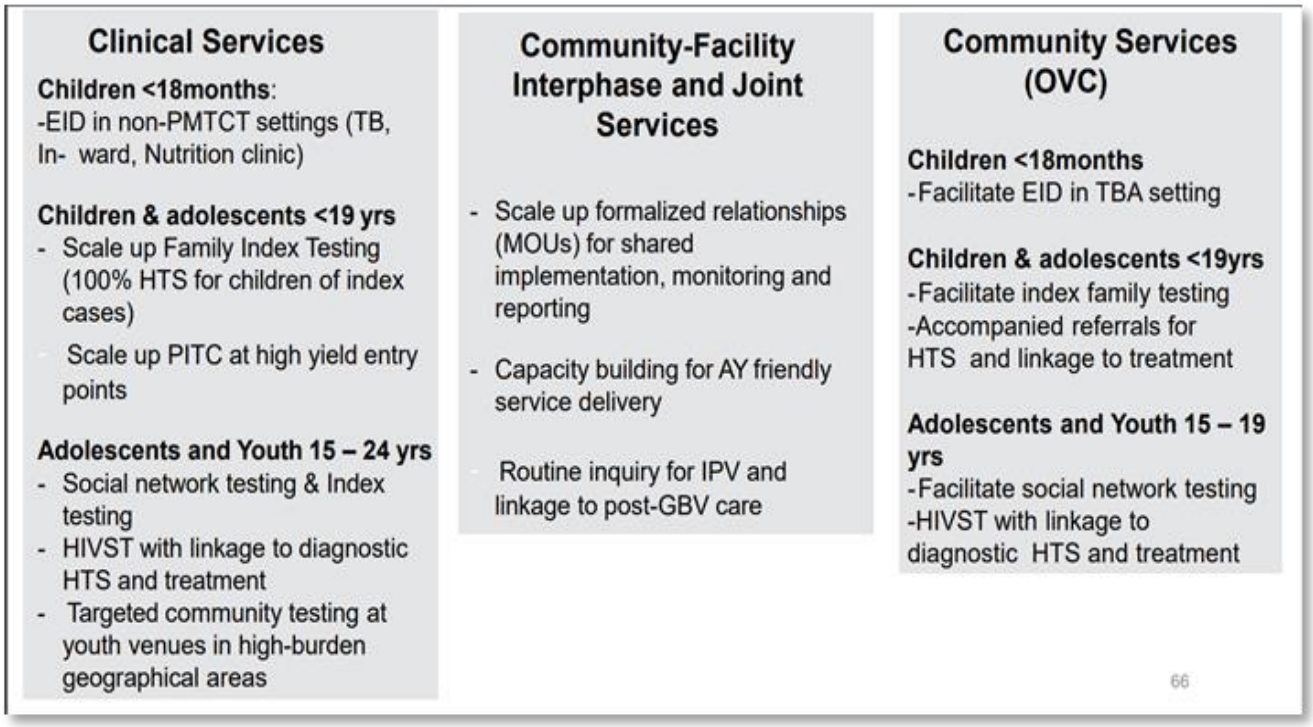


Figure 4.1.3 Pediatric Case finding strategies

In COP19, linkage rates amongst children and men ranged from poor to average at the OU level and will remain an area of focused attention as the country to continues to build the Tx_Curr. HTS will be client centered and providers will support clients to navigate client specific linkage barriers. To improve linkage amongst men, efforts will be put in to address ART initiation times by shortening waiting times in facilities, same day ART initiation, use of differentiated models of care to motivate ART initiate and reduce burden on men. Male peer navigators will be engaged and paired with men, and confidential spaces identified to provide services. Also, demand creation messaging will be focused on reassuring men that they can be in control of their lives using platforms such as the "Undetectable equals Untransmittable" (U=U) campaigns and men that are living positively.

4.2. Retaining clients on treatment and ensuring viral suppression

PEPFAR Nigeria will continue to improve quality of patient care in COP 20 by focusing on improving retention across all SNU in Nigeria. The drive to optimize retention will be built

around a client centric case management approach that tailors support for care and treatment service to meet the specific needs of individual clients by dedicated case managers from initiation on ART through continued care and treatment services aimed at ensuring optimal retention and virologic suppression. This case management approach will leverage on the use of trained case managers, mostly PLHIVs as peer supporters to all clients enrolled into care and treatment services. An active management of client retention will be implemented using the following prongs:

Newly identified clients: Every newly identified HIV positive client will be assigned to a case manager that will be responsible for facilitating linkage to ART, reinforce adherence-counselling messages and initiate personalized support by verifying client contact details. A one-month case management schedule will be developed by the client and the case manager to support the client adhere to his/her medication, adhere to clinic appointment and overcome initial stigma and prepare the client psychologically for management of chronic illness. The case manager will call the client at least once every week for the first month on treatment to provide support in ensuring the client takes his/her medications.

Client already on ART: Appointment reminders by the case manager will be done at least a day or two to the client's clinic or laboratory scheduled appointment. At the end of the clinic day Case managers will on same day identify clients who missed their scheduled clinic or laboratory appointments and they will be contacted through phone call or home visit where applicable to remind them of their appointment.

At the site level, the OU will prioritize the following activities to ensure improved retention

1. Elimination of all formal and informal user fees affecting access to HIV testing and treatment and prevention in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, Cotrimoxazole, cervical cancer, PrEP and routine clinical services.
2. Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups
3. Rapid optimization of ART by offering TLD to all PLHIV weighing >30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing >20kg, and removal of all nevirapine-based regimens.
4. Adoption and implementation of differentiated service delivery models for clinically stable clients that ensures choice between facility and community ART refill pick-up location and individual or group ART refill models. All models should offer patients the opportunity to get 6 months of medication at a time without requiring repeat appointments or visits.

The above three site level intervention without the exception of elimination of user fees, the case manager will support the clients to navigate through the hospital to receive the services.

Other strategies will include use of technology on the NDR to develop algorithm that will predict clients that will be lost to follow up. PEPFAR Nigeria will strengthen NDR to conduct predictive analysis of clients likely to be lost and develop interventions to address possible challenges/bottlenecks. Continue to leverage on available social media platforms for priority client groups to reinforce adherence and retention messages and provide dedicated peer to peer support.

PEPFAR Nigeria will deploy geo mapping to identify geographies with the highest LTFU and tailored intervention in the area to suit the needs of the clients for them to be retained on treatment. Weekly facility level granular analysis of retention outcomes and weekly ECHO call with care provides to drill down on identified reasons for missed appointment and intervention to be provided.

For clients who became lost to follow up, PEPFAR Nigeria will continue to use case managers to provide weekly tracking of these clients through phone calls and/or home visits where feasible. Upon returning to care, reason for LTFU will be determined through the application of the 'reason for LTFU' checklist. A central collation and qualitative analysis of the reasons for LTFU will be used to further refine interventions aimed at optimizing retention at facilities.

To ensure and sustain VLS, children and adolescents will receive optimized pediatric ART. This will entail 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. 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. Prevention, specifically detailing programs for priority programming:

a. HIV prevention and risk avoidance for AGYW and OVC

In the current COP19, PEPFAR aligned OVC and clinical programs to prioritize and optimize clinical outcomes of CALHIV in 14 States (Adamawa, Akwa Ibom, Bauchi, Benue, Cross River, Delta, Enugu, Gombe, Imo, Kaduna, Lagos, Kano, Nassarawa) and the FCT Abuja with OVC program footprints. OVC program has continued to use case managers and bidirectional linkage coordinators for viral load monitoring, and linkage of HIV positive OVC to treatment respectively.

As at APR COP18, after two quarters implementation of surge, total OVC HIV STAT POS, proxy for CALHIV on treatment (TX_CURR <19) enrolled into OVC program increased from 10,445 to 17,790. (Figure 4.3.1). This is a 59% improvement on SAPR and represents 35% of Children Currently on Treatment (TX-Curr 0-19) at 50,458 in the states with OVC programs (USAID is only implementing OVC programs in 6 states). However, the 50,458 includes individuals 18-19 who do NOT qualify for the OVC program. Therefore, it is difficult to ascertain the exact number of individuals on treatment who are eligible for OVC services and what percentage of that number has been enrolled and what is outstanding. It remains a challenge to align the OVC HIV STAT POS indicator and the TX CURR (0-19) indicator because of the differing age disaggregation.

Funding Agency	Indicator	FY19 Q2	FY19 Q4
OU Total	OVC_HIVSTAT_POS	10,445	17,790
CDC	OVC_HIVSTAT_POS	7,999	8,325
USAID	OVC_HIVSTAT_POS	2,446	9,465

Figure 4.3.1 – Update on Number of OVC's Testing Positive within the OVC Program

In response to this ongoing challenge, in COP19, the OVC program is conducting a profiling exercise of all enrolled OVCs by the most vulnerable subpopulation groups. This will allow the program to better target services and interventions specific to enroll CALHIV, HEIs, SVAC, Children 9-14, CSFW, etc. The profiling exercise originates from the national OVC database NOMIS which consists of client-level information that will include CALHIV on ART and the corresponding facility. Implementing partners will place a POC in each facility to harmonize client-level information entered into NOMIS with the NDR. Additionally, at the national level, IPs will work on the interoperability of NOMIS and NDR to better monitor CALHIVs in the OVC program. Furthermore, the pediatric targets for COP 20 for the six OVC states is 208,149 (and includes the ineligible 18-19 age bracket). Of this number, the OVC program purposes to enroll the eligible CALHIV (less than 18) and to move from a 35% coverage in COP18 to 50% in COP 19 and 95% in COP 20.

Addressing the poor interoperability of the NOMIS and NDR databases is an ongoing priority in COP19. The PEPFAR interagency technical and SI teams are working to review the NOMIS/NDR platforms. To formalize shared implementation, PEPFAR will ensure signing of MOUs between

OVC and treatment IPs in COP19. Trainings in OVC and clinical package of care will also be conducted for clinical and OVC staff respectively.

In COP20, the OVC program will focus in SNUs with significant CALHIV unmet burden and high TX_CURR yet to be enrolled on in OVC program. This pivot will be informed by the ongoing deep dive analysis of the OVC program data layered on the CALHIV-specific epidemic status analysis (Figure 1)

PEPFAR Nigeria in COP19, is scaling up targeted pediatric HIV testing. Pediatric specific screening tools have been developed. In COP20, OVC case managers will be trained to drive HIV testing for all biological children (<15) of all adult PLHIV on treatment and siblings (<15) of HIV positive children and sexually active adolescents who are HIV positive. This activity will be prioritized in states with high pediatric unmet burden (Figure 4.3.2).

