Nigeria

Country Operational Plan (COP) 2021

Strategic Direction Summary

May 26, 2021

Table of Contents

Acronyms

AHD	Advanced HIV Disease
ARV	Antiretroviral Drug
ASC	AIDS Spending Category
ART	Antiretroviral Therapy
CALHIV	Children Living with HIV
CBS	Case-Based Surveillance
CLM	Community-Led Monitoring
CSO	Civil Society Organization
DTG	Dolutegravir
ECHO	Extension for Community Healthcare Outcomes
EMR	Electronic Medical Records
ESM	Enhanced Site Management
FBO	Faith-Based Organization
FCT	Federal Capital Territory
GBV	Gender-Based Violence
GF	Global Fund
GON	Government of Nigeria
HEI	HIV-Exposed Infants
HIS	Health Informatics System
HIV	Human Immunodeficiency Virus
IIT	Interruption in Treatment

IP Implementing Partner

IPV Intimate Partner Violence

KP Key Population

MMD Multi-Month Dispensing

MSM Men who have Sex with Men

NASCP National AIDS and STI Control Program

NAIIS Nigeria HIV/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

NHLMIS National Health Logistics Management Information System

NISRN National Integrated Sample Referral Network

OI Opportunistic Infection

OSS One-Stop Shop

OU Operational Unit

OVC Orphans and Vulnerable Children

PrEP Pre-Exposure Prophylaxis

PEPFAR US President's Emergency Plan for AIDS Relief

PLHIV People Living with HIV

PMTCT Prevention of Mother-to-Child Transmission

RST Risk Stratification Tool

S/GAC Office of the U.S. Global AIDS Coordinator

STI Sexually Transmitted Infections

SNU Sub-National Units

SVAC Sexual Violence Against Children

TB Tuberculosis

TPT TB Preventive Therapy

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

UNAIDS Joint United Nations Program 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 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 Operational Plan for 2021 (COP21) builds off the Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS) and the Antiretroviral Therapy (ART) Surge from COP19 and COP20. These efforts allowed the PEPFAR team to focus on states with the largest treatment coverage gap. With this backdrop, the theme for PEPFAR Nigeria's COP21 plan is "Going Green": Leaving No Geography or Population Behind. The PEPFAR interagency plans to support Government of Nigeria in "Going Green," that is, achieving treatment saturation across most of the states in Nigeria (2nd 95) by the end of FY22.

In COP19, PEPFAR Nigeria utilized results from the NAIIS to prioritize states for rapid ART scale-up: 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, Imo, and Lagos), the "green" states with high saturation and low unmet need (Benue, Federal Capital Territory [FCT], Nasarawa, 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).

At the end of quarter one of FY21 (December 2020), PEPFAR Nigeria has made significant progress: the surge state of Akwa Ibom; the red states of Delta and Lagos; the yellow states of Adamawa, Cross River, FCT, Kaduna, Bauchi, Sokoto, Niger, Plateau and Kano; and the green states of Benue, Gombe, and Nasarawa have all achieved at least 81% treatment coverage. Furthermore, three states with over 81% treatment coverage, Benue, Gombe, and Nasarawa, were further saturated by age and sex groups and have reached at least 90% treatment coverage.

For COP21, at the operating unit (OU) level, the PEPFAR Nigeria program will aim to increase the percentage of people living with HIV (PLHIV) who know their status from the current rates of 92% to 95%, increase the percentage of PLHIV on treatment from current 90% to 100%, and continue to maintain the proportion of PLHIV who are virally suppressed from current 59% to greater than 95%. Thus, COP21 will witness an acceleration of the response and bring the country closer to achieving the UNAIDS goal of 90-90-90 by 2023 and 95-95-95 by 2030. This effort will also include on-the-ground technical assistance to support National Agency for the Control of AIDS (NACA) in scaling-up HIV services in Abia and Taraba states, which had previously been outside of PEPFAR's geographical coverage.

The PEPFAR Nigeria program will build upon the three broad strategies laid out during the 'surge' in COP19 and COP20, and address key programmatic challenges as laid out in the COP21 Planning Level Letter (PLL). Our strategic direction will include client-centered care, improved patient retention, and the continued collaboration the Government of Nigeria (GON) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) on the National HIV Alignment. To improve client care and retention, PEPFAR will continue to scale-up recently available program innovations from enhanced site management (ESM), real-time data monitoring using electronic

medical record (EMR) systems (with data warehousing in the National Data Repository [NDR] for real-time data analysis) and facilitating knowledge sharing using virtual platforms such as "Project ECHO."

Using virtual platforms for alternative methods of program management became increasingly important during COP20 implementation due to the risks associated with the COVID-19 pandemic. Because PEPFAR Nigeria had already established virtual platforms and interventions as part of our core ESM approach, we were able to adapt immediately to the lockdown and travel restrictions imposed during COP19 and COP20 implementation. Implementing Partners (IPs) were able to shift testing and treatment modalities to focus more on community settings and were able to bring HIV services directly to the patients. In doing so, PEPFAR Nigeria was not only able to retain most of our patient cohort during COVID-19, but also increased TX_CURR by an additional 300,000 PLHIV, all while ensuring the safety of our staff and beneficiaries.

While continuing to mitigate the effects of COVID-19 on our program, "Going Green" will require that no geography or population is left behind. This will include the continuation of our three broad strategies, while addressing the four highlighted four highlighted challenges OGAC noted in the COP21 PLL. First, PEPFAR Nigeria will work to ensure treatment coverage for all by addressing gaps in the continuity of treatment, particularly in a sub-set of states that experienced higher levels of interruptions in treatment (IIT). Second, PEPFAR Nigeria will avoid the historic patient losses during Q1 that have traditionally plagued the PEPFAR Nigeria ART program. Third, we will protect pediatric populations, who have generally had lower treatment coverage and poor treatment outcomes, by leveraging the orphan and vulnerable children (OVC) program. Fourth, we will reach and sustain the 3rd 95 for all by addressing gaps in viral load coverage and sub-optimal viral load suppression among certain populations, including pregnant women.

Ultimately, COP21 will also showcase the increased collaboration with stakeholders including the Global Fund, civil society, and the Government of Nigeria to create an aligned national treatment program. To date, the National HIV Alignment has improved program synergies and resource efficiency by preventing duplication of efforts. Thus, significant improvements have been made in our program outcomes, all through shared learning and harmonization of program standards. The National Alignment has created a 'whole of Nigeria' approach around HIV programing and has encouraged information and data sharing across donors, increasing collaboration and transparency. In COP21, we hope to build off the great success of the Alignment, under which the "National Consolidated Service Delivery Guidelines on HIV and STI for Key Populations (KP) in Nigeria" were recently launched, to include a more aligned KP program, as well as a more coordinated and robust laboratory network that includes GON and Global Fund laboratories.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

Nigeria is a lower-middle-income country (GNI: 2,100 per capita, Atlas method[1]) with a current population estimate of 219,243,344 (population demographics: 49 percent female and 51 percent male[2]).

The HIV epidemic in Nigeria affects populations of all age groups and geographic locations. The 2018 NAIIS estimated national HIV prevalence as 1.4% among adults aged 15 years and above, with a higher prevalence among women 1.8% compared to males 1.0%. Also, NAIIS reported 8 new infections per 10,000 population. In 2020, there were an estimated 1,804,612 PLHIV in Nigeria.

Regarding progress toward achieving the 95-95-95 goals, as of December 31, 2020, among all PLHIV in Nigeria, 92% know their status, 90% are on HIV treatment, and 59% are virally suppressed. As at December, 2020, the states with the largest ART unmet needs are now Rivers (unmet need = 69,063) and Anambra (unmet need = 57,172).

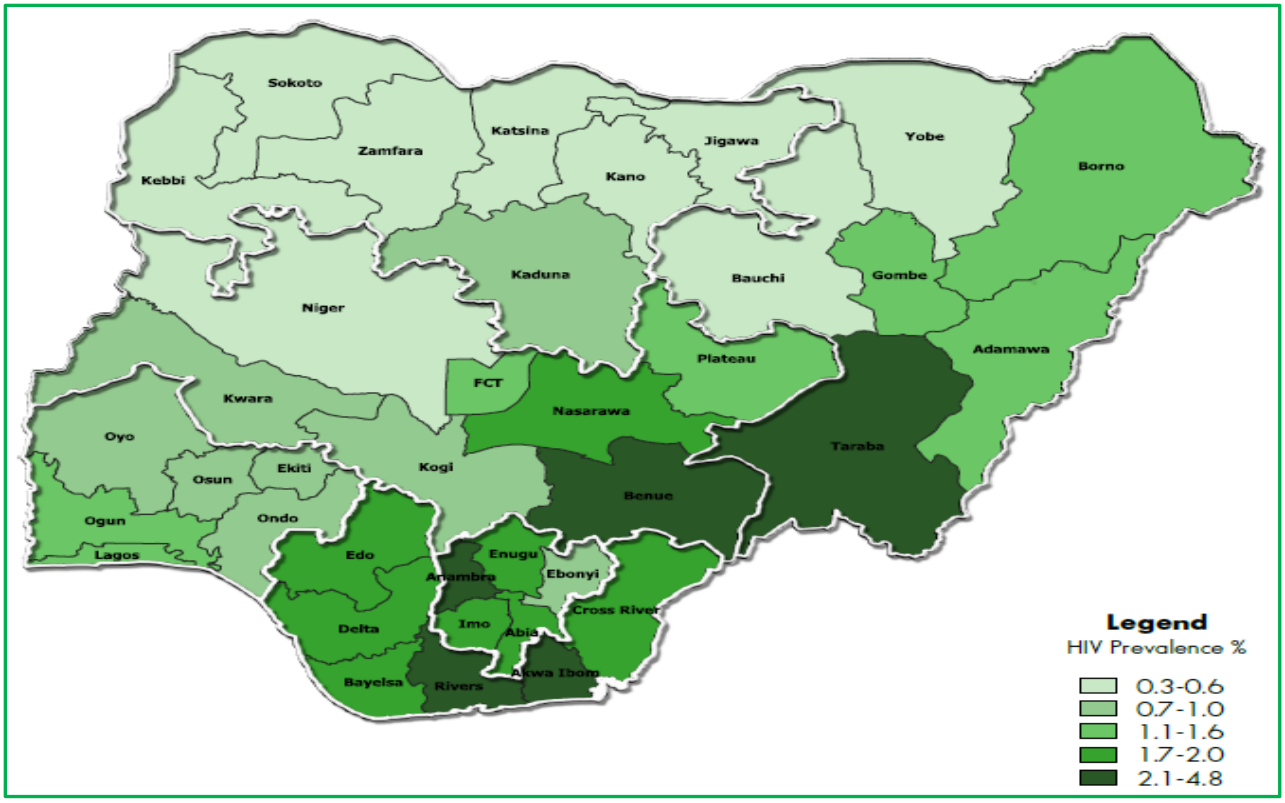


Figure 2.1.1: HIV Prevalence in Nigeria by States source: NAIIS 2018

[1] World Bank, 2017 data https://data.worldbank.org/country/Nigeria
[2] 2020 Spectrum data, 2019

There remains significant variation in HIV prevalence across the 36 states and the FCT, as shown in Figure 2.1 above. 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.

According to the UNAIDS Spectrum 2020 estimates, the states with the highest burdens are Rivers (burden = 193,423), Akwa Ibom (burden = 176,311), Benue (burden = 160,523), and Lagos (burden = 125,410). 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[3].

The prevalence of HIV in the country also varies by sex and across age groups. Overall, the national HIV prevalence among females and males was 1.8% and 1.0%, respectively. The prevalence among children 0-14 years old was 0.1%. Starting from the 15-19 years age group, a sex-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.

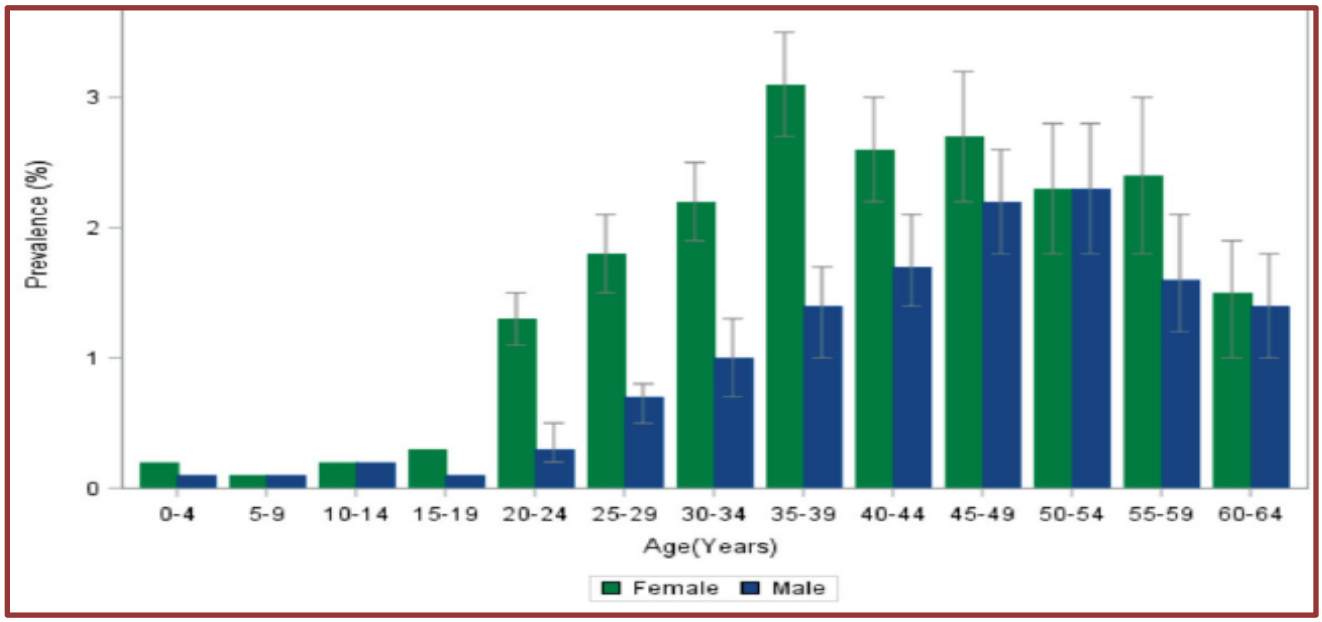


Figure 2.1.2 - HIV Prevalence by Age and Sex

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

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

men of similar age; this pattern continues through most of the childbearing years, with the sex 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%).

NAIIS was used to update the UNAIDS Spectrum data for the country, which subsequently estimated that approximately 1,804,612 PLHIV in Nigeria in 2020, and approximately 1,492,154 of those were reportedly on treatment at the end of 2020. This suggests that about 82% of the estimated number of PLHIV in the country are on treatment. Based on the COP21 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 99.6%.

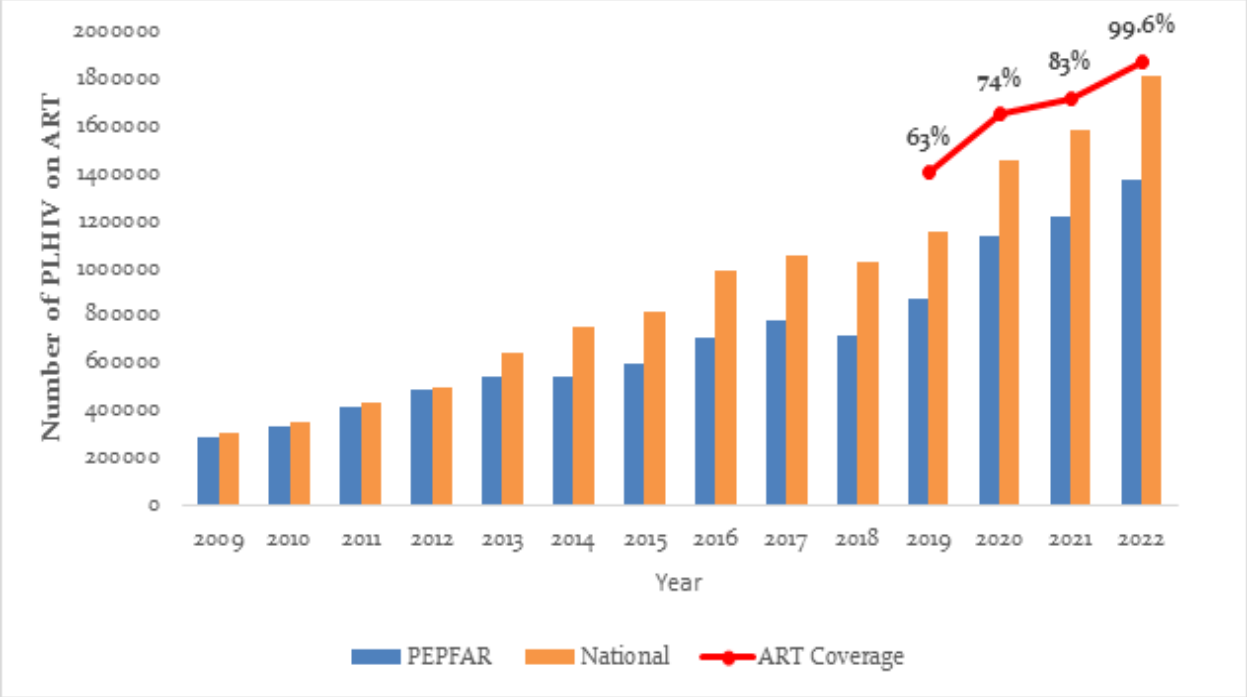


Figure 2.1.3 National and PEPFAR Current on Treatment Numbers

The program also continues to have huge gaps in case finding among pregnant women with HIV infection; the annual estimate for this population remains about 150,000, with only about 41,000 reported nationally to have received antiretroviral drugs (ARVs). This reflects the huge gap in the coverage of prevention of mother-to-child transmission of HIV (PMTCT) services in the country,[4] with just 10-20% of ANC sites offering PMTCT services[5]. It also reflects the gap in the uptake of ANC services, with just 67% of pregnant women received ANC from a skilled provider.[6] These

[4] FHI360 (2014), 'Rapid Health Facility Assessments in Eight Nigerian States'. https://www.fhi360.org/resource/rapid-health-facility-assessments-eight-nigerian-states
[5] 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
[6] NDHS 2018

findings highlight the need for a more integrated approach to the delivery of reproductive health services in the country.

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.[7] Additionally, a high prevalence of HIV was reported in the 2020 Integrated Biological and Behavioral Surveillance Survey (IBBSS) among several KPs: brothel-based female sex workers (17.1%), non-brothel-based FSWs (15%); people who inject drugs (10.9%) and men who have sex with men (25%). 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 (GBV) 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. That said, the program has managed to expand these programs significantly in the last fiscal year. This progress is summarized for all the differentiated care models in the Minimum Program Requirement review table (see Appendix D).