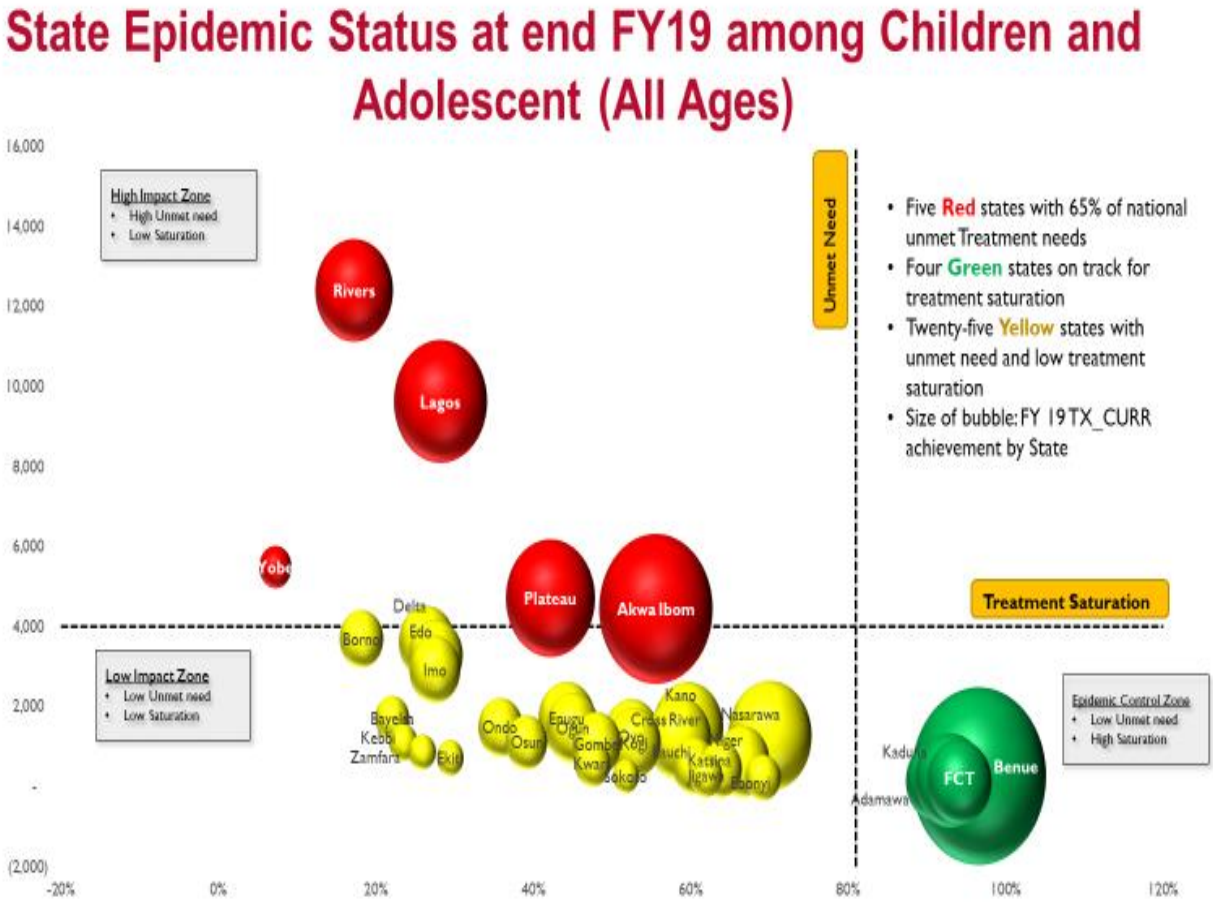


Figure 4.3.2 – State Epidemic Profiles for Children and Adolescents age-group

In COP 20, the Nigeria OVC program will provide evidence-based interventions which are targeted at the primary prevention of sexual violence and HIV to Adolescents aged 9-14 who live

in the priority SNUs; Akwa Ibom, Rivers and Lagos in localities with history of high sexual violence. Three OGAC approved curricula have been adapted to be implemented in Nigeria - Families matter program (FMP), Coaching Boys into Men (CBIM) and IMPOWER. Targeting children to be included in these interventions will be done through assessments and selection of 9-14 YO who are in already existing sports groups, faith-based youth groups and school and community groups. Parents of these teens will benefit from FMP, while IMPOWER targets boys and girls and their parents. CBIM primarily targets boys in soccer groups which are a very popular group in many Nigerian communities. Boys are a key stakeholder in changing community attitudes towards sexual violence. These boys and girls will receive the appropriate interventions over several weeks through trained coaches and other facilitators. In addition, using a referral directory, trained facilitators will ensure that children have access to post GBV and other relevant services where needed. Approximately 35% of the total OVC caseload will receive these prevention interventions in COP 20.

To address the sub-optimal outcomes for AYPLHIV, PEPFAR Nigeria commenced scale up of Operation Triple Zero in COP19. The scale up is projected to reach 30% and 80% AYPLHIV_TX_CURR by end of COP19 and COP20 respectively (Figure 4.3.3).

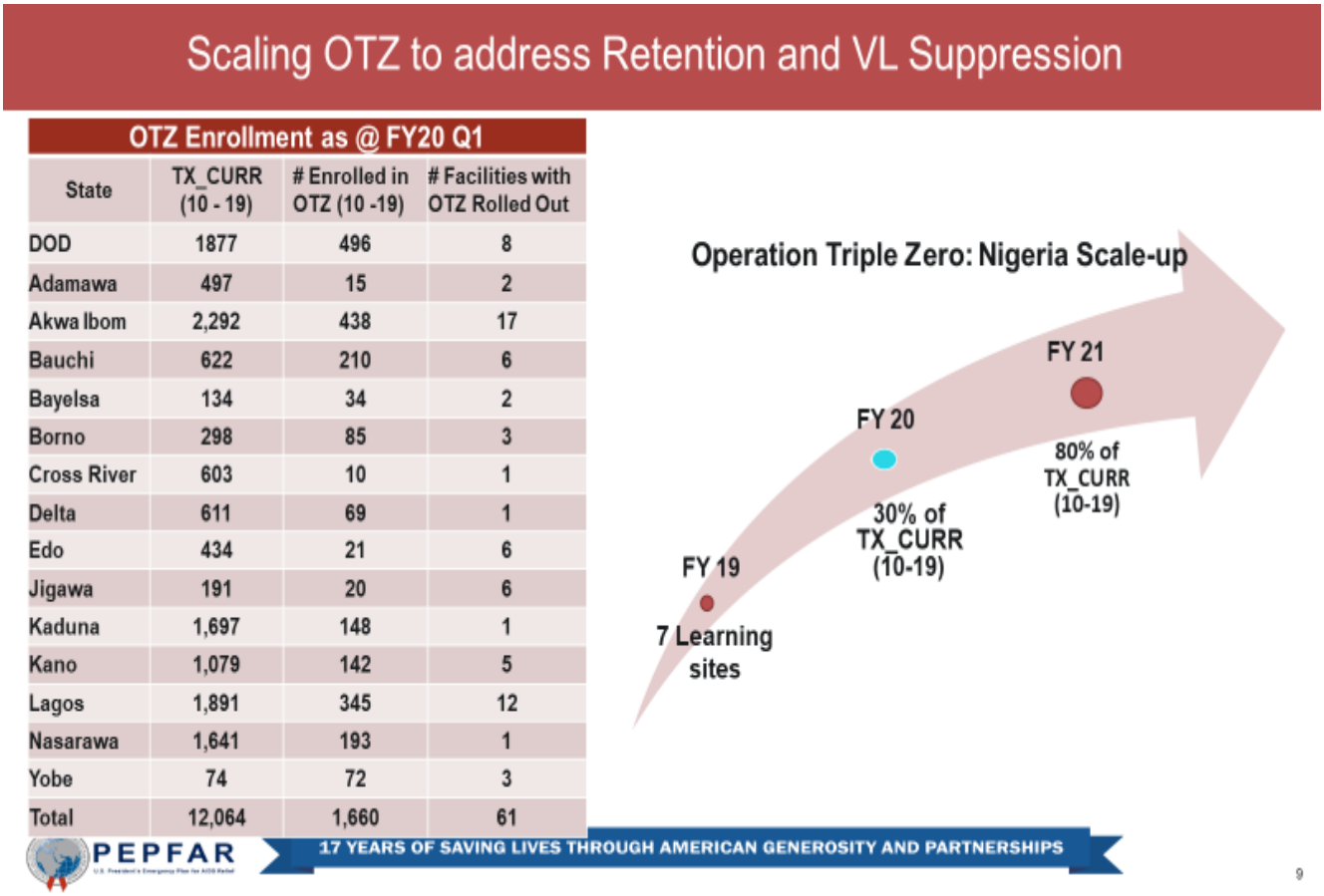


Figure 4.3.3 – The OTZ Scale-up Plan

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	97,817	36,696	27,522
Akwa Ibom	200,687	142,111	106,585
Bauchi	106,098	38,314	28,736
Benue	316,276	131,765	98,837
Cross River	136,367	53,125	39,841
Delta	124,279	49,262	36,952
Enugu	94,445	34,752	26,066
FCT	117,840	47,911	35,937
Gombe	62,562	24,597	18,450
Imo	96,393	24,649	18,496
Kaduna	194,275	68,972	51,732
Kano	345,541	118,994	89,242
Lagos	415,134	155,226	116,420
Nassarawa	123,408	51,558	38,671
Rivers	200,188	120,685	90,519
TOTAL	2,781,639	1,098,617	823,996

b. Prevention of Mother-to-Child Transmission

The total fertility rate in Nigeria is 5.3 with a slight decrease from 5.5 in 2013, varying from 3.4 children per woman in Lagos to 7.3 children per woman in Katsina state. The sexual and reproductive health status of women is poor due to lack of access to sexual and reproductive health information and services, early onset of sexual activity (median age of 15.7 years for females and 20.6 for males); multiple sexual partners and low utilization of modern family planning methods (4.7 per cent among married females aged 15-19). One of the most devastating consequences of the HIV epidemic is the transmission of HIV from mothers to children (MTCT). Nigeria continues to embrace the UN four prong approach in the provision of PMTCT services across the Nation. These include (i) primary HIV prevention among women of reproductive age, (ii) prevention of unintended pregnancies among HIV positive women, (iii) prevention of HIV transmission from an infected pregnant woman to her child, and (iv) care and treatment for women, their children, and families. There are still gaps and challenges in integrating PMTCT services into existing reproductive health programs thereby limiting the implementation of a full comprehensive PMTCT package at various service delivery points.

The current national level of PMTCT coverage of all pregnant women accessing HIV testing and counselling falls far short of the UN fast-track strategy, 2016 with only 67% of pregnant women accessing ANC services by a skilled provider. Ensuring that 95% of all HIV infected persons,

including pregnant women, have access to lifelong ART by 2030 needs the collaborative efforts of all stakeholders.

In COP20, all pregnant women attending ANC services for the first time in PEPFAR-supported facilities, will be provided HIV test. This service will also be provided to women presenting at labor and delivery settings without previous ANC service utilization. There will be community mobilization activities for increase ANC uptake in all states identified with huge treatment gap, ensuring integration of services in KP settings to link pregnant FSW to ANC, coordination of services with family planning, and other reproductive maternal and health services. PEPFAR Nigeria will conduct dual HIV and syphilis testing in two states of Akwa Ibom and Rivers.

All identified HIV pregnant women will have access to lifelong ART services with PEPFAR Nigeria supported partners targeting 95% of identified positives and linking them to ART using various linkage services including peer escorts, mentor mothers, ensure partner testing for all identified HIV positive pregnant women and provide PrEP services where applicable. HIV negative pregnant women will be provided partner testing services once there is determination of the status of relationships, ensuring that gender-based violence services are provided as necessary and PrEP services where applicable. IPs will utilize tracking tools to monitor program success. Cotrim and INH screening will be provided to all eligible HIV positive pregnant women and necessary treatment when indicated. In addition to routine HIV services and care, cervical cancer screening services will be provided to 50% of HIV positive women age 25 to 49 attending ART clinics to receive screening by Visual Inspection of the Cervix with Acetic Acid (VIA). PEPFAR Nigeria will work with the Clinton Health Access Initiative (CHAI) in targeted states for capacity building, advocacy services and equipment for management of pre cancer lesions and refer clients who are highly predisposed to developing cancer and clients with advanced sickness to other facilities.

Health providers will ensure that all pregnant women living with HIV have at least one Viral Load test conducted before delivery in accordance with the national integrated national guidelines for HIV prevention, treatment and care as well as ensuring that 80% of these are virally suppressed. All HIV exposed infants (HEIs) are provided enhanced Post Natal Prophylaxis[16] at birth to prevent HIV and ensure that 80% of all HEIs have EID services by birth to 8 weeks post-delivery. By 12 months of age, all HEIs have EID services and identified positives are enrolled on pediatric ART. In order to ensure success, the HEIs cohort monitoring and tracking tools will be integrated into the EMR and NDR systems.