[7] 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	216,762,158	100%	41,861,843	19%	44,504,344	21%	20,493,590	9%	21,734,557	10%	43,754,961	20%	44,412,863	21%	Spectrum, 2020
HIV Prevalence (%)		1.30%													NAIIS, 2018
AIDS Deaths (per year)	46,066	100%	19,347			42%	26,719							58%	Spectrum, 2020
# PLHIV	1,804,612	100%	68,728	4%	73,557	4%	133,742	7%	74,463	4%	820,681	45%	633,711	35%	Spectrum, 2020
Incidence Rate (Yr)		8%													NAIIS, 2018 (Preliminary)
New Infections (Yr)	76,204	100%	21,337			28%	54,867							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	99,194														Spectrum, 2020
Orphans (maternal, paternal, double)	2,150,821														Spectrum, 2020
AIDS Orphans (maternal, paternal, double)	227,345														Spectrum, 2020
Notified TB cases (Yr)	103,921														WHO Global TB report 2020
% of TB cases that are HIV infected	12,700	12%													WHO Global TB report 2020
[8]% of Males Circumcised		98.90%													Morris et. al (2016)
[9]Size & Prevalence Estimates of MSM	238,522	25%													1. Nigeria KP Size Estimates Studies
Size & Prevalence Estimates of FSW	621,219	17.10% (BBFSW) 15% (NBBFSW)													2. IBBSS 2020
Size & Prevalence Estimates of PWID	227,068	10.9%													

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

[9] Estimates are for 15 states only: Abia, Akwa Ibom, Anambra, Benue, Gombe, Kaduna, Kano, Lagos, Nassarawa, Oyo, Rivers, Taraba

Table 2.1.2 95-95-95 Cascade: HIV Diagnosis, Treatment and Viral Suppression										
Epidemiologic Data					HIV Treatment and Viral Suppression			[10]HIV Testing and Linkage to ART Within the Last Year		
	[11]Total Population Size Estimate (#)	[12]HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	[13]Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	216,762,158	1.30%	1,804,612	1,392,670	1,492,154	83%	86%	8,235,834	341,379	347,378
Population less than 15 years	86,366,187	0.10%	142,285	58,022	57,445	40%	70%	407,899	9,641	9,763
15–24-year-olds	42,228,147	0.50%	207,935	132,348	131,530	63%	85%	1,952,454	53,746	52,784
25+ year old's	88,167,824	1.80%	1,454,392	1,202,300	1,303,179	90%	86%	5,875,453	277,989	284,831
MSM	238,552	25%								
FSW	621,219	17.1% (BBFSW)								
		15% (NBBFSW)								
PWID	227,068	10.9%								

2.2 New Activities and Areas of Focus for COP21, including Continuity in Treatment

In COP21, PEPFAR Nigeria will continue to consolidate on COP20 gains in the program by strengthening client-centered, program quality approach within the key domains of prevention, case finding, treatment, optimized retention, and viral suppression. In addition, the innovative approaches implemented during the COVID-19 pandemic will be further strengthened and mainstreamed. This will help to sustain the drive to support continuity in treatment built around a client-centric management approach, including the use of dedicated case managers across the full clinical cascade to ensure sustain optimal VLS.

In COP21, PEPFAR Nigeria will strive to attain epidemic control in most of the SNUs. Robust evidence generated in COP20Q1 from program data indicated a 97% retention on treatment. In COP21, the focus will be on sustaining the continuity of treatment via client-centric, community-based ART initiation/delivery, strengthening virtual platforms for enhanced adherence, scaling up MMD6 especially for pediatrics, full ARV optimization including among children and adolescents (e.g., DTG) and scaling of Pediatric ART Saturation Strategy (PASS) and alignment with OVC.

The successful implementation of the ART Surge strategy has significantly shifted the unmet need distribution in Nigeria. For example, Akwa Ibom and Rivers states contribution to unmet need

[10] PEPFAR data only
[11] Data source: Estimates from Nigeria 2020 Spectrum File
[12] Data source: HIV Prevalence from NAIIS 2018 and IBBSS 2020 for KP data
[13] Viral suppression among patients who had a viral load in 2020

has dropped from 30% to 18%. In COP21, PEPFAR Nigeria will expand on these gains. In addition, the lessons learned from the ART Surge will be rigorously transferred and mainstreamed to the seven (Imo, Abia, Lagos, Borno, Osun, Oyo and Enugu) and 15 (Delta, Kano, Edo, Ogun, Kogi, Zamfara, Bayelsa, Ondo, Kebbi, Katsina, Ekiti, Kwara, Yobe, Sokoto, and Jigawa) SNUs that now account for 43% and 39% of the unmet need respectively. The strategies and lesson learned from the ART surge implementation that will be scaled up to these SNUs includes ESM, community ART service delivery, community oriented DSD, scaling and strengthen virtual platform for patient and program management, strategies to increase pediatrics ART saturation and MMD6 for pediatrics.

Sustaining Continuity in Treatment

Based on lessons learned in COP20, PEPFAR Nigeria will ensure continuity in treatment, by institutionalizing MMD, ensuring patients tracked back to care are placed on DSD models based on their need. Additionally, the program will leverage centralized patient-level data centralized in the NDR to strengthen continuity in treatment through machine learning and predictive analysis. A prevention package of pre-appointment calls and 2-week, 2-days and 24 hours' pre-appointment check-ins will be provided, listing with identified early defaulters and a list-serve generated list to track patients within 24-48hrs of a missed appointment. Other measures to be expanded include MMD6 for patients requiring temporary relocation, and travelers; expansion of community models of ART delivery (e.g., community ART refill groups [CARGs]) and family-centered approaches targeted at patients that cannot afford transportation to health facilities; linkage to community resources for household economic strengthening activities; fast tracking of patients to reduce waiting time within the facilities, and routine collection of patient satisfaction surveys during visits to support continuous quality improvement of services.

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[14]. 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. PEPFAR and the GF cover the stipend payment for almost all the lay workers (data clerks, peer educators, lay counsellors, and case managers) in the program. While the program

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

has very detailed data on expenditure support this category of workers, it was however not reported in the most recent National AIDS Spending Assessment[15].

The investments for the support of OVC is 100% from the PEPFAR program, but it is noted that the program currently only supports OVCs in 28 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
Program management & admin. (including Above Site)	$ 34,782,609	$ 111,371	$ 98,197,237	$ 27,951,621	$ 1,473,580	$ 162,516,418
Systems Strengthening & Program 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**

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%

[15] PEPFAR facility HRH assessment 2014.

Program management and administration (including Above Site)	21%	0%	60%	17%	1%	31%
Systems Strengthening & Program 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%

COP21 updates: Nigeria was unable to complete the COP21 HIV Resource Alignment Profiles in time to use these data in this section as recommended by the Office of the U.S. Global AIDS Coordinator (S/GAC). The team will continue to follow-up with country stakeholders to complete these profiles and will publish these as soon as they are completed and ratified by all. There is also no update yet to the 2019 National AIDS Spending Assessment (NASA), so the Investment Profile tables, and narratives remains as reported in the COP20 SDS. However, please note the following updates.

- Plans underway to complete and disseminate the 2020 NASA by August 2020.
- Local Civil Society Organizations (CSOs) have expressed some concerns about some of the data reported in the 2019 NASA. For instance, the $21.5m reported by GON to have been spent on HIV prevention activities is considered to have probably been misallocated as there is no evidence to support the likelihood of this expenditure.
- Overall, the CSOs have initiated a process to work with the GoN and other stakeholders to produce future iterations of the NASA and will work to ensure that all the data collected are fully validated and can be matched with budgets to ensure that expenditures follow the actual priorities identified during program planning process.

2.3.2 – National Procurement of Key HIV Commodities

For the year ending December 2020, National Commodities and Supply Chain Program reported a total investment in HIV commodities of $195m. This is significantly more than the $126M reported in 2019 and the $181.6M reported in 2018. While the reduction in 2019, was reportedly due to the reduction in the levels of holding stock of commodities at the central warehouse from six months levels to two months, the increase for 2020 is reportedly due to the progress that has been made with MMD (and the impact this has had on volume of commodities needed to sustain the ARV drug pipeline). About 94% of clients now reported to be on a >3 months dispensing schedule to reduce the frequency of their engagement with the hospitals. This was one of the measures taken as part of the Country's COVID-19 control strategies. The chart below shows how MMD has evolved in the four quarters of fiscal year 2020.