In order to improve health outcomes and deliver on the universal health coverage plan for Nigeria, the National Primary Health Care and Development Agency (NPHCDA) developed the Community Health Influencers, Promoters and Services (CHIPS) as a strategy. PEPFAR Nigeria

[16] Enhanced postnatal prophylaxis - The 2016 WHO guidance on infant prophylaxis (6) recommends that newborns at high risk of acquiring HIV should receive dual prophylaxis with AZT and NVP for the first six weeks of life followed by an additional six weeks using either AZT and NVP or NVP alone. https://www.who.int/hiv/pub/paediatric/postnatal-care-hiv-infant/en/index5.html

will work with NPHCDA and leverage on CHIPs' interventions to reach communities and households for improved delivery of PMTCT services. With the planned revitalization of ten thousand primary health centers, PEPFAR Nigeria will explore the use of point of care machines for hard to reach facilities and deploy these for EID services for HEIs. In addition, PEPFAR Nigeria will work with CHIPS to increase demand for PMTCT services integrated with other sexual reproductive, maternal and child health services.

c. Key Populations

The KP program strategy for COP20 is further pivoted to achieve community viral suppression among KPs through the 95-95-95 goal and using the One Stop Shop (OSS) strategy as the basis of service delivery. The OSS strategy is a nuanced community-oriented approach that uses a suite of mutually reinforcing HIV prevention, treatment, and care in a safe space to optimally reduce new infections among the KP populations. It rides on the community connectedness of KPs to achieve peer to peer and support strategy as a basis for service delivery.

The OSS strategy features 'Shops' that act as hubs for a broader mobile community programs that replicates services delivered in the physical 'Shops'. Services provided include HIV prevention services (social and behavior change communication programs, condoms, lubricants, pre-exposure prophylaxis, HIV testing services, STI management services, cervical cancer screening services); HIV treatment services with a focus on scale up of provision of optimized regime and TB services , differentiated models of care and Multi-Month Dispensing(MMD); HIV viral load services that includes U=U services, VL demand creation and use of Dried Blood Specimen(DBS) collection of specimen. Peer driven linkage and case management strategies using offline and online technology platforms will continue to be implemented support retention of KPs across the cascade of HIV, STI and TB services.

An overarching theme of service delivery for KPs under the OSS strategy is to ensure at a minimum, equitable utility of service delivery for both HIV-negative and positive KPs and their partners as a means of reducing stigma, discrimination and ostracization of HIV-positive KPs. In the course of service delivery, the scale up of PrEP will be prioritized among HIV-negative KPs with the aim of reducing the rate of new infections. Where possible etiologic management of STIs will be prioritized as against syndromic management such as scaling up the availability of cryotherapy services for treatment anal warts amongst others will be implemented. Individual and community level HIV communication interventions will be pivoted to improve health seeking behavior of KPs along all points of the 95-95-95 cascade. HIV testing services will feature HIV self-testing for KPs who may not be reached by traditional testing services, including leveraging on social media chat rooms and dating platforms, piloting the use of recency testing and scaling up with fidelity social network testing using redeemable coupons. HIV Testing services will align with National algorithm and continue to implement same-day initiation while efforts will be made to increase coverage of viral load services. Ancillary services including TB, cervical cancer, and prostate cancer screening; income generating activities, legal/paralegal support and other supporting services will be provided as required.

Key population groups to be targeted include Female Sex Workers (FSWs), Men-who-have-sex-with-men (MSMs), People-who-inject-drugs (PWIDs), Transgender persons (TG) and People-in-incarceration (PI). These persons will be reached with services based on a triangulation of size estimate surveys that seek to determine the population of KPs in states of interest. Where partners of KPs are identified and are willing to access services within the OSS strategy, access and utilization will be supported.

The children of KPs and adolescent KPs who are considered Orphans and Vulnerable Children (OVC) by PEPFAR definition will be mapped and identified. Accordingly, they will receive pediatric treatment services under the OSS strategy and be closely integrated into the OVC programs to support community non-health interventions. The KP program will utilize patient engagement surveys and leverage on PEPFAR-CSO platform as it concerns feedback on OSS services and client satisfaction through community led monitoring activities.

In broadening the reach of KPs beneficiaries and building sustainability of the OSS strategy, sustained government engagement, institutionalization of stakeholder community advisory teams and implementation of total market approach to leverage additional sources of funding including private sector resources for commodities and service delivery. Due to the hostile and non-permissive environment as evidenced by the Same Sex Marriage Prohibition Act and other constraints, the continuous and multi-level advocacy with government and non-government stakeholders will be prioritized. The use of tracking systems to address duplication and timely reporting such as use of biometric electronic medical systems will be implemented. However, the priority of data collection and reporting of data generated from key populations programs will be to DO NO HARM. The data generated will be managed with confidentiality to ensure the identities of the individuals are protected to prevent further stigma and discrimination of key populations. Continuous Quality improvement activities will be utilized to ensure quality of data collected and reported is achieved.

d. TB/HIV

In FY19, the goal of TB/HIV activities were to reduce the mortality of PLHIV from TB, through screening for TB among PLHIV, treatment of PLHIV diagnosed with TB and TPT for eligible PLHIV. In addition, the impact of HIV on TB patients was minimized by testing of TB patients for HIV and timely linkage of HIV infected cases to ART. PEPFAR Nigeria ensured 97% of TB patients had documented HIV status, while 93% of co-infected patients were place on ART. Over 91% of PLHIV were screened for TB with a positive screen rate of 3.5% and 5.2% among PLHIV already on ART and those new on ART respectively. Among patients with positive TB screen, 88.9% had their samples collected and tested for TB with 12.8% diagnosed with TB mostly by GeneXpert (94%). The TPT coverage stands at 60% of eligible PLHIV with TPT completion rate of 85%.
In COP20, PEPFAR Nigeria will prioritize TPT scale up with the aim of achieving a 100% TPT coverage among eligible patients. This will be achieved by sensitizing health workers on the importance of TPT and ensuring that they are involved in implementing the scale-up plan; conducting folder audit to ascertain TPT eligibility, flagging TPT-eligible clients to ensure they

are offered TPT during their next clinic visit; making TPT available through all DSD models, conducting site-level TPT performance review, reporting on progress in closing the TPT coverage gap, full procurement of isoniazid to prevent stock-outs experienced in FY19 and monitoring of treatment completion and adverse events.

Other priority areas will include sustaining timely TB diagnosis and treatment completion through TB intensified case-finding among PLHIVs, using GeneXpert, TB-LAM and chest x-rays for TB screening and diagnostic evaluation. To sustain the gains in COP 18, where 94% of all TB tests were carried out with GeneXpert machines, the program will scale up and optimize the use of GeneXpert MTB/Rif Ultra and implement the TB LF-LAM using urine samples at out-patient and in-patient units for easy and early TB diagnosis among very sick patients. The TB-LAM will complement early TB screening and will not replace GeneXpert for TB diagnosis. Furthermore, PEPFAR will sustain the gains of COP 18 by ensuring that 100% of TB patients have a documented HIV status and 100% of dually infected patients are placed on ART. It 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 TB transmission among HIV patients.

4.4. Additional country-specific priorities listed in the planning level letter

Nigeria has witnessed an unprecedented move to make services more accessible to PLHIV in the fiscal year 2019 (FY 19). The program expanded access to ART services and initiated 160,000 new PLHIV on treatment in FY 19 alone. Additionally, significant progress was made in targeted and efficient testing through the scale-up of index testing. Furthermore, the program is creating an enabling policy environment that encourages access to ART. Starting in Q2 of FY 19, through advocacy and government engagement, the governors of at least 10 high burdened states have made pronouncements eliminating all user fees that hitherto hindered access to same-day ART. However, a lot more needs to be done to further improve the quality of service delivery. The following are key programmatic issues that will be addressed in COP 20:

- Improve the quality of HIV Care and Treatment Services by ensuring client-centered care across all sites.
- Improve case finding across sites and state to achieve an overall HIV testing yield higher than NAIIS state prevalence for each state
- Increase proportion of PLHIV identified through index testing from the current 22% at FY 20 Q1 to 30% at FY 21.
- Standardize index testing across sites to reduce variability in yield from index testing across PSNUs, and improve opportunities for sharing of best practices with PSNUs with sub-optimal results
- Improve patient proxy retention rate from the OU level 96% at FY 20 Q1 to 98% at FY 21
- Establish the NDR as a trusted and definitive record of HIV services by all stakeholders and across all states.

- Optimize supply chain visibility and forecasting to better support client-centered services.

Continuous Quality Improvement (CQI) strategies pivoted on client-centered care is currently being implemented as part of PEPFAR Nigeria enhanced site management in all high-volume sites. However, starting in COP 19 quarter two (Q2), PEPFAR has begun scaling up the use of client satisfaction surveys to obtain clients perspectives on how their health care can be improved. The information obtained through such CQI processes will be utilized to refine the current strategies for case finding, improving retention and improving overall client experience at the site. In other to improve testing yield and testing uptake of index testing, health care workers will intensify discussions around the benefits of index testing during post-test counseling.

Additionally, clients will be informed about integrated health messaging and free integrated health service package which has previously helped in increasing the acceptance rate. In order to further improve uptake of index testing, experienced counselors with a track record of high uptake rates in providing index testing will be used to mentor other health workers at other sites to build the capacity of counselors. To ensure standardization of the process of index testing, health workers will also receive didactic training across all high-volume sites starting in Q2 of COP 19. Furthermore, the NDR will be used to monitor and shape efforts to improve the quality of service, retention, and continuity of treatment across PEPFAR supported sites. Additionally, the USG PEPFAR team will also work with appropriate stakeholders to optimize supply chain visibility and forecasting to better support client-centered services at all PEPFAR sites. The team will also include commodity dashboards to the current surge dashboards and periodically monitor commodity supply and consumption at the site level.

PEPFAR Nigeria has achieved major successes in the implementation of the minimum program requirements. For example, “test and start” with same-day ART initiation is being implemented across all PEPFAR supported sites. Additionally, over 95% newly identified PLHIV are linked to treatment and over 80% of all patients currently on ART are receiving a Dolutegravir (DTG) based regimen. In addition, PEPFAR supported sites are implementing various forms of differentiated service delivery models, including fast-track, four and six months, multi-months scripting, all tailored to the clients’ needs. The country is also currently on track to eliminating all user fees which serve as a barrier to accessing HIV prevention, care, and treatment services. Furthermore, PEPFAR Nigeria has consolidated its engagements with civil society, the government of Nigeria and multilateral partners, to negotiate the waiver of user fees, especially for pregnant women, children and other vulnerable populations. Moreover, PEPFAR Nigeria has made great progress in encouraging the host government to fund HIV/AIDS service delivery through the expansion of the National Health Insurance Scheme, the private sector trust fund and the National Treatment Program launched in 2018.

Figure 4.4.1, summaries PEPFAR Nigeria's progress towards achieving the minimum program requirements. The figure shows that PEPFAR Nigeria has made significant progress towards

implementing nearly all MPRs. In COP 20, in addition to the MPRs already being implemented, PEPFAR Nigeria will be focusing on three pending MPRs, expanding self-testing, PrEP for the high-risk general population and scaling up the use of unique identifiers at all supported sites.

	S/No	Minimum Program Requirements	COP19 Status	COP20 Status
Care and Treatment	1	Test & Start	Completed	Completed
	2	Linkage >95%	In-Progress	Completed
	3	TLD transition and ARV regimen optimization (including DTG for children >20kg)	In-Progress	Completed
	4	Differentiated Service Delivery and Multi-Month Scripting	In-Progress	Completed
	5	TB Preventive Therapy scale-up	In-Progress	Completed
	6	VL/EID Optimization	In-Progress	Completed
Case Finding	1	Index testing, and Enhanced Pediatric + Adolescent Case Finding	In-Progress	Completed
	2	Self-Testing	Yet-to-Commence	In-Progress
Prevention and OVC	1	PrEP for KP and other high-risk population	Yet-to-Commence	Completed
	2	Alignment of OVC Program to CLHIV & 9-14 year old	In-Progress	Completed
Policy & Public Health Systems Support	1	Elimination of User Fees	Yet-to-Commence	In-Progress
	2	Integrating CQI practices into site and program management	In-Progress	Completed
	3	U=U and other literacy activities	Yet-to-Commence	Completed
	4	Clear evidence of agency progress toward local, indigenous partner direct funding.	In-Progress	Completed
	5	Host government demonstrating greater responsibility for the HIV response	In-Progress	In-Progress
	6	Monitoring morbidity/mortality outcomes	In-Progress	Completed
	7	Unique identifier and EMR	In-Progress	In-Progress

Figure 4.4.1: Progress towards achieving the Minimal Program Requirements

4.5. Commodities and Supply Chain Systems

Nigeria implements a pooled procurement system for HIV/AIDS drugs and commodities used in the country. This system includes commodity investments by PEPFAR, the Global Fund, and the Federal Government-funded program in Abia and Taraba. COP20 commodity investment will be aligned between these three major stakeholders with the Global Fund increasing her investment by $60 million while the GON will also invest an additional $16 million for commodities for 100,000 additional patient's and maintain that number of patients. PEPFAR's commodity

investment will ensure commodity availability for the PEPFAR program in Nigeria, hence there will be limited concern for stock-outs during the FY.

PEPFAR doesn't envision any commodity shortages in FY2021, however there may be stock challenges at the beginning of the next FY if COP funding isn't received early enough to place orders for commodities. This is due to the lean inventory which has reduced buffer stock in-country from 6 months of stock to less than two months of stock for most commodities.

Health system strengthening investments in supply chain include a robust National Health Logistics Information Management System which is integrated across the disease areas with bi-monthly reporting of data on HIV, Malaria and Family Planning commodity utilization. This was a joint investment with the Global Fund, UNFPA, PMI and USAID Family Planning Program. There are plans to include TB logistics data on the platform within the current FY. This investment will also be expanded to improve diagnostics and data triangulation with treatment data in the NDR going forward.

PEPFAR and these stakeholders will complete the process of completing the implementation of the private sector management of the GON central pharmaceutical warehouses in Lagos and Abuja under GON coordination. This will ensure efficient operation of the warehouses and sustainability going forward.
PEPFAR will also be working with these stakeholders (Global Fund, UNFPA, PMI and USAID FP) to support the development of an electronic database of essential medicines in the country to serve as a data backbone for the implementation of end-to-end traceability of commodities using barcode technology for supply chain efficiency.

PEPFAR Nigeria team plans to implement client – centered supply chain by conducting accurate and complete forecasting with consideration to patient months of stock, buffer stock, expiry, warehousing, distribution chain, lead time for delivery to point of service and stock outs.

The program will strengthen supply chain data availability, visibility and use through granular level reporting of commodity data. This will include the tracking and reporting of supply chain MER indicators which started in FY20, this will ultimately improve the management of HIV product inventory, optimize TLD transition and PEPFAR Nigeria MMD implementation.

4.6. Collaboration, Integration and Monitoring – The National Alignment Plan

PEPFAR and the Global Fund together fund 94% (78% PEPFAR; 16% Global Fund) of the national HIV treatment program and have shared responsibility along with the Government of Nigeria for HIV service delivery all the 36+1 states. The three partners have had some success in the past with attempts to improve program efficiency by reducing the risk of duplication by clearly delineating (rationalizing) States to be supported by different partners (especially for KP programming).

Despite this, challenges persist with parallel programming and use of different service packages with varying levels of quality. The variation in planning cycles for the PEPFAR COP, the Global Fund concept Note and the Government of Nigeria annual budget process has challenges with effecting new approaches and decisions mid-implementation leading to off-cycle unplanned major shifts which have resulted in high transactional costs relating to site-level transitions and delays in implementation.

The COP20 and the Global Fund 2021-2023 planning cycles are occurring simultaneously for the first time and presents an opportunity for joint planning and better alignment. The GoN, PEPFAR and the Global Fund have seized this opportunity to unite behind a national plan to align the HIV programs and to systematically address long-standing challenges experienced with parallel programming. The cornerstone of the PEPFAR Nigeria COP20 strategy is the alignment of Global Fund and PEPFAR support behind a national strategy led by the Government of Nigeria.

The primary objective is to maximize the HIV coverage in Nigeria by 2023 behind a Government of Nigeria-led national strategy, aligning Global Fund and PEPFAR financing and generating synergies across all programs. Additionally, the alignment would achieve a single 'version of truth' by having access to data across the national program and joint reviews to use the data to course correct and accelerate results.

PEPFAR	Global Fund	GoN
• Proximity to program implementation and capacity for oversight and technical support • Investments in, availability and use of data and review processes for evidence-based decision-making • Quality of service delivery with ESM and CQI regularly	• Fund gaps, HIV prevention, harm reduction • Allow greater focus by Global Fund on TB and malaria • Leverage RSSH investments to boost HIV investments (e.g. community monitoring, supply chain, HMIS-LMIS interoperability)	• Increase and maintain financial contributions to HIV as required in allocation letter • Strengthen state-level engagement: user fees, policy barriers • Strengthen Government leadership and ownership for long term sustainability as part of the national treatment and prevention program
• Joint advantages created by this approach: • A unified investment strategy presents the opportunity to advocate together at the highest levels in order to address bottlenecks and political challenges as they arise on the portfolio. • Demonstrate joint investment for impact		Increased Government capacity on data governance and performance management of the HIV response towards long term impact.

Figure 4.6.1: Comparative advantages of each institution informed the proposed alignment

For the first time, the three partners (GoN, PEPFAR, GF) will use a common target and performance framework which will reflect the contributions of the three partners to program target and financing. Procurement of commodities to meet national targets will be set and shared between the three partners and all parties will have real-time access to all data and jointly decide on investments (reprograming and performance management). This approach for COP20 highlights another key advantage and opportunity for efficiency as both the Global Fund and PEPFAR fund the same institutions in Nigeria. As donors, we are limited in our ability to achieve synergies because of this structure. The alignment allows donors to integrate new partnerships into a national program using comparative advantage and strength of each institution to inform the alignment.

A team made up of representatives from PEPFAR, GoN, GF/FHI360, multilateral partners and other stakeholders including NEPWHAN, has been constituted to oversee the alignment process. The alignment process will be implemented in 2 phases beginning in April 1 and November 30, 2020. The first stage will focus on the standardization of service packages and harmonization of data elements and data management systems and while the second phase will involve the transitioning of sites between partners.

Service Package Standardization will include the review and development of standard package of treatment services including standard operating procedures (SoP) for use across all facilities in the country. This will ensure uniformity and quality of service packages across board.
Data systems harmonization will ensure aligned EMR infrastructure and seamless onboarding to the National Data Repository (NDR). Data validation will include a 28-day definition for LFTU to establish a uniform validation of the number of PLHIV in sites across the country.
All sites transition is planned to be completed by November 30, 2020.

4.7 Advanced HIV Disease Management and CD4 assay

Historically, CD4 assay played a significant role in determining ART eligibility using immunological criteria and in defining treatment success. However, in the past few years with widespread access to viral load assays which is the gold standard for treatment monitoring coupled with test and start policy, CD4 cell assay not required for monitoring patients on ART nor determination of ART eligibility. However, CD4 cell assay continues to have a role in determining which patients newly diagnosed as HIV positive has advanced HIV disease (AHD) and therefore benefit from further investigations to rule out opportunistic infections before commencing them on ART to ensure a better outcome.

Based on WHO criteria, HIV positive adults and children aged greater than five years, with a CD4 count of less -than 200 cells/mm3 or a WHO clinical stage 3 or 4 diseases at the time of presentation and all HIV positive children aged less than five years will be considered as AHD. In line with best practices, PEPFAR Nigeria will provide access to CD4 count tests to newly diagnosed HIV positive patients to aid the diagnosis of patients with AHD. The CD4 count test will be done onsite or through sample referral to laboratories within the National Integrated

Sample Referral Network (NISRN). To address the leading causes of morbidity and mortality which include severe bacterial infections, cryptococcal meningitis, and cerebral toxoplasmosis among patients with AHD, the World Health Organization (WHO) recommended a package of interventions for screening, treatment and/or prophylaxis for major opportunistic infections. These include the use of co-trimoxazole prophylaxis and TB preventive treatment. PEPFAR Nigeria will ensure access to CPT and TBT to all patients with AHD.

Furthermore, WHO also recommends using Gene Xpert MTB/RIF for TB diagnosis among symptomatic patients, and use of the lateral flow lipoarabinomannan (LF-LAM) antigen test for people with symptoms suggesting TB and who have a CD4 count less than 100 cells/mm3 and cryptococcal antigen screening in patients with CD4 cell count less than 100, in addition to pre-emptive antifungal treatment for those with positive blood cryptococcal antigen. In Cop 20, in line with WHO recommendations, PEPFAR Nigeria will ensure that Patients with AHD have access to screening for cryptococcal disease using cryptococcal antigen (CrAg) tests (plus anti-fungal treatment) and screening for active TB using Gene Xpert or urinary TB Lipoarabinomannan (LAM) test as appropriate. Planning for COP 20, procurements for requirements for patients with AHD was based on program data which suggested that at the OU level, about 25% of patients at ART enrollment have AHD.

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. Cervical cancer screening and treatment services are available in some PEPFAR supported health facilities across Nigeria as part of Reproductive, Maternal, Newborn and Child Health (RMNCH) services. Screening for cervical cancer just like other forms of cancer is largely funded by clients directly as part of out of pocket expense for healthcare services. Current efforts to ensure increased access to screening and utilization of treatment services are poorly coordinated, expensive and the proportion of HIV positive women among beneficiaries cannot be ascertained due to weak reporting systems.

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. In COP 19, forty-seven ART sites located in the surge, red states and high-volume ART sites across Nigeria are implementing cervical cancer screening using VIA and have capacity for thermos-coagulation for identified women living with HIV between 25 and 49 years. The lessons learnt from these demonstration sites will be scaled-up in COP 20. In COP20, selected high volume ART sites will receive support for cervical cancer intervention using the screen-and-treat approach. Service delivery will be by Visual Inspection with Acetic (VIA) acid and treatment for precancerous lesions will be using cryotherapy or thermal ablation. Women having initial VIA negative screening result will have opportunity for every-other-year rescreening, thus assisting in the reduction of loss to follow-up among PLHIVs. This service will

be targeted to all HIV positive women at time of diagnosis and as part of care and support services. In addition, one to two sites per state will receive funding to provide Loop electrosurgical excision procedure (LEEP) services for women with cryotherapy-ineligible lesions. A referral network will be established between LEEP supported sites and all sites providing cervical cancer screening using VIA. Scaling up this life saving intervention will require additional skills by the ART service providers and thus capacity building will be provided to health care workers to perform the VIA. 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. The developed electronic master facility list will be leveraged to facilitate linkage to treatment of patients identified positive lesion for further management. A cervical cancer referral coordinator, whose main role is to ensure that all referrals are completed and reported, will be identified for each site.

In COP 20, PEPFAR Nigeria has budgeted $200,000 for cervical cancer screening and this will include the procurement of Human Papilloma Virus (HPV) screening kits.

PEPFAR is collaborating and will be leveraging from Clinton Health Access Initiative's (CHAI) support for cervical cancer screening and treatment program (provision of thermo-coagulators) in three CHAI's focus states of Lagos, Rivers and Kaduna. PEPFAR Nigeria is working with CHAI and other stakeholders to engage GoN on updating the cervical cancer-training curriculum, data collection tools and reactivation of the cancer TWG. The National Primary Health Care Development Agency (NPHCDA) is also considering inclusion of HPV vaccination into routine immunizations schedule for the country and have submitted a proposal to GAVI for its inclusion.