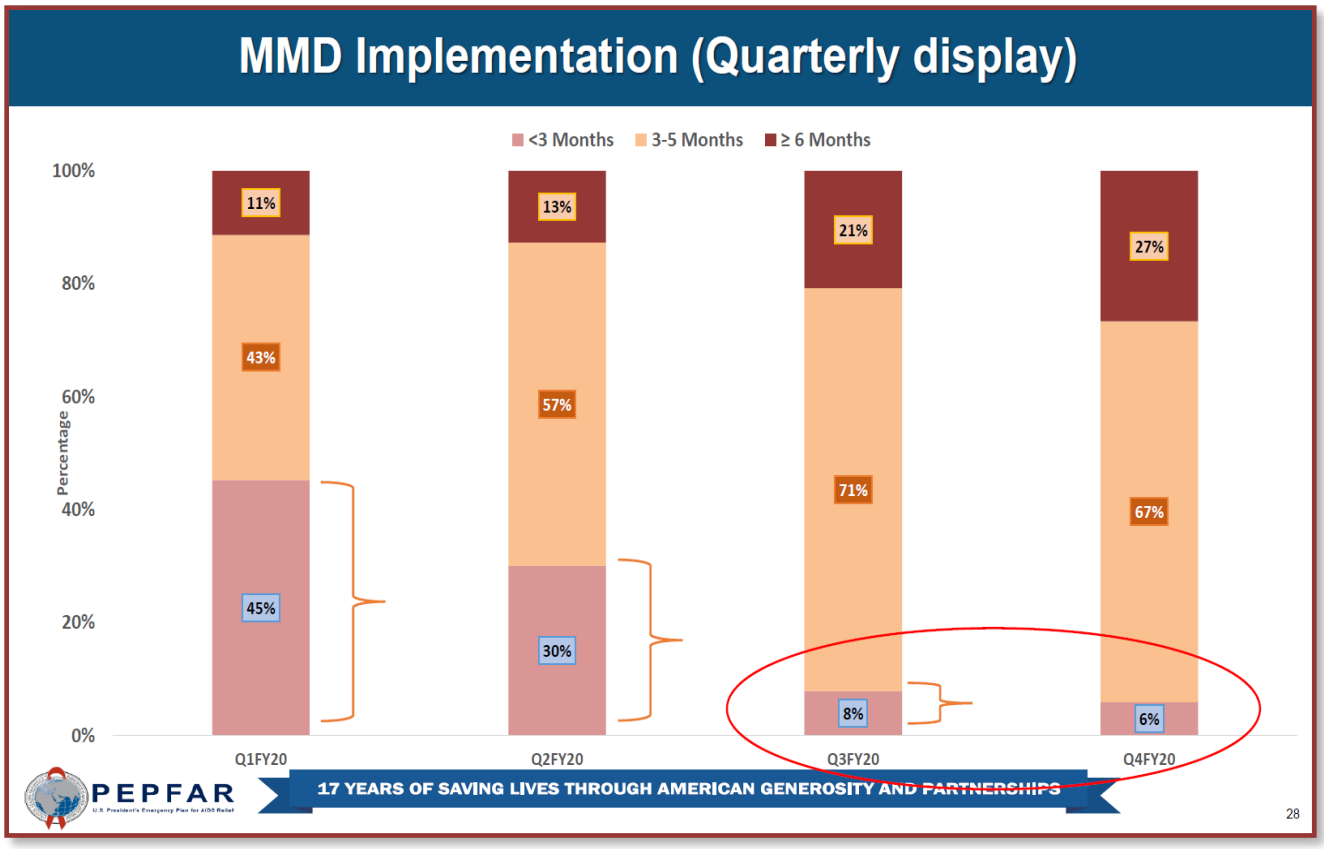


Figure 2.2.3 – The progress on Multi-Month Dispensing in FY2020

Donor investments continue to account for majority of country's HIV commodities procurements (99%), with PEPFAR and the Global Fund contributing 80.7% and 16.5%, respectively. UNITAID also made a $4.01m investment (2.1%) in HIV self-test kits, Viral Load reagents and drugs for treatment of opportunistic infections.

At 71%, ARV procurements still make up most of the expenditures, while viral load commodities and RTKs, account for 13% and 9%, respectively. These proportions deviate slightly from the previous year's amounts of 77.7%, 11.5% and 5.7% for the three commodities with a gradual shift towards the two diagnostics commodities. Actual procurements reflect a 42% increase in ARVs, 72% increase in Viral Load commodities and 149% increase in RTKs.

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

Commodity Category	Government of Nigeria	Private Funds	PEPFAR	GF	Others (UNITAID)/ (JPEIGO)	Totals
ARVs	$342,165	$-	$122,704,702	$16,009,325	$-	$139,056,193
Rapid test kits	$228,000	$729,600	$9,496,474	$7,093,073	$487,578	$18,034,725
Other drugs (OIs)	$149,125	$-	$5,715,832	$2,786,766	$545,610	$9,197,333

Table 2.2.2a Annual Procurement Profile for Key HIV Commodities (Amounts in USD) **						
Commodity Category	**Government of Nigeria**	**Private Funds**	**PEPFAR**	**GF**	**Others (UNITAID)/ (JPEIGO)**	**Totals**
Lab reagents (CD4 commodities)	$-	$-	$838,982	$1,222,135	$-	$2,061,117
Condoms	$-	$-	$-	$-	$-	$-
Viral Load commodities	$-	$-	$16,873,266	$4,992,021	$3,016,443	$24,881,730
EID commodities	$-	$-	$788,628	$110,488	$-	$899,116
Other commodities (GeneXpert Cartridges)	$-	$-	$1,095,305	$-	$-	$1,095,305
Total	$719,291	$729,600	$157,513,189	$32,213,808	$4,049,631	$195,225,518

Table 2.3.2b Annual Procurement Profile for Key HIV Commodities (Percentages) **						
Commodity Category (CC)	**Government of Nigeria**	**Private Funds**	**PEPFAR**	**GF**	**Others (UNITAID)/ (JPEIGO)**	**Proportion by CC**
ARVs	0.2%	0.0%	88.2%	11.5%	0.0%	100.0%
Rapid test kits	1.3%	4.0%	52.7%	39.3%	2.7%	100.0%
Other drugs (OIs)	1.6%	0.0%	62.1%	30.3%	5.9%	100.0%
Lab reagents (CD4 commodities)	0.0%	0.0%	40.7%	59.3%	0.0%	100.0%
Condoms	Nil	Nil	Nil	Nil	Nil	Nil
Viral Load commodities	0.0%	0.0%	67.8%	20.1%	12.1%	100.0%
EID commodities	0.0%	0.0%	87.7%	12.3%	0.0%	100.0%
Other commodities (GeneXpert Cartridges)	0.0%	0.0%	100.0%	0.0%	0.0%	100.0%
Total	0.4%	0.4%	80.7%	16.5%	2.1%	100.0%

Unfortunately, there was no reported condom procurements for the second year in a row. This gap is being addressed in the current fiscal year through procurements by the Global Funds and a country allocation from a USAID Washington pool, while in the COP21, it will be addressed through a planned $1.5m budget for condoms, as reflected on the commodities summary sheet in appendix G.

Through the Nigeria Comprehensive AIDS Program in States (NCAPS) program, funded by the National Agency for the Control of AIDS (NACA) in Abia and Taraba states, the GON reportedly spent about $720,000 on HIV commodities in 2020. This is significantly less than the $2.6m spend in 2019. This decrease in domestic expenditure likely reflects the shrinking fiscal space as oil prices fell to all-time lows, driven by COVID-19-derived global economic issues.

The success of the treatment surge over the last fiscal year will ultimately warrant an increase in commodities investments in the coming years. The National Alignment efforts launched last year

will help to ensure that resource allocations reflect this increasing need, which unfortunately may result in reduced allocations to other program areas unless there is improvements in domestic financing for HIV services. NACA and the FMoH continue to reassure stakeholders of the Government's commitment to increase investments in the coming years.

2.2.3 - US Government health-sector investments outside PEPFAR

Aside from HIV/AIDS program investments, the USG agencies supporting PEPFAR have proposed other health-sector related investments in 2022 amounting to a total of $188,530,512. The US Agency for International Development (USAID) will invest $13 million in support of the National TB and Leprosy Control Program, $74 million in the National Malaria Control Program and $32 million in Maternal and Child Program. USAID also invested about $25 million investment in support of Family Planning and Reproductive Health services, $7 million in Nutrition and $14 million in Water and Sanitation.

The US Centers for Disease Control and Prevention (CDC) similarly will invest about $16.1 million in the Polio Eradication efforts, to help sustain Nigeria's newly acquired status as a "polio-free" country (Nigeria eradicated Wild Polio Virus 1 in August 2020). These investments will also support Routine Immunization and disease surveillance efforts in collaboration with the FMoH. CDC will also invest about $2.77m to support Nigeria's global health security response and reporting initiatives.

Lastly, the US Department of Defense (DoD)/Walter Research Army Institute of Research (WRAIR) will support various health collaborations with the Nigerian Ministry of Defense, the FMoH, and academic institutions to support approximately $4.6m in programming and research in malaria, Lassa fever, and other emerging infectious diseases.

Table 2.2.3 USG Non-PEPFAR Funded Investments and Integration

Funding Source	Total USG Non-PEPFAR Resources	Objectives
USAID TB	$13,000,000	Accelerate case-finding and increase national case detection rate.
USAID Malaria	$74,000,000	Reduce malaria burden under the PMI.
USAID Maternal & Child Health	$32,000,000	End preventable child and maternal deaths.
USAID Family Planning & Rep. Health	$25,000,000	Improve access to and use of quality and voluntary Family Planning services including long acting and permanent methods to reduce unwanted pregnancies.
USAID NUT	$7,000,000	Reduce malnutrition among women and children.
USAID WASH	$14,000,000	Improve water supply and sanitation.
CDC Global Immunization Division (GID)	$16,137,285	• Attained and sustained certification for wild polio type 1 (WPVV1) free status in Nigeria. Note that Nigeria eradicated WPV1 in August 2020. • Improved and targeted surveillance activities across states with CDC/AFENET presence • Strengthened polio SIA campaigns and outbreak responses efforts in response to circulating vaccine derived polio vaccines