4.9 Viral Load and Early Infant Diagnosis Optimization

The country program has continued to scale-up Viral load and EID testing across all HIV treatment and PMTCT sites in all states of the Federation using the optimized network of PCR laboratories and sample referral system. As a result of these efforts, viral load coverage increased from 55% to 80% by the end of FY19.

To facilitate the scale-up of viral load and EID testing efforts, the country program completed a Diagnostics Network Optimization (DNO) for viral load and EID in FY19. Six Mega PCR labs have been identified as the hubs for the Lab network, increasing the testing capacity to a atleast **1,500,000** tests annually.

The completed optimized network currently covers all (100%) of ART/PMTCT sites supported by PEPFAR, Global Fund, AIDS Healthcare Foundation (AHF), and GON. The National Integrated Sample Referral Network (NISRN) has been reviewed and updated, and currently supports VL/EID sample referrals and return of test results from about 2,797 facilities across the country, and provides VL/EID access to 100% of patients served nationwide including priority populations.

The sample referral network also includes One-Stop-Shops (OSS) that primarily serve the needs of key populations (KP). To fully address the needs of this population, the use of Dried Blood Spot (DBS) for VL is being expanded in FY20 to make sample collection in communities, outside the conventional health facility settings, less challenging. For other priority populations (mainly HIV+ pregnant women and their HIV-exposed infants), a standardized monitoring and tracking tool will be developed and deployed for use by all facilities to ensure that VL coverage and service uptake by pregnant and breastfeeding women are adequately monitored and documented based on defined clinical cascade. The Operation Triple Zero (OTZ) strategy aims to achieve the same objectives for children and adolescents.

The country program is leveraging UNITAID funding through CHAI, to roll-out (in COP19) the use of Point-of-Care/Near Point-of-Care (POC/N-POC) – GeneXpert Instruments, for EID testing to complement the EID testing within the Optimized Network in order to further reduce the testing Turn-Around-Time (TAT) for EID and increase EID service uptake, as well as further strengthen TB/HIV collaboration with regards to instrument optimization.

All but one of the PCR Laboratories on the Optimized Network are linked to the Web-based National Laboratory Information Management System (LIMS). Planned enhancement of the LIMS in COP19/20 will enable health facilities to remotely log-in samples to the LIMS and download results when test is completed. These are aimed at decreasing the TAT for VL as well as EID tests. The ongoing linkage of the LIMS with the EMR/NDR, will ensure that VL/EID results are uploaded to the patient's records and are available for the care team to use in making clinical decisions when completed.

To ensure consistent and accurate tracking of samples shipped through the referral network, and end-to-end monitoring and tracking of sample TAT, an electronic system for tracking of sample movement and results return to health facilities, turnaround time and sample rejection rate, is being rolled-out to facilitate this process.

In COP20, the country program is focused on sustaining implementation with fidelity and at scale, the best practices and interventions that contributed to the increased coverage as the program continues to target a viral load coverage of at least 95% for all populations served, including priority populations, at all supported sites in FY20 and moving forward.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

A. AFRICOS - is a multi-country, multi-year cohort study managed by DOD. It is in the seventh year of implementation across Kenya, Tanzania, Uganda and Nigeria. Study outputs have resulted in more than 80 publications and presentations since inception, and informed programming decisions to improve the quality of patient care. A prospective cohort study, it has enrolled 3,503 patients (comprising of 2,918 HIV positive patients and 585 HIV negative participants as at September 1, 2019) 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 is evaluating 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. The AFRICOS protocol was amended in October 2019 to increase the cohort from 3,500 to 4,200 including youth cohort of adolescents aged 15 years and above to study HIV dynamics specific to this population. In COP 20, Nigeria's participants' enrollment target was increased 500 to 550 participants. The Cohort will provide useful information regarding morbidity and mortality monitoring, effect of TLD transition on clinical outcome and understanding of persistent low-level viremia among other variable being monitored. This will guide our understanding of the disease progression to formulate policies that will improve clinical outcome.

B. CSO Oversight, Monitoring and Engagement Plan – PEPFAR's collaboration with the CSO community will be greatly expanded in COP20. In line with S/GAC's guidance to support local Civil Society Organizations in the conduct of oversight activities especially at the level of the service providers and the implementing partners, $1 million of COP funding has been set aside to support the rollout of Community-Led Monitoring (CLM) activities, the scale-up of the Community components of the U=U campaign which was launched in FY20. Other activities to be supported include patient education and empowerment activities such as the development and dissemination of appropriate culture-sensitive messaging for service providers and patients on client retention, self-care and the mitigation of HIV-related stigma and discrimination.

C. Ambassador's Small Grants - The United States Ambassador's Small Grants program (ASG) provides one-time small grants to community development programs that improve the socio-economic wellbeing and/or health of the community. The ASG Program is designed to support communities help themselves. Funding under the ASG Program is largely provided by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and by the U.S. Department of State, Africa Bureau's Ambassador's Special Self-Help (ASSH) Program.

A budget of $300,000 has been set aside in COP20 to support projects in three categories: projects that target care for children orphaned by HIV/AIDS and other vulnerable children, projects that promote human rights for key populations, and projects that support community development in the larger community.

D. National Integrated Sample Referral Network (NISRN)- currently transfers Viral Load, EID, CD4 and TB samples from about 2,752 HIV treatment sites, 4,500 TB DOTS sites/patent medicine vendors. The number of laboratory samples processed by the reference labs increased by more than 700% following the implementation of NiSRN using local third-party logistics agents to ensure its sustainability. In COP 20, this activity will continue to support all partners to pick up lab samples and deliver to Laboratories within the optimized laboratory network.

While the NiSRN has been successful in minimizing delays in sample pick -up and the return of results, prolonged processing time due to paper-based documentation in the reference laboratories is still a major constraint. The impact of the paper-based system on the turn-around-time (TAT) for return of patient results to patient folders has been identified as a major challenge to viral load uptake and the improvement in viral suppression.

In COP 20, NiSRN plans to implement an electronic system to track sample movement and results return to health facilities, measure turnaround time and sample rejection rates. This is of utmost importance considering the high volume of samples and results being moved by NiSRN to ensure end to end visibility for client samples and results.

E. Domestic Resource Mobilization and Tracking - HIV user fee elimination and domestic resource mobilization is a COP19 minimum program priority. To this end, PEPFAR supported an HIV user fee survey in the surge states of Rivers, Akwa Ibom, Lagos in addition to Kano. This provided a snapshot quantification to the user fee challenge. The key findings have informed policy advocacy for the elimination of user fee, especially at the SNU level. As at date, a total of 7 states have declared user fees elimination for HIV-related services in public facilities.

PEPFAR is also supporting a review of the National Health Insurance policy framework for an inclusion of HIV services within the benefit package. The technical work has been performed and a blueprint to guide implementation drafted for ratification by the National Council on Health.

At State level, Lagos and Kano are currently receiving technical assistance to develop and implement a roadmap for integration of HIV into State Health insurance benefit package. Currently, a priority is a review/update of the actuarial analysis to inform this integration.

This structural and strategic approach to drive domestic resource mobilization is considered more sustainable. This is based on lessons learned from intervention targeted at only achieving increases to budgetary allocation, releases and utilization for HIV/Health. The states will be supported to implement the roadmap and commence HIV service provision through health insurance within the current year.

In COP20, PEPFAR will also be supporting efforts to improve government expenditures on HIV through public budgets. A public finance management landscape analysis conducted in both states identified challenges with government spending on HIV and evidence generated is being used to advocate for increased government expenditure. Resultantly, Kano achieved a 28% release (NGN 88,494,380) in 2019, compared to 10% in 2018, with a 25% budget increase in 2020(NGN392,600,000). Currently a memo of NGN100,000,000 is awaiting approval for HIV control activities.

In Lagos state, a 2020 budget increase of 28% was achieved (NGN637,517,642), and 46% budget expenditure was achieved in 2019 (N228,367,750). Sustained efforts are ongoing to ensure that these funds are released and expended towards improving government budget execution on HIV. Effort is currently focus on monitoring utilization at facility level.

F. Nigeria AIDS Indicator and Impact Survey (NAIIS) – Following the completion of data collection activities in all states and the Presidential announcement of NAIIS results in 2018, NAIIS national and state summary sheets were developed and disseminated. In 2019, laboratory testing for biomarkers such as viral load, Hepatitis B, Hepatitis C infection, HIV drug resistant and presence of antiretroviral drug metabolites will be completed just as the staff at the National Reference Laboratory are receiving training to manage the stored samples in the biorepository lab which was also set-up with Survey funds. Data analysis and validated has been completed and the draft technical report is currently undergoing review and before it is cleared for dissemination.

With COP20 funds ($528,243), the biorepository sample management system will be upgraded to international standards to enhance quality assurance in the storage and retrieval of samples for further testing.

G. National Data Repository (NDR)/HMIS activity - The National Data Repository (NDR) now has de-duplicated patient-level data for more than 82% of people living with HIV receiving treatment in PEPFAR-supported facilities. PEPFAR reports the MER Treatment indicators for over 50% of its supported patients directly from the NDR through flat files generated for DATIM import while National HIV program can track treatment outcomes and other clinical assessments at patient level. Patients biometric solution (PBS) devices were introduced and fingerprint data capture is ongoing across PEPFAR sites.

In COP20, fingerprint capture shall be scaled up to 100% of PEPFAR supported patients. This will support further de-duplication of patients in treatment across the country as well as track patients self-transferring to other facilities without adequate documentation. With the fingerprint data, facilities that appeared to have lost patients due to self-transfers can be informed appropriately and retention efforts can be targeted. Also, the National Data Repository (NDR) infrastructure will be enhanced to continue to support the growing data demand and data role the program intensively requires. It would be sustained as an integrated near real-time platform for program monitoring of the entire HIV cascade. Models will be built around the data on the NDR to predict clients who have potentials to be LTFU. This will guide patient-specific

interventions to prevent clients from getting lost to follow up. The program will also track case-based surveillance and continue monitoring program outcomes.

The Nigeria OVC Management Information System (NOMIS) platform will be integrated with the NDR to ensure quality socio-economic services delivered to vulnerable children translates into ensuring adherence to treatment, retention in treatment and virologic suppression.

Similarly, the Laboratory Information Management System (LIMS) will be enhanced to remotely link with Electronic Medical Records (EMR) in health facilities. This will improve efficiencies within the laboratory, facilitate electronic return of viral load results to the EMR, shorten the turn-around-time of results from PCR labs to the facilities and enhance patient care and clinical decision. Viral load and EID will be logged remotely at the facilities in the EMR for tests at the PCR labs. This remote sample logging will reduce processing time at the PCR lab.

H. National Data Repository (NDR)/Recency Infection Surveillance - In COP19, HIV Recent Infection Surveillance was funded through ICAP and UMB. ICAP had CDC HQ direct funding of $2.2M to implement Recency surveillance in Nigeria. ICAP is supporting implementation in five Surge states namely Akwa Ibom (USAID), Benue (CDC), FCT (CDC), Lagos (USAID and CDC), and Rivers (CDC); in addition to military facilities supported by DOD across these states. While, UMB is supporting implementation in Cross River (USAID), Enugu (CDC) and Nasarawa (CDC) states and the military facilities supported by DoD. The COP19 total recency target in the 8 surge states is 64,820 which represents 30% of HTS_TST_POS targets in the states. Implementation is being carried out through existing comprehensive partners supporting the states.

In COP20, the proposal is to increase the number of states to 9 by including Kano (USAID). The number of sites will be scaled up to 175. Recency testing targets in COP20 is 36,854 representing 30% of the HTS_TST_POS target of 122,473. Implementation will continue through the comprehensive partners. The proposed COP budget is $359,000. No other source of funding has been identified to support Recent Infection Surveillance in COP20.