Table 2.2.3 USG Non-PEPFAR Funded Investments and Integration		
Funding Source	Total USG Non-PEPFAR Resources	Objectives
		• Strengthened collaboration with the Government of Nigeria (and other partners) on the transition of polio resources and structures to support broader surveillance, routine immunization, and PHC services as GPEI funding dwindles • Improved routine immunization coverage from 33% to 80% by 2028 through a variety of RI strengthening strategies (e.g., IMOP, integrated campaigns and RI services etc.) • Measles elimination: through increase in measles coverage, introduction of measles dose 2 and quality measles campaigns • Strengthened surveillance and testing of vaccine preventable diseases such as measles, yellow fever, and congenital rubella syndrome. • Improved response to the COVID-19 pandemic and increased uptake of the COVID-19 vaccine
CDC Division for Global Health Protection (DGHP)	$2,765,408	Strengthening of International Health Regulations core capacities to promote global health security primarily through: • Workforce development through frontline, intermediate and advanced training programs for field epidemiologists through the NFELTP program. • Establishment and operationalization of Emergency Operations Centers. • Development/improvement/strengthening of Real-Time Surveillance and Border Health Security. • Development/improvement/strengthening of Information Systems and GHSA Reporting • Development of Public Health Emergency Management programs
DOD JWARG	$587,729	Joint West Africa Research Group.
DOD AFRICOS Science	$111,142	African cohort study: longitudinal follow up of PLHIV
DOD INLAP	$6,339	External quality assurance panels for clinical laboratory testing performed under the MHRP research program
DOD LASSA EPI	$480,363	Prevalence of Lassa virus-specific antibodies (IgG and IgM) among adult human populations
DOD Malaria	$2,525,122	Malaria diagnostics and quality assurance
DOD Key Populations (Global Fund support)	$556,526	Support for the development of KP guidelines under the national alignment.
DOD RV466 MALARIA	$60,755	To obtain four genetically diverse strains of *P. falciparum* parasites representative of the global diversity for cGMP manufacturing for use in Controlled Human Malaria Infections (CHMI).
DOD RV466 ULTRASOUND	$37,033	Determining the infectious etiologies and their frequencies among adult patients with acute febrile or other severe acute illness with a suspected infectious source presenting to study hospitals in Lagos.
DOD BIOSAFETY AND SECURITY	$262,813	Supporting IPC against especially dangerous pathogens and increasing capacity in biosafety, biosecurity, and bio risk management.
Total	**$188,530,512**	

COVID 19-related Investments

Outside of the Country Operational Plan 2021, PEPFAR has allocated additional funds to Nigeria under the American Rescue Plan Act (ARPA) COVID-19, "to support programs for the prevention, treatment, and control of HIV/AIDS to prevent, prepare for, and respond to coronavirus, including to mitigate the impact on such programs from coronavirus and support recovery from the impacts of the coronavirus." Following the ARPA guiding principles, PEPFAR Nigeria is approved for **$17,525,000** to support activities around the two purposes of ARPA PEPFAR planned funds: 1) Prevent, prepare for, and respond to coronavirus, and 2) Mitigate COVID-19 impact on PEPFAR programs and beneficiaries and support program recovery from the impacts of coronavirus. All planned activities are aligned with broader USG global COVID-19 response and recovery strategies and objectives and are non-duplicative of existing support to the Government of Nigeria's COVID-19 response. The PEPFAR Nigeria team has completed the PEPFAR ARPA COVID-19 Assistance request, including the table of the various activities to be undertaken (see in appendix), which has also been entered in the COP21 FAST, per the guidance.

Table 2.2.4 PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP

Funding Source	Total PEPFAR Non-COP Resources	Objectives
USAID – COVID ARPA Funds	$8,308,250	Funds will be used to support PEPFAR programming as stated below: • Build COVID-19 vaccine module in EMR (LAMISPlus) to support surveillance of COVID-19 vaccinations in PLHIV in USAID –supported SNUs. • Improve IPC practices among health care workers in USAID-supported sites. • Produce and disseminate evidence-based COVID-19 prevention messages and will drive demand for COVID-19 vaccine via multimedia. • Support COVID-19 vaccine access for PEPFAR beneficiaries and staff at targeted sites, including coordinating the prioritization of vaccines for PLHIV with NPHCDA, NCDC, and state-level. • Support the transport of COVID19 test samples in Nigeria, leveraging the HIV viral load sample transport network that exists via PEPFAR. • Support COVAX rollout in Nigeria, leveraging the health commodity supply chain and logistics system that USAID supports in Nigeria, including storage/warehousing and distribution of COVAX to the state-level; and • Support scaling of decentralized drug delivery (DDD) and MM6 reducing client exposure to COVID-19 within health facilities (including partnering with private sector actors to leverage investments).

Table 2.2.4 PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP		
Funding Source	Total PEPFAR Non-COP Resources	Objectives
DOD - COVID ARPA Funds	$500,000	• Strengthen Infection, Prevention and Control (IPC) among HCWs. This will build on the results of the IPC study among HIV HCW, to include training of over 1,000 health care workers across 32 military health facilities. The training will be in two phases with ToT and step down at each facility. Disinfectant such as Sodium Hypochlorites, Medical Grade Alcohol-based Hand sanitizer, Auto Sanitizer Dispenser etc will be procured to improve supplies at the sites. • Strengthening military-supported COVID-19 laboratory testing platforms to primarily serve the HCWs that have been more prone to getting infected with COVID-19 when caring for PLHIV, and to provide confirmatory testing in the event of inconclusive results on the COBAS 8800 or GeneXpert systems. This include purchase of ancillary supplies for open PCR platforms (Roche LightCycler and ABI 7500), including RNA extraction kits, that are not included in the procurements by the GoN or Global Fund. • COVID-19 vaccine sensitization. Data has shown that HCWs are hesitant to receive COVID-19 vaccination in military health facilities.
CDC – ARPA Funds	$8,716,750	Support PEPFAR programming to prevent, treat, and control HIV AIDS to prevent, prepare for, and respond to coronavirus, through: • Strengthened infection prevention and control (IPC) programming at over 1,700 CDC PEPFAR-supported sites. • Increased COVID-19 testing among CDC PEPFAR beneficiaries and staff • Enhanced COVID-19 laboratory capacity for genotyping to track COVID-19 variants of concern. • Enhanced COVID-19 laboratory capacity for serologic testing, including to understand evidence of previous SARS-CoV-2 infection among PEPFAR beneficiaries and serologic testing of HIV viral load remnant samples. • Enhanced PEPFAR data management systems for COVID-19, including site-level electronic medical records (EMR), the Laboratory Information Management System (LIMS), and the National Data Repository (NDR); and, • Expanded virtual telecommunications to allow for continued PEPFAR program management during ongoing COVID-19 mitigation efforts (e.g., lockdowns).
Total	**$17,525,000**	

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 2020, 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. Despite slight reversals observed in a few areas. Nigeria achievements continue to be sustained due to the fat that most of the structural and systematic recommendation identified in previous assessments remain intact.

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, as evidenced by the open pronouncement by the Federal GON of its commitment to provide domestic funding for the treatment of an increasing number of PLHIV in Nigeria 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 introduce optimized drug regimens and improve program coordination through regular engagements with stakeholders and the reintroduction of Joint Annual Program Review, all 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, most of the States had yet to make any concrete steps in this regard. One State (Rivers) 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 re-emergence 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 (NISRN) 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.

New in COP21 *- Since the completion of the SID, the National Quantification Team led by the HIV Department of the FMOH prepares a bi-annual supply planning report that tracks procurement and utilization of HIV commodities which is shared widely across all stakeholders. In addition, the National Health Logistics Management System (NHLMIS) has been scaled up and is being utilized by all health facilities providing HIV services in the country with bi-monthly reporting on stock levels, utilization/consumption, and commodity receipts at facility level. This platform is accessible to all state MOHs through the Logistics Management Coordination Units (LMCU) and is currently being upgraded to provide dashboards on commodity status to inform decision making. Similarly, data visibility for the National Integrated Sample Referral Network (NiSRN) is being improved through the following strategies; 1) activation of sample management module with in the Lab Information Management Systems (LIMS) and remote login of samples from the collection sites which enables end-to-end visibility and electronic return of results thereby improving turnaround time for lab results and the activation of e-Labs and an electronic platform to track movement of the lab samples from collection sites to the labs.*

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 EMR systems for optimized biometric data capturing and linkage to the 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.

What's new in COP21 – *Given that the SID is a biannual process, there is no update to the 2019 iteration of the document. The only update to this section is inserted above.*

2.5 Alignment of PEPFAR investments geographically to disease burden

Nigeria has made significant progress towards achieving the UNAIDS goals of 95-95-95 by 2023. At the end of December 2020, there were about 1,804,612 PLHIV in Nigeria. Due to concerted efforts by several stakeholders, the country had 1,492,154 PLHIV currently receiving ART across all SNUs, with PEPFAR alone responsible for 83% of PLHIV on ART, bring the country's treatment coverage to 83%. 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. In 2019, the two states accounted for 18% of the unmet treatment needs in Nigeria.