6.0 Operations and Staffing Plan to Achieve Stated Goals

USAID

In COP19, USAID increased support to technical and program management through procurement, human resource and financial management to allow USAID to efficiently manage the program going forward. In COP20, the team will operate within the overall staffing structure to continue to support the management burden.

All vacant positions (2 FSO, 2 USPSC, and 6 FSN) are currently at different levels of recruitment processes. Three of the six FSN vacant positions (Project Management Specialists, Lab/Supply Chain, Domestic Resource Mobilization and Testing/Linkages) have been filled by HR and have assumed duty. All other positions in clearance process are expected to be filled by Q4 of FY 20.

In COP20, USAID proposes one new local staff position (Driver) to support the frequent travels for enhanced site management in the surge state.

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 FY19. SIMS data is reviewed to show quality improvement in surge states and help in focusing on retention of ART clients. Findings from SIMS data also help in documenting and showcasing success stories, innovations and areas requiring remediation to ensure high quality of HIV services within the system.

In FY20, the third-party contractor continued to reinforce its strategies in communicating and presenting SIMS assessment results to USAID Implementing Partners through written responses and corrective actions to address SIMS assessment findings. USAID reviews the third-party contractor quarterly planned schedules, prioritizing SIMS assessments for high volume sites and sites that need focused quality improvement.

In FY21, USAID will continue to focus SIMS visits to sites with much higher volume of clients. 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 within the yellow and red states.

The 2% increase in overall USAID's CODB in COP20 is mainly due to the one new local staff position, increased program travel because of the surge and the full engagement of the FSL positions. USAID also plans to continue to utilize the institutional contractors for SIMS and enhanced partner management activities in COP20.

CDC

CDC Nigeria works closely with other Mission offices ensuring compliance with existing procedures. This includes coordination with the relevant Mission offices for official travel, on and offsite events, visitor management, front office approvals, etc. CDC also ensures close

collaboration with other PEPFAR agencies for joint activities, including regular meetings and ad-hoc meetings for specific tasks. There is close coordination within CDC between the Partner Management Team (PMT), technical Project Officers (POs)/Lead Activity Managers (LAMs), and the CDC finance team. This close coordination ensures synergy and focus, for effective management of Cooperative Agreements. While the POs and LAMs provide technical oversight to the grantees' program activities, the finance and PMT teams provide oversight for grant and financial compliance. The joint efforts of the teams ensure effective partner implementation and grant management of agency funded PEPFAR activities carried out by CDC implementing partners in Nigeria.

All CDC Nigeria's technical staff are included in SIMS activities and follow pre planned schedules coordinated by the Health Informatics and Health Systems team. Each SIMS team consists of a mix of staff from different program areas to ensure programmatic balance and insight during the visits. CDC Nigeria is currently supporting scale-up of access to HIV Care and Treatment services in 9 states (Rivers, Enugu, Lagos, Imo, Delta, Benue, Gombe, FCT, and Nasarawa). The approach currently being used is the Enhanced Site Management (ESM). The ESM requires more intensified support and collaboration between State Government staff, implementation partner, facility staff and CDC staff, and requires increased granularity, deep dives of site level data, continuous quality improvement projects, periodic client satisfaction surveys, weekly ECHO video conferencing sessions with site staff ,and weekly feedback on performance to partners and sites. The ESM will coordinate with the SIMS activities not to duplicate efforts.

As CDC increases case finding and initiates more patients on antiretroviral drugs, we are faced with an increasing need for improved accountability of utilization of HIV rapid test kits, laboratory commodities, consumption of antiretroviral medications; and improved quantification for HIV rapid test kits, laboratory reagents, and antiretroviral medication at state, regional and national levels. To meet current and future strategic goals, CDC's management reviewed its program priorities, assessed its current staffing mix based on those priorities and identified the need to have a full-time Supply Chain Management Specialist as part of the Care and Treatment team. To this end, CDC is repurposing an existing vacant LES position from Public Health Administrative Specialist to a Senior Program Specialist, Supply Chain Management position. The current staffing complement of the PMT is adequate to provide effective administrative oversight of CDC awards.

CDC has two vacant positions that have been vacant for more than six months – the Prevention Specialist (reported in COP19) and the OVC Specialist (vacated in May 2019). Discussions are currently ongoing on how best to utilize existing vacant Prevention position to meet strategic program needs. CDC is currently in the process of filling the OVC Specialist position, position is expected to be filled by Q3 of FY20. Other vacant positions reported in COP19 have been filled.

The 9 states that CDC currently supports using ESM approach have witnessed improvements in performance in nearly all indices. However, we have observed poor performance and attrition in our yellow states, suggesting that a similar level of intensified support is needed. The current CDC

staff strength has been stretched to its limits to allow the intensity of support needed for the 9 rapid scale-up states, therefore to enable CDC strengthen support to the remaining 10 CDC supported yellow states (Kaduna, Ebonyi, Plateau, Kogi, Katsina, Ondo, Oyo, Ogun, Ekiti, and Osun states), CDC is adding two new HIV Treatment Specialists positions to support the ESM and Surge strategies. These positions will serve as Operations Chiefs and will monitor and coordinate surge activities with CDC partners in their assigned states.

DOD

Major changes on DOD COP20 CODB comprises of proposed plan for the purchase of additional Government Armored Vehicles (3units) to replace aging vehicles that have been subjected to long distance interstate trips across different sites in Nigeria. In COP 20, it is anticipated that the cost of travels will increase across all sites in the country to support HIV case finding, retention and viral suppression.

DoD team's staffing analysis shows the need to close identified gaps and strengthen the ability of the agency to improve case finding and retention in COP 20. As part of COP20 staffing analysis, the assessment covered routine and emergency business processes, partner management, and technical support and leadership. With the continued surge strategy, and enhanced site management (ESM), there is need to fill the approved COP 19 positions as quickly as possible. These positions are 1 NSDD-38 and 4 LES positions that will ensure improvement in retention, weekly data analysis and review and ensuring un-interrupted supply of commodities to the sites. The four LES positions are:

- Continuous Quality Improvement (CQI)
- Monitoring and Evaluation
- Supply Chain Management (PSM)
- HIV counselling and Testing

There is delay in DoD's HQ approval to recruit the position in country, however DOD's DP is working to ensure quick approval.