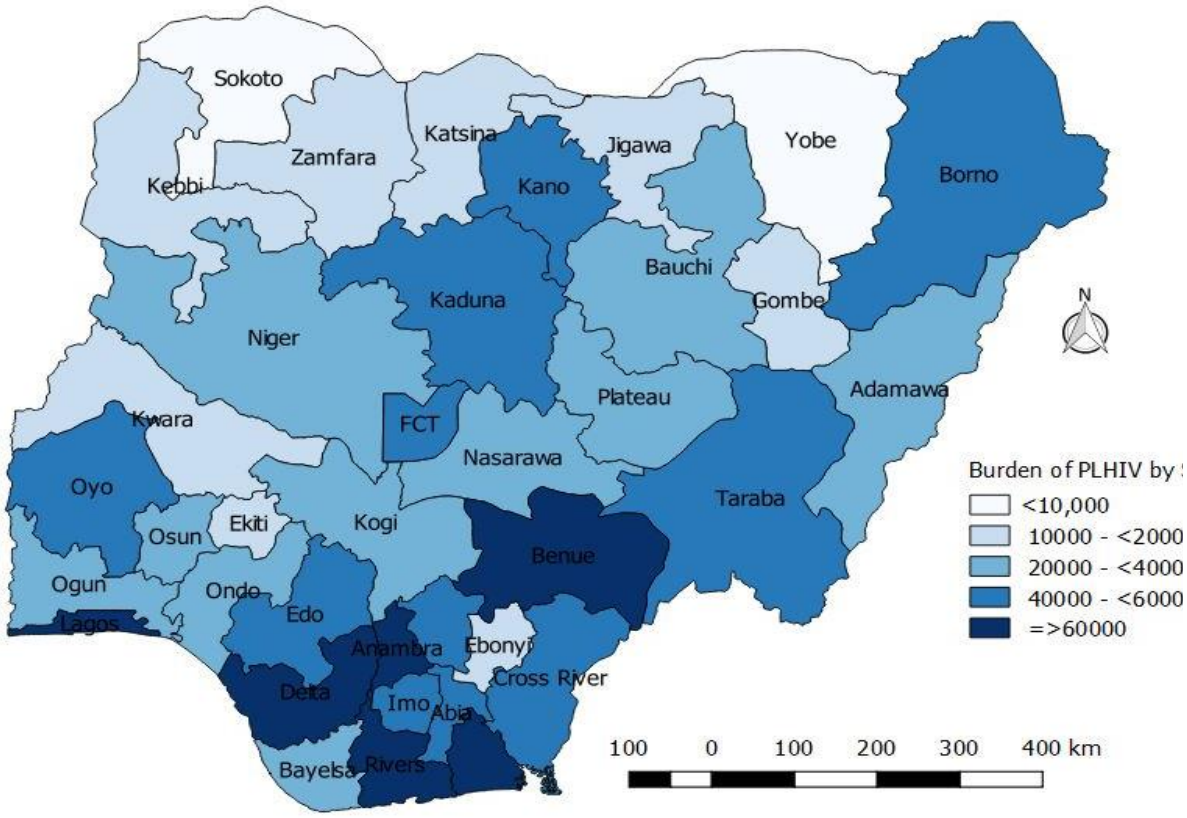


Figure 2.5.1: Nigeria's PLHIV burden by SNU

Figure 2.5.3 depicts the SNUs in Nigeria by treatment coverage and contribution to unmet need. In COP21, PEPFAR will achieve treatment saturation (81% treatment coverage) in 29 states with 6 states having treatment coverage of 60% including programing in Abia. Concurrently, the Global Fund will scale up ART services in Ebonyi and Anambra.

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 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.

2.6 Stakeholder Engagement

Leveraging the opportunity of the virtual meeting space, the country team enjoyed the most in-depth and robust country engagement with Civil Society, implementing partners, GoN, the UN system, and the Global Fund partners, in developing the COP21 planning proposals.

Key Dates	Activity
January 25th – 29th, 2021	**Country Strategic Retreat/COP Launch –**
February 4th – 6th, 2021	**1. Orientation meeting with 7 CSO reps** Thursday 4th Feb - Saturday 6th Feb: 3-day in-person orientation meeting with 7 CSO reps. • **Objective:** To develop an inclusive workplan for CSO participation in the COP21 process
February 9th-10th 2021	**2. Technical level engagement with national stakeholders** • First 90 TWG – 9th Feb Morning • Second 90 TWG - 9th Feb Afternoon • Third 90 TWG – 10th Feb Morning • KP Program TWG - 10th Feb Afternoon
31st March – 1st April, 2021	**UNAIDS-facilitated Community Dialogues to collate community inputs for the COP21 process**
April 1st, 2021	**Live Virtual Plenary for all Stakeholders (Details to follow)**
April 8th – 9th, 2021	**3. Technical level engagement with national stakeholders (Continued)** • PMTCT TWG – 8th April Morning (10am-12noon) • OVC, Peds, Adolescents TWG - 8th April Afternoon (1pm-3pm) • System Health Investments/Table 6 – SI, Supply Chain, Health Finance - 9th April Morning (10am-12noon)
April 13th, 2021	**4. CSO Reps Engagement with Country Team** • **Objective:** CSO reps to provide feedback & recommendations to PEPFAR country team for review and consensus ahead of the engagement with S/GAC
April 22nd and 23rd	**5. Review of Country team's responses initial CSO recommendations with CSO reps**
April 19th, 2021	**Submit Draft Documents to S/GAC** • FAST (free of all validation errors) • Datapack (free of all validation errors) • Supply Planning Tool (free of all validation errors)
April 26th –27th, 2021	**COP Planning Meeting** with HQ and external stakeholders to finalize COP proposal

Figure 2.6.1: PEPFAR Stakeholder Engagement Schedules for the COP21 planning meeting

Starting with the COP21 launch week between January 25 – 29, 2021, the team ensured that there were several more meetings for both CSO and Government stakeholders to meet with the PEPFAR team to review and make inputs to the COP21 planning process. In addition to a three-day orientation meeting for the seven CSO representatives (elected by the CSO leaders' groups that PEPFAR supports), stakeholders had the opportunity to engage with PEPFAR technical working groups in a review of their thematic areas planning proposals and subsequently received all the draft documents required to be disseminated by S/GAC.

The new PEPFAR Advisor in the UNAIDS country office, Ms. Erva-Jean Stevens, facilitated a 3-day series of community dialogues for civil society members to engage in their respective communities to review the COP21 proposals as well as the feedback from the Community COP documents developed by civil society to develop their feedback and recommendations to the PEPFAR country team.

The CSO representatives presented their feedback to the PEPFAR team in a meeting on April 13, and received written feedback as recommended by S/GAC. The key issues raised at that meeting included the desire to have more direct support and funding to local CSO organizations, health knowledge and patient rights programs for PLHIV and key population clients, and others related to individual and community level empowerment. At this meeting and the subsequent COP21 planning meeting, the major CSO discontent was with the feedback from community level field

workers who had been mis-categorized as volunteers, when in fact their time commitments and level of effort should qualify them to be remunerated as full-time workers, especially since the country program made a shift towards community programs to mitigate the challenges of the COVID-19 pandemic.

The PEPFAR leadership team has made a strong commitment to address this issue by:

1. Ensuring an appropriate categorization of community field workers recruited by IPs (by expected level of effort and time commitment) and helping to set baselines for appropriate compensation of community workers,
2. Reviewing current IP workplans and ensuring proper measures are taken to properly compensate community staff, and
3. Setting up appropriate feedback mechanisms for complaints on this and other related issues to be flagged by CSOs.

Community Led Monitoring (CLM) and Community Systems Strengthening

Continuing with the progress on our plans for the roll-out of Community- Led Monitoring, the team has concluded plans with local CSOs to commence data collection for the current fiscal year in May/June. Recruitment is currently underway for CSO members who will conduct the field surveys that will help to gather patient and community levels insights on local factors that may contribute to program outcomes in health facilities, One-Stop Shop facilities offering HIV/AIDS prevention, care, and treatment services. A national CLM framework has been developed in collaboration with other stakeholders and launched by the NACA to provide policy backing to the CSOs leadership of these activities.

Current year plans aim to set appropriate standards of operation for the CLM that will ensure that PEPFAR agency and Implementing Partner teams are collaborating with local CSOs in triangulating the data from the CLM process with the program MER data and appropriately following up on CSO recommendations to improve services at the facilities in line with S/GAC's guidance. In COP21, CSOs will receive funding directly (through the Ambassador's Small Grants' program), to conduct CLM activities in preselected facilities which will be monitored using agreed upon indicators to develop recommendations to the PEPFAR CLM team. Upon review the team will develop appropriate work plans and work collaboratively with the hospitals and OSS facilities to implement these plans. A total of $300,000 has been budgeted for this activity.

Another community system strengthening activity to be implemented in COP21 will build on the progress already made with the Patient Education and Empowerment Project, which is currently being implemented with the Network of People Living with HIV in Nigeria (NEPWHAN) and will support the development and rollout of a curriculum that will help to improve PLHIV's knowledge of HIV-related health literacy (what it means to live positively with HIV, how to set and achieve health outcome goals, how to adopt personal responsibility for health outcomes etc.) and health rights (anti-stigma and discriminations legal framework, grievance communication and feedback etc.) The two phases of this activity in the current fiscal year will train about 1,200 PLHIV support group leaders and Ministries of Health officials (from Federal and State level) who

will eventually collaborate to help disseminate this knowledge amongst PLHIV in the country and set-up a grievance reporting and management process. In COP21, the project will be extended to address similar reported needs among KP clients in One-Stop Shops.

Funds have also been set aside to help map and address the needs of youth-led organizations working in HIV, health, and other related fields and to engage with key population CSOs to determine how best to address the ongoing issues of rights abuse and discrimination through engagement with structural systems. The table below summarizes all the planned CSO system building activities for COP21.

Table 6 - CSO Engagement Plan ($800,000)

Activity	Sub-activities
Patient Education and Empowerment Plan ($150,000)	Capacity Building for NEPWHAN & KP system to develop & disseminate knowledge on; 1. **Health Literacy** (Living Health with HIV, Health Outcome Goals, Personal Responsibility & Package of supported services) 2. **Health Rights** (Anti-stigma and discriminations legal framework, Patient Bill of Rights, grievance communication and feedback)
Community-Led Monitoring through the Ambassador's Small Grants ($300,000)	Local CSOs will access small grants to implement CLM activities in pre -selected sites to collate data on the issues affecting the capacity of service providers to improve program outcomes by improving their service delivery processes
Capacity building for AYP -led CSOs	Mapping of AYP -led organizations and needs assessment
CSO Domestic Resource Tracking and Advocacy	Support CSO work with NACA to improve accountability for HIV program investment through the National AIDS Spending Assessment.
U=U Campaign rollout	Support On-going CSO campaigns on UequalsU
PEPFAR/CSO/stakeholder quarterly meeting	> Quarterly monitoring meetings > Production of briefs for dissemination and action
Structural Interventions to respond to KP rights issues	> KP CSOs capacity strengthening > KP advocacy actions for community needs
Support for CSO Accountability Forum	> Annual conference for stakeholder engagement to enable CSO identify gaps in response for action in subsequent year.

Overall, these plans respond significantly to the feedback and recommendations the Country PEPFAR team received from local CSO stakeholders in the COP21 planning process. Where possible, the other requests will be addressed programmatically while the country team explores opportunities to address the rest through advocacy and collaboration with other stakeholders.

3.0 Geographic and Population Prioritization

3.1. Geographic Prioritization

In COP21, PEPFAR Nigeria will build on the gains of ART surge in COP20 to achieve HIV epidemic control in all geographies and populations through an efficient, multi-sectoral approach.

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 2021 HIV spectrum projections, continuously generated program data, trends and analytic derivatives from NDR, the country program will align and consolidate the COP20 State, LGA, site and community-level geographical prioritization that is categorized by the burden of HIV, unmet treatment need, and treatment saturation. With consolidation, the country is moving from the five core clusters listed in table 3.1 to achieve a minimum 81% Treatment saturation across all except six SNUs: Osun, Ekiti, Bayelsa, Borno, Zamfara and Abia, that have HIV Treatment coverage below 40%, HIV prevalence less than National average and are prone to insecurity.

Table 3.1: Clusters of SNU based on Treatment coverage and unmet treatment needs

Cluster	Description
A	**High unmet need > 100,000 and low saturation < 81% - The high impact zone** o Akwa Ibom & Rivers **(Surge States)**
B	**Moderately high unmet need >30,000 & low saturation < 81% - The high impact zone** o Abia, Delta, Enugu, Imo and Lagos **(Red States)**
C	**Low unmet need and high saturation > 81%, termed the Epidemic control zone** o Benue, Gombe and Nasarawa **(Green States)**
D	**Low unmet need < 30,000 & low saturation < 81% -, termed the low impact zone** o All other states **(Yellow States)**
E	**States with >90% ART coverage across all age and sex disaggregation (in COP20)** o Yellow & Green SNUs meeting the above criteria **(Attained Saturation States)**

PEPFAR Nigeria has made significant progress across the Surge, Red and other target States. At the end of December 2020, the OU TX_CURR grew to 1,243,734. At the SNU level, significant gains were made in Akwa Ibom and Rivers, with both states moving closer to epidemic control. Similarly, Lagos, FCT, Cross River, Kaduna, Niger, Bauchi, Plateau and Adamawa all entered the epidemic control zone as highlighted in Figure 3.1.1. Based on the 2021 SPECTRUM estimates, Akwa Ibom and Rivers states account for 18% of the country unmet treatment need. Seven states (Imo, Abia, Lagos, Borno, Osun, Oyo and Enugu) contribute 43% of the total unmet need (PLHIV yet to be placed on treatment). Fifteen states (Delta, Kano, Edo, Ogun, Kogi, Zamfara, Bayelsa, Ondo, Kebbi, Katsina, Ekiti, Kwara, Yobe, Sokoto, and Jigawa) contribute 39% of the country's unmet need.

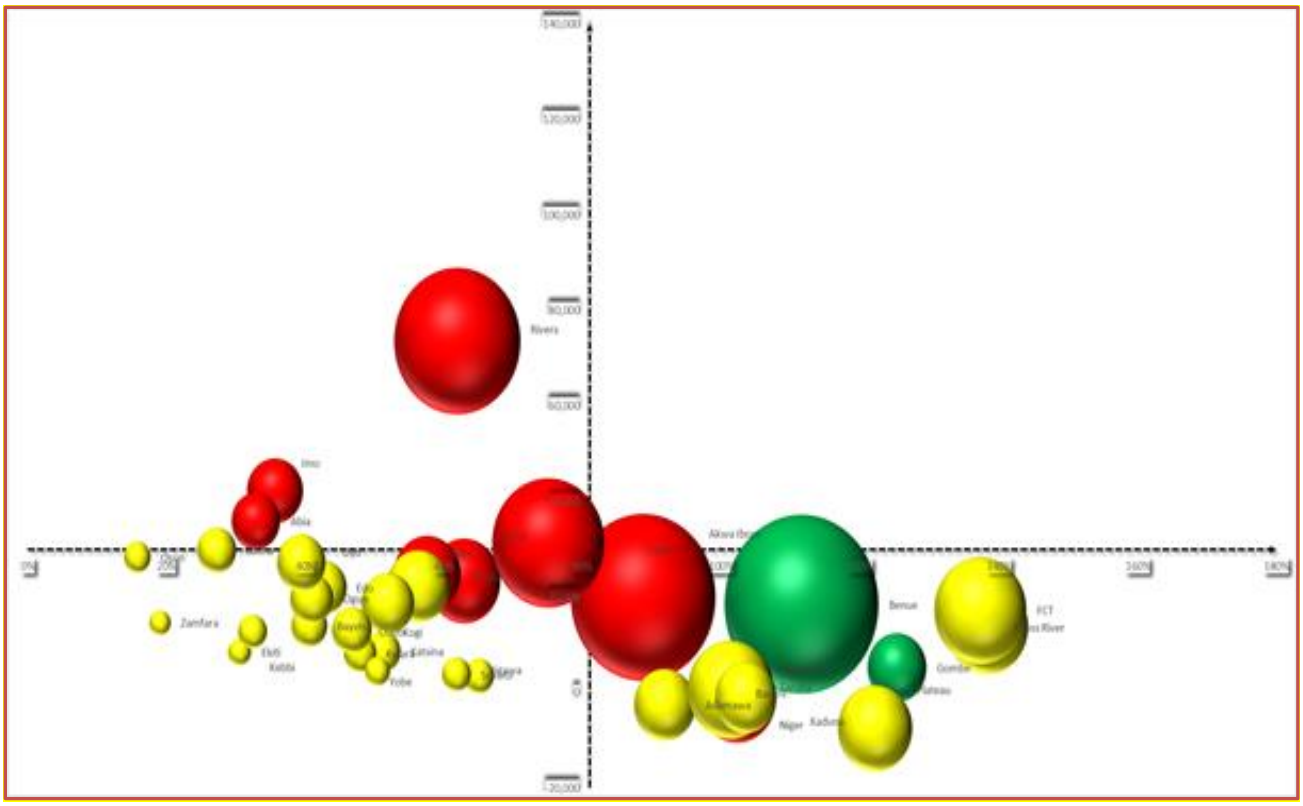


Figure.3.1.1: SNU Epidemic Status at FY 21 Q1

The National Alignment Plan aims to coordinate GON, 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, Abia and Taraba states, which together contribute 7% 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 state of Anambra and a yellow state of Ebonyi.

3.1.1 – COP21 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 COP21 geographical prioritization is intended to facilitate attainment of a PEPFAR new on treatment target of 123,532 and a current on treatment target of 1,691,582 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 PEPFAR Nigeria program across the 34+1 supported states, from the OU FY21Q4 treatment coverage of 89% to 99.6% at end of FY22 (COP21).

Additional contributions to this achievement are expected from the Global Fund and other stakeholders as part of the **National Alignment Plan[16].**

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

I. Achieve 95% treatment saturation in the Surge States of Akwa Ibom and Rivers, moving both from the high impact to the epidemic control zone
II. Achieve 90% treatment saturation in the Red States of Lagos, Imo, Enugu and Delta moving them from the high impact to the epidemic control zone
III. Achieve 81% treatment saturation in all other states except in Osun, Ekiti, Bayelsa, Borno, Zamfara and Abia that will achieve 60% treatment saturation.
IV. Address age and sex saturation gaps in all states with over 81% treatment coverage, to achieve at least 90% treatment saturation by age and sex group
V. Optimize retention services across all SNU to achieve and maintain a maximum 2% interruption in treatment.