APPENDIX A

Continuous Nature of SNU Prioritization to Reach Epidemic Control

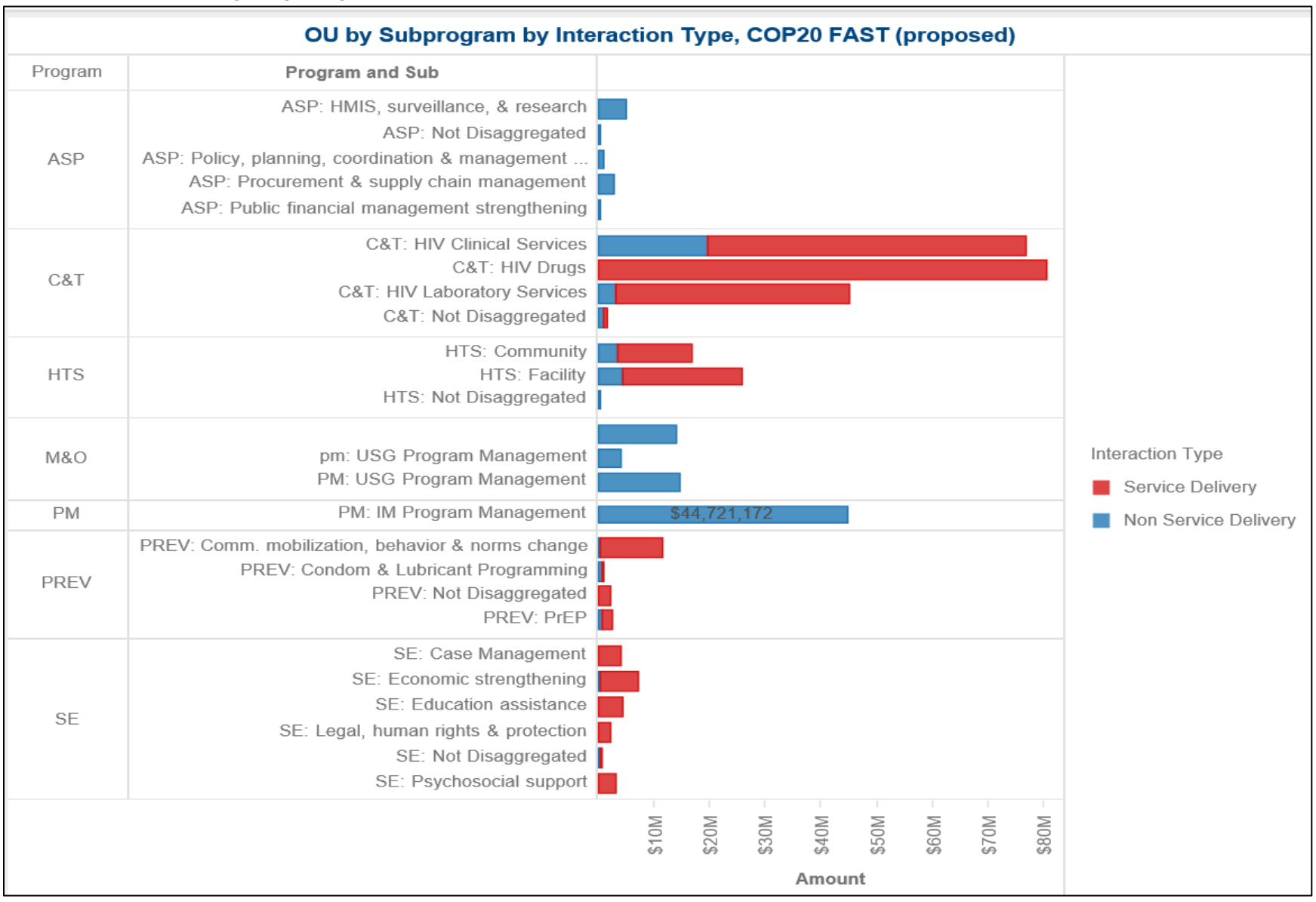
Table A.1

	State	<1		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
		Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
Surge	Akwa Ibom	79%	80%	193%	172%	195%	180%	98%	66%	119%	40%	180%	42%	75%	58%	102%	70%	72%	79%	77%	102%	89%	111%	79%	69%
	Rivers	17%	17%	112%	107%	98%	89%	111%	104%	44%	53%	109%	93%	94%	85%	121%	61%	78%	101%	88%	102%	76%	122%	63%	75%
Red States	Abia			32%	34%	76%	77%	38%	39%	14%	29%	20%	18%	35%	17%	51%	27%	63%	38%	73%	49%	79%	56%	82%	64%
	Delta	0%		56%	53%	58%	60%	72%	94%	42%	53%	51%	39%	85%	43%	142%	53%	155%	85%	216%	184%	103%	89%	107%	153%
	Enugu	16%	17%	59%	51%	121%	122%	82%	88%	37%	59%	37%	31%	58%	27%	82%	34%	98%	53%	125%	87%	107%	76%	110%	86%
	Imo	4%	4%	26%	25%	72%	74%	46%	52%	32%	39%	31%	26%	45%	30%	63%	39%	74%	50%	93%	70%	92%	73%	97%	104%
	Lagos	13%	13%	36%	33%	37%	38%	42%	42%	31%	49%	63%	58%	81%	88%	100%	85%	106%	96%	125%	129%	98%	99%	234%	106%
Green States	Benue	128%		232%	175%	190%	187%	153%	151%	85%	61%	154%	40%	201%	49%	231%	61%	185%	71%	119%	81%	172%	87%	122%	92%
	Gombe	0%		81%	70%	93%	94%	53%	55%	102%	81%	251%	88%	259%	117%	215%	154%	140%	149%	149%	233%	108%	100%	108%	101%
	Nasarawa	80%	81%	162%	132%	81%	82%	72%	73%	101%	106%	144%	102%	215%	105%	222%	107%	165%	109%	167%	143%	110%	110%	110%	110%
Yellow States	Adamawa	40%	40%	215%	193%	161%	145%	149%	130%	126%	93%	232%	69%	266%	157%	310%	144%	275%	160%	164%	139%	188%	152%	124%	119%
	Bauchi			86%	80%	111%	111%	87%	84%	106%	73%	198%	66%	190%	111%	213%	94%	181%	95%	115%	87%	116%	91%	116%	101%
	Bayelsa	26%	27%	29%	30%	30%	31%	22%	22%	56%	48%	71%	31%	83%	34%	91%	37%	98%	45%	103%	56%	107%	66%	108%	78%
	Borno	21%	21%	22%	`	23%	24%	23%	22%	11%	8%	30%	15%	54%	23%	71%	36%	82%	55%	90%	74%	94%	86%	89%	95%
	Cross River	50%	51%	65%	60%	82%	83%	94%	77%	145%	91%	209%	104%	193%	128%	168%	96%	162%	100%	116%	103%	165%	140%	118%	119%
	Edo	24%	25%	36%	37%	56%	58%	68%	66%	63%	62%	69%	40%	91%	39%	116%	51%	127%	70%	137%	91%	142%	109%	145%	122%
	Ekiti	29%	31%	34%	35%	45%	46%	36%	42%	24%	23%	25%	16%	39%	15%	52%	22%	64%	30%	74%	47%			82%	55%
	FCT	51%	51%	204%	192%	127%	119%	112%	126%	95%	99%	150%	104%	276%	108%	309%	121%	223%	131%	247%	225%	111%	111%	110%	164%
	Jigawa	96%	100%	95%	87%	73%	74%	80%	82%	130%	57%	200%	50%	149%	94%	166%	76%	149%	96%	115%	97%	118%	99%	121%	99%
	Kaduna			96%	96%	104%	105%	96%	96%	75%	32%	131%	16%	228%	33%	299%	59%	240%	75%	117%	85%	127%	103%	103%	152%
	Kano	94%	95%	74%	75%	84%	86%	75%	79%	58%	47%	109%	45%	132%	86%	143%	65%	121%	76%	109%	74%	114%	88%	117%	100%
	Katsina	100%	97%	77%	78%	119%	119%	62%	72%	91%	55%	106%	54%	124%	54%	121%	65%	128%	81%	133%	100%			136%	120%
	Kebbi	49%	46%	32%	31%	56%	58%	39%	41%	33%	49%	87%	48%	90%	61%	106%	75%	117%	95%	125%	112%	128%	123%	127%	129%
	Kogi	0%		93%	80%	76%	77%	71%	73%	59%	48%	90%	60%	100%	195%	115%	208%	114%	109%	168%	120%	101%		103%	48%
	Kwara	30%	30%	61%	56%	78%	78%	57%	60%	32%	39%	42%	49%	75%	100%	98%	46%	98%	38%	91%	31%	94%	37%	113%	53%
	Niger	64%	60%	168%	153%	129%	119%	79%	86%	75%	76%	78%	66%	187%	77%	190%	71%	163%	81%	114%	90%	119%	96%	162%	122%
	Ogun	35%	36%	86%	87%	74%	75%	71%	71%	43%	45%	47%	29%	67%	33%	87%	41%	103%	55%	133%	89%			129%	101%
	Ondo	27%	28%	37%	38%	56%	57%	39%	38%	31%	25%	32%	22%	53%	17%	79%	23%	83%	31%	113%	85%			76%	59%
	Osun	61%	62%	65%	66%	63%	65%	56%	57%	32%	35%	36%	27%	48%	30%	60%	34%	73%	41%	93%	49%			101%	68%
	Oyo	25%	27%	67%	65%	94%	96%	72%	78%	51%	23%	79%	21%	96%	28%	107%	42%	115%	56%	182%	84%	117%	71%	123%	211%
	Plateau	59%	59%	35%	35%	57%	58%	36%	37%	80%	95%	101%	99%	106%	104%	107%	106%	107%	106%	201%	257%	107%	106%	446%	380%
	Sokoto			65%	62%	119%	119%	145%	171%	32%	23%	77%	54%	108%	89%	147%	105%	146%	113%	112%	117%	117%	140%	111%	263%
	Taraba	126%	127%	90%	92%	101%	102%	70%	71%	156%	116%	153%	107%	161%	102%	165%	111%	167%	125%	168%	138%	168%	147%	169%	155%
	Yobe					106%	109%	57%	58%	73%	112%	118%	155%	92%	291%	117%	136%	128%	100%	124%	130%	127%	147%	128%	159%
	Zamfara	28%	28%	27%	28%	33%	34%	22%	18%	47%	55%	52%	109%	66%	154%	82%	161%	96%	137%	108%	90%	115%	78%	121%	93%

Legend
<70%
71%-79%
80%-89%
>90%

APPENDIX B – BUDGET PROFILE AND RESOURCE PROJECTIONS

Table B.1.1 COP20 Budget by Program Area



B.2 Resource Projections

B.1.1 Total Funding Level				
Applied Pipeline	**New Funding**	**Total Spend**		
$72,928,504	**$298,206,496**	**$371,135,000**		

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	$694,291	$ 2,765,539	$3,459,830
HVAB	Abstinence/Be Faithful Prevention	$0	$ -	$0
HVOP	Other Sexual Prevention	$14,523,193	$ 4,291,199	$18,814,392
IDUP	Injecting and Non-Injecting Drug Use	$0	$ -	$0
HMBL	Blood Safety	$0	$ -	$0
HMIN	Injection Safety	$0	$ -	$0
CIRC	Male Circumcision	$0	$ -	$0
HVCT	Counseling and Testing	$36,218,176	$ 10,797,671	$47,015,847
HBHC	Adult Care and Support	$694,291	$ 2,867,661	$3,561,952
PDCS	Pediatric Care and Support	$7,903,574	$ 3,551,754	$11,455,328
HKID	Orphans and Vulnerable Children	$17,054,527	$ -	$17,054,527
HTXS	Adult Treatment	$90,161,905	$ 38,637,505	$128,799,410
HTXD	ARV Drugs	$82,674,894	$ -	$82,674,894
PDTX	Pediatric Treatment	$877,798	$ 4,547,635	$5,425,433
HVTB	TB/HIV Care	$9,225,590	$ 851,074	$10,076,664
HLAB	Lab	$0	$ -	$0
HVSI	Strategic Information	$5,079,518	$ 63,851	$5,143,369
OHSS	Health Systems Strengthening	$4,708,417	$ 278,815	$4,987,232
HVMS	Management and Operations	$28,390,322	$ 4,275,800	$32,666,122
TOTAL		**$298,206,496**	**$ 72,928,504**	**$371,135,000**
***Central Funding - KPIF**			**$ 1,966,708**	

B.2 Resource Projections

The resource projections for COP20 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 COP20 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 COP19 work plans of implementing partners to determine the items they would need after COP19 implementation. Items of equipment and renovations costs that will be incurred in FY20

APPENDIX C – Tables and Systems Investments for Section 6.0

Funding Agency	PrimePartner	COP20 Program Area	COP20 Beneficiary	COP20 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP20 Benchmark
DOD	Henry M. Jackson Foundation For The Advancement Of Military Medicine, Inc., The	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Research	Program Gap 1 (1st 90) - Barrier One: existing data, including national and sub-national surveys and statistics, may not reflect accurate population estimates, seroprevalence and HIV burden. Concerns about methodologies and sampling frames limit confidence in efforts necessary for planning, monitoring and evaluation.	COP16	COP22	To enroll 550 clients comprising of 459 HIV positive and 91 HIV negative participants
DOD	Henry M. Jackson Foundation For The Advancement Of Military Medicine, Inc., The	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Civil society engagement	Program Gap 1 (1st 90) - Barrier Three: attitude and cultural practices (norms and community structures) limit access to and uptake up of HIV testing services by persons more likely to be infected.	COP19	COP21	1. Conduct at least 4 CSO engagement events and at least 4 country level stakeholder events in collaboration with the global fund
State/AF	DEPARTMENT OF STATE	ASP: Not Disaggregated-NSD	Key Pops: Not disaggregated	Civil society engagement	Program Gap 1 (1st 90) - Barrier Three: attitude and cultural practices (norms and community structures) limit access to and uptake up of HIV testing services by persons more likely to be infected.	COP16	COP22	1. Grants to be issued and implemented as planned.
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Supply chain infrastructure	Program Gap 3 (3rd 90) - Barrier Three: there are poor transport systems and referral networks for viral load.	COP17	COP22	Improve turnaround time of sample pickup and results returned and E-Lab Improvement
USAID	Palladium International, LLC	ASP: Public financial management strengthening-NSD	Non-Targeted Pop: Not disaggregated	Domestic resource mobilization	Program Gap 2 (2nd 90) - Barrier Four: facility-based patient fees for service negatively effect linkage and retention.	COP19	COP21	1 - Set up of domestic resources monitoring system; 2 - Advocacy for elimination of user fees in selected states; 3 - Continuous government engagement in including HIV packagges in health insurance
HHS/CDC	UNIVERSITY OF MARYLAND	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	Program Gap 1 (1st 90) - Barrier One: existing data, including national and sub-national surveys and statistics, may not reflect accurate population estimates, seroprevalence and HIV burden. Concerns about methodologies and sampling frames limit confidence in efforts necessary for planning, monitoring and evaluation.	COP17	COP20	1. Technical report completed and disseminated 2. Sample repository upgraded to international standards
HHS/CDC	UNIVERSITY OF MARYLAND	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	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	COP22	1. 100% of PEPFAR supported facilities and at least 50% of HTS_Pos data is available in NDR for use in program monitoring and planning 2. 100% of PEPFAR treatment numbers are reported through NDR 3. Deduplication of PEPFAR data begins in at least 30% of supported facilities 4. Laboratory information system and facility level EMR are interoperable and data reflected in NDR dashboard
HHS/CDC	UNIVERSITY OF MARYLAND	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	Program Gap 1 (1st 90) - Barrier One: existing data, including national and sub-national surveys and statistics, may not reflect accurate population estimates, seroprevalence and HIV burden. Concerns about methodologies and sampling frames limit confidence in efforts necessary for planning, monitoring and evaluation.	COP19	COP22	To scale up recent infection surveillance enrolled sites to 175 in selected

APPENDIX D– Minimum Program Requirements

Below is a summarized update on the minimum program requirements for continued PEPFAR support include:

	MRP	*Updates (Please Qualitative and Quantitative Measures where possible)*
Care and Treatment	1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.[17]	Test and Start policy adopted in the country since 2016. The program had a proxy linkage rate of 97% in FY19. Strategies such as same day ART initiation, accompanied referrals and use of referral coordinators facilitated high linkages. The program is working assiduously to improve linkage rates among age bands 1-14 amongst males and females in the yellow states in FY20.
	2. Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.[18]	Since the November/December 2019 supply cycle the number of clients received TLD has increased from 737,392 (male - 298,410; female - 438,982) to 753,164 (male - 304,793; Female - 448,371) by the January/February 2020 supply period. Based on these numbers; more than 80% of clients on TLD.
	3. Adoption and implementation of differentiated service delivery models, including six-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents.[19]	Program does not yet have visibility on the number of clients that are benefiting from multi-month dispensing. A program is currently underway to determine these metrics.
	4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by end of COP20, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.[20]	In FY19, PEPFAR Nigeria rapidly scaled up TPT reaching a coverage of about 60% with a TPT completion rate of 85%. It will sustain this momentum through COP19 and into COP20 with the aim of reaching a TPT coverage of at least 80% and 100% by the end of COP19 and COP20 respectively. This will be achieved by sensitizing health workers on the importance of TPT and ensuring that they are involved in implementing the scale-up plan; conducting folder audit to ascertain TPT eligibility, flagging TPT-eligible clients to ensure they are offered TPT during their next clinic visit; making TPT available through all DSD models, conducting site-level TPT performance review, reporting on progress in closing the TPT coverage gap as a routine part of the clinical cascade, full procurement of isoniazid to prevent stock-outs experienced in FY19 and monitoring of treatment completion and adverse events.
	5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.	The Diagnostic Network Optimization (DNO) for Viral load and EID has been completed. As part of the DNO, the country program has completed the standing-up of 6 Mega PCR laboratories in COP18. These with additional six standard PCR labs supported by PEPFAR, four supported by Global Fund and one by GON constitute the National PCR Lab Network. The network currently covers all (100%) of ART/PMTCT sites supported by PEPFAR, Global Fund, AIDS Healthcare Foundation (AHF), and GON. The National Integrated Sample Referral Network (NISRN) has been reviewed and updated, and currently supports VL/EID sample referrals and return of test results from all 2,797 HIV treatment/PMTCT sites, and about 2,500 TB DOTS and community pharmacies/patent medicine vendors across the country. Through this mechanism, the DNO provides VL/EID access to 100% of patients served nationwide.
Case Finding	1. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.[21]	Index testing was scaled up in FY 19 across all high yield facilities in FY19. This resulted in an average Index testing yield of 16% and a steady increase of the percentage contribution of index testing to HTS_TST_POS from 7%-21% between Q1 and Q4.Service providers were trained and re-trained to adopt the WHO 5Cs and conduct IPV screening for partners of index clients with standard question that screen for the three forms of GBV. All biological children of HIV positive mothers <15 were tested for HIV in line with OGAC guidance and will engage relevant government agencies to reach biological children under the age 19. TA was provided to government to develop HIVST operational guidelines through a PEPFAR/USAID mechanism. PEPFAR FY20 targets are 4,476 however GON has procured 10,000 HIVST kits for distribution in-country and the program will leverage on these kits to commence implementation focusing on hard to reach partners of index clients, AGYP and Key Populations.
Prevention and	1. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)[22]	In FY19, HIV negatives at substantial risk were provided with prevention services including PrEP. Consented HIV negative PBFW in discordant relationships, partners of index clients and high-risk HIV negative KPs were initiated on PrEP, monitored for sero-conversion and retention.

	2. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on; • actively facilitating testing for all children at risk of HIV infection, • facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, • reducing risk for adolescent girls in high HIV-burden areas and for 9-14-year-old girls and boys in regard to primary prevention of sexual violence and HIV.	In COP 19, OVC programs provided client centered services that improve access to HIV testing and treatment services for children and adolescents. Prevention and Sexual Reproductive Health messaging was integrated into curriculum used for adolescent groups along with the relevant follow up referrals to sexual reproductive health services. In COP 20 adolescents ages 9-14 year old (boys and girls) and their parents will also receive a time limited, evidence based prevention intervention delivered primarily through already existing faith based or community based groups that aims to reduce risk of sexual violence and HIV for this age group. OVC programs coordinated with health facilities using case conferencing, defaulter tracking and active referral to the appropriate health and other services to ensure retention in treatment and viral suppression for HIV positive children and adolescents. Case managers conducted home visits to follow up on clinic appointments for ART and viral load tests. Case workers also monitored client's viral suppression, in conjunction with health facilities and provided adherence education, pill counts and follow up with families whose children were not virally suppressed. Other strategies adopted included referral to a comprehensive package of facility and community-based services that provide psychosocial support, nutritional support and transportation assistance.
	1. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention.[23]	PEPFAR Nigeria has engaged state governments on the abolishment of user fees that affect the three 90s. In FY 19, there was an increased number of states that augmented the supply of test kits to government supported facilities.
t	2. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.[24]	In FY 21, PEPFAR partners will focuses on using in-depth analysis of site-level data to obtain a deeper understanding of health facility and patient-level factors affecting performance. The information will then be applied to improve program performance. Program efficiency is improved by increasing testing yield (e.g., lowered number of tests conducted with an increased number of PLHIV identified), improvement in linkage and improvement in retention. Partner CQI activities will be clearly outlined in their workplans.

Policy & Public Health Systems Suppor	3. Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	PEPFAR Nigeria supported NACA to launch the U=U campaign as part of the World AIDS Day activities in 2019. Subsequently several strategy planning sessions have held stakeholder to determine how to rollout/scale-up the campaign across the country. Implementing Partners as part of their contributions to the campaign have since started to support several State Governments to launch their local "U=U" campaigns. The IPs agenda aims to use the campaign as an opportunity to improve their program outcomes especially as regards retention in care and closing gaps in LTFU rates. They are hence taking the lead with engagement of health professionals and service providers. CSOs partners on the other hand will focus on the linked opportunities to drive anti-stigma and anti-discrimination messaging as well as to disseminate self-care information. PEPFAR will fund CSO action on this as part of CSO Engagement Plan.
	4. Clear evidence of agency progress toward local, indigenous partner direct funding.	All CDC OVC, KP and Care and Treatment partners in Nigeria are currently local indigenous partners. USAID has transitioned its Key Population and OVC portfolios to local indigenous partners and is on track to transition its Care and Treatment Portfolio to local indigenous partners by end of FY 21.
	5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	Through the NCAPS program, the Government of Nigeria has since 2016, assumed responsibility for HIV service delivery in two States (Abia and Taraba). As part of the national HIV program alignment discussions, the Government has committed to investing additional funds to cover the treatment needs of a 100,000 PLHIV in FY2020 (estimated $16.5 million). This is in addition to the $12 million pledged to the Global Fund (a 20% increase from the what was pledged in the previous replenishment cycle).
	6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	The PEPFAR Nigeria program has improved reporting on morbidity and mortality using site level electronic medical records and at the national level using the national data repository. Moving forward, PEPFAR will work with partners to further improve the timeliness of reporting, completeness and accuracy of morbidity and mortality data.
	7. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	

Site level MPRs related to linkage and retention: During FY 2020 (COP19 implementation), all OUs are expected to fully implement retention-related PEPFAR Minimum Program Requirements at every PEPFAR-supported site, as these have a known impact on continuity of ART.

Site level implementation of these 4 elements must be assessed to inform COP20 planning;

- Direct and immediate (>95%) linkage of clients from testing to treatment…
- Rapid optimization of ART by offering TLD to all PLHIV weighing >30 kg….
- Elimination of all formal and informal user fees….
- Adoption and implementation of differentiated service delivery models….

In addition, an effective tracking and tracing system must be in place at each site.

APPENDIX E – Feedback on CSO Input for COP20

CSO Priority Areas	CSO Requests and Recommendations	PEPFAR Feedback on CSO Input
1. User Fees: We acknowledge the positive actions of governors of two states in Nigeria abolishing user fees in Rivers & Akwa Ibom states. Our recently concluded community monitoring found user fees however remain a significant barrier to treatment scale up and retention.	A sustained campaign on removal of user fees and close monitoring especially in the states that have committed to its abolishment so patients can be aware of their rights and demand services and/or report non-complying facilities. • A sustained response to user fees in ALL SURGE STATES AND BEYOND with a focus on all surge states in COP20	PEPFAR will sustain the advocacy efforts on this at the very highest levels for Government (State Governors and the Presidency) will effort led by the US Embassy Front Office and will work with Civil Society to track and monitor commitments.
2.Community Led Monitoring (CLM): We acknowledge and appreciate the investment for CSO community led monitoring in COP20.	• CLM should be community driven in its entirety from design, implementation through reporting and collaborative (with stakeholders) reviews for continued quality improvement of data. • To develop a broader consensus for the framework and work plan for CLM there will be a need for increased engagement with community to discuss program.	The PEPFAR Country team is eager to collaborate with CSOs in this way.
3. Continued CSO engagement: We acknowledge and appreciate the investment in community engagement especially in FY19.	We request a more encompassing program review with CSOs and recommend the instrumentation of retreats to achieve this. Continued support for CSO platforms.	These recommendations will be incorporated into future engagement plans and the additional funding in COP20 will help to ensure that adequate time is allocated to conduct meetings with the needed scope and depth.
4. Index Testing: We agree that Index Testing is an important strategy. However, we note that index testing targets increase the risks of Gender Based Violence, IPV, and stigma that may arise	Index Testing should only be conducted in conformity with WHO guidelines 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	PEPFAR aligns with WHO index testing guidelines and is commitment to setting up appropriate systems for preventing, tracking and mitigating GBV.
5. Retention: We note the positive expansion of innovative programming to improve retention in the surge states. However, we note that there no plans to expand programming, or elements of it, in the green and yellow states.	Expand testing and linkage through CAGs and population specific programs, such as a KP-competent and adolescent-friendly programs Ensure integration of STI, HepB, HIV and Family planning services as well as access to FP commodities. Expand innovative retention programming from surge states to include green and yellow states to ensure retention of clients and to safeguard gains in coverage.	Additional considerations for client-centered care model will be implemented from the current FY and will continue to expand to reflect the core need to clients. Opportunities exist within the agreed Program Alignment discussions to standardize a more robust package of care services for Key Populations and to engage with beneficiary communities to identify and address the reasons for poor retention in care.
6. Key Populations: We note positive data on KP cascade in FY19, and increased PrEP programming in COP 20. However, programming is hampered by the lack of KP, and particularly TG population estimates and needs assessments as well as structural protection for KPs especially TGs.	Improve KP (and in particular, TG) population estimates to allow for adequate programming for these populations, including layering of service incentives like Hep B, prostate cancer services. • Safe housing, education and capacity development opportunities	Services will be expanded to address these health needs in the standardized package of services, while opportunities have been created within the CSO engagement funds to accommodate other ancillary needs including community and personal empowerment and capacity building.
7. TLD transition by gender: We acknowledge the progress in increasing the number of women on TLD. However, our community led monitoring concluded in January found only 11-50% females on TLD	We would like to see a further progression to 80% or higher women transition to TLD	Progress on this is on-going and the community will be updated in our Quarterly meetings.

APPENDIX F – Summary of COP20 Program Targets

Treatment			
Indicator	Pediatric	Adult	Total
TX_CURR	84,922	1,343,672	1,428,594
TX_NEW	7,856	115,709	123,565
TX_NET NEW	3,397	44,989	48,386
PVLS (Denom.)	81,183	1,288,715	1,369,898

OVC	
OVC_SERV (Active)	988,752
OVC_HIVSTAT	823,996
PMTCT	
PMTCT_STAT (Denom.)	1,570,463
PMTCT_STAT (Num.)	1,556,142
PMTCT_STAT (newly tested)	1,519,832
PMTCT_STAT POS	7,910
PMTCT_ART	35,929
PMTCT_EID	34,733
< 2 months	29,249
2-12 months	5,484

HTS	
PMTCT_STAT (newly tested)	1,527,742
TB_STAT (newly tested)	36,312
Pediatric HTS_TST	573,984
Adult HTS (excludes, EID, PMTCT, TB)	3,135,990
Key Population HTS	241,003
HTS_SELF (KP)	44,078
KP	
KP_PREV	258,720
KP_PREV MSM	68,122
KP_PREV FSW	145,112
KP_PREV PWID	38,931
TB	
TB_STAT (Denom.)	52,093
TB_STAT (Num.)	52,093
TB_STAT (newly tested)	36,312
TB_STAT POS	1,725
TB_ART	17,470
TX_TB (Denom.)	1,503,773
TB_PREV (Denom.)	391,376
TB_PREV (Num.)	352,254