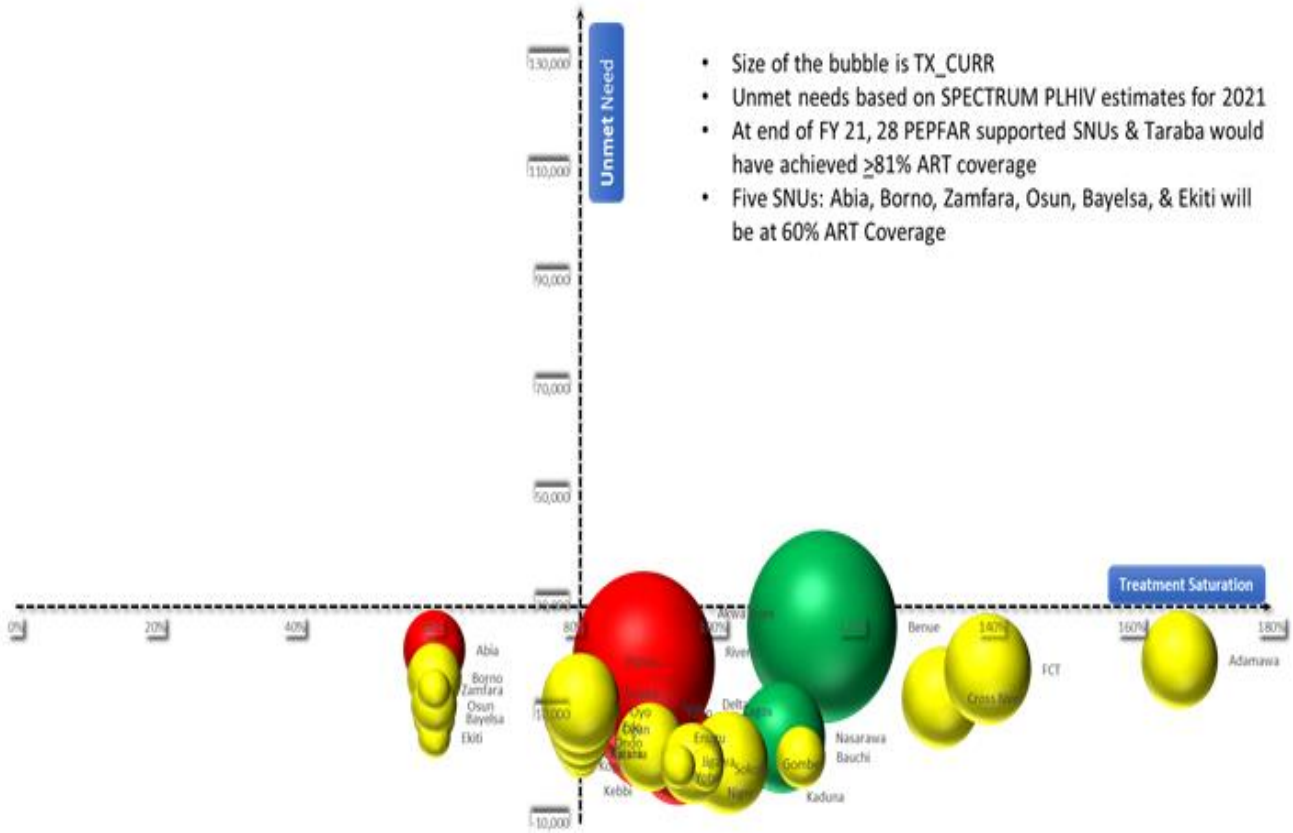


Figure.3.2.2: COP21 Geographical prioritization

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

[16] *A stakeholder's group has been set-up to develop the details of this plan and the document.*

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 females under 35 will be institutionalized as depicted above in Figure 3.1

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 identify significant gaps in treatment saturation including children, adolescents, and young persons (see Table 3.1 below).

4.0 Client Centered Activities for Epidemic Control

4.1 Finding the missing and getting them on treatment

Efforts in reaching the missing populations and sub-populations enabled the identification of 341,379 new PLHIV who were also linked to treatment in COP19 and results in COP20 are quite promising as the program looks set to surpass its case-finding target by a very wide margin. The HIV testing strategies in COP21 will support the overall goal of "Going Green" in all but six of the PEPFAR-supported states by ensuring a treatment coverage of 81% or higher in each state. The experience gained from ART Surge program will be utilized by PEPFAR Nigeria to prioritize the use of potent and efficient HIV testing strategies to improve case finding especially among populations that are being missed, such as men, adolescents, and children across all age groups. These testing approaches will be tailored to the different geographic prioritization zones in Nigeria as the situation varies by location.

The program will continue to work with the partners to utilize data to determine who is being missed in different locations at all levels and follow transmission dynamics to improve case finding efforts. While also working to sustain high quality HIV testing across testing streams through effective implementation of HIV Rapid Testing Continuous Quality Improvement (RTCQI).

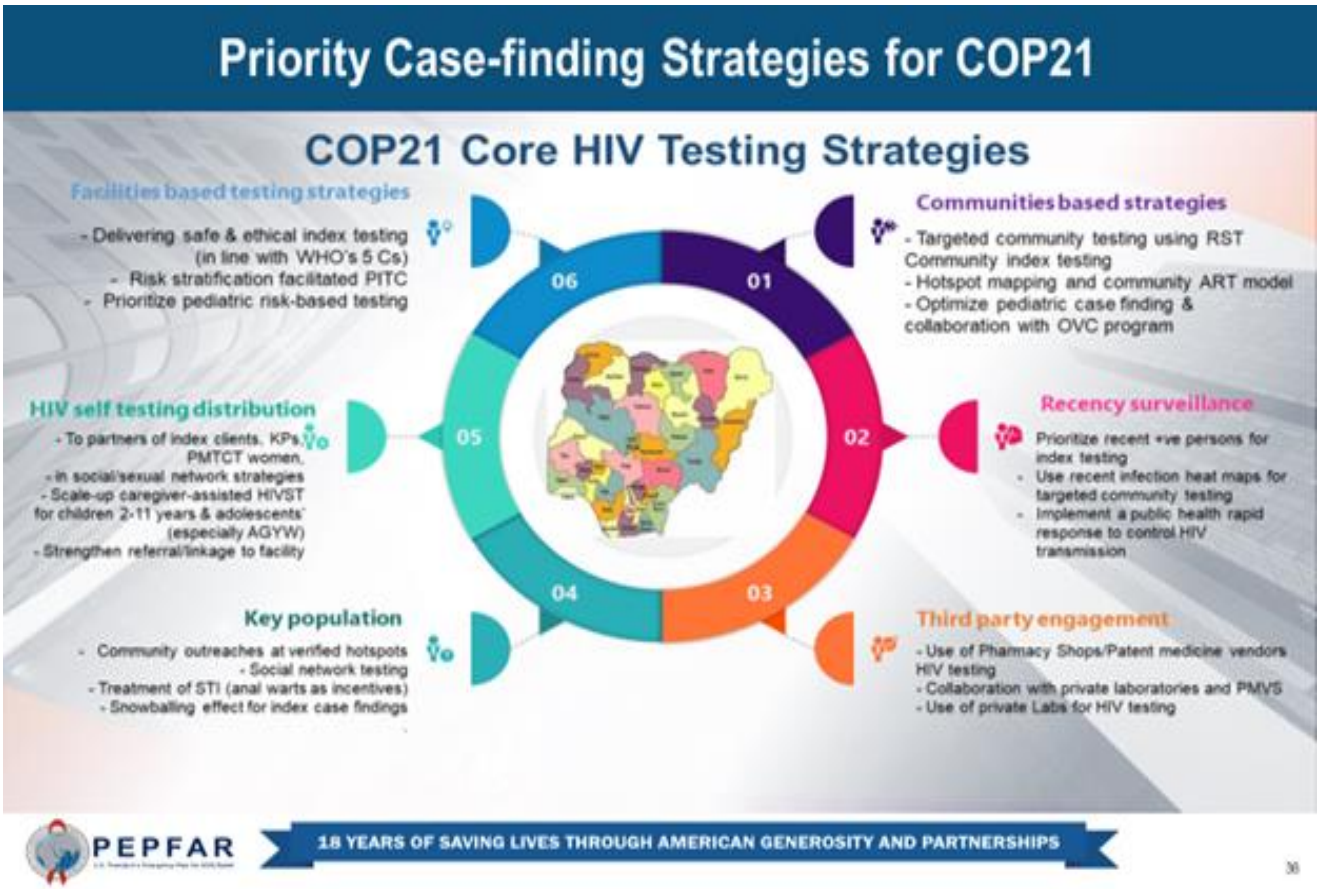


Fig 4.1.1 Core HIV testing strategies

The core HIV testing strategies in COP21 will include:

1) Facility-based strategies such as index testing, provider-initiated testing, and counselling (PITC) based on clinical indication (use of risk stratification tool) and risk-based pediatric testing and
2) Community-based strategies such as targeted community testing, use of a risk stratification tool (RST), community index testing, hot spot mapping/community ART model, optimized pediatric case finding in collaboration with OVC program.

Other contributory strategies for optimal achievement of case finding targets will include, HIV self-testing (HIVST), HIV recency surveillance, third party engagement and HIV case finding strategies tailored for key populations as seen in fig 4.1.1 above.

In COP21, at least 98% of newly identified PLHIV using the above listed HIV testing strategies will be linked to treatment in all PEPFAR supported states in Nigeria. Learning from COP20, the RST will continue to be used to clinically indicate clients eligible for HIV testing, improve the yield and volume of HIV positives identified; hence the program will continue to enhance the capacity of HTS providers to correctly administer the RST. PEPFAR Nigeria will also continue to scale up high-quality, safe, and ethical index testing with fidelity across all geographic prioritization zone as a critical case finding strategy that will contribute at least 30% of newly identified PLHIV (HTS_TST_POS) in the Red and Yellow states and 40% in Green states with at least an overall 18% yield, with offer rates above 80%.

PEPFAR Nigeria will work in consultation with civil society to monitor PEPFAR supported facilities to ensure adherence with the WHO 5Cs (consent, confidentiality, counselling, correct results and connection[17]) and all other minimum standards for index testing set by S/GAC, such as ensuring providers are trained on index testing procedures including human rights, ethics, gender issues especially Intimate Partner Violence (IPV) screening, provision of first line support (LIVES) for IPV etc., are in place as services are being scaled up.

As new sites are continuously assessed for the provision of ethical and safe index testing, an actionable and time bound remediation plan will be developed for sites that do not meet the minimum standards 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 (SOP) 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

[17] *World Health Organization. (2015). Consolidated guidelines on HIV testing services: 5Cs - Consent, Confidentiality, Counselling, Correct results, & Connection, 2015.* https://apps.who.int/iris/handle/10665/179870

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. Expert counselors will support poorly performing sites to scale up with fidelity without compromising quality, ethics, and safety of index client. Index clients with hard-to-reach partners will be offered HIV self-test kits after screening out IPV. Assisted and unassisted approaches will be utilized with HIV Self testing targeting, sexual partners of index clients (also in PMTCT), men, adolescent girls and young persons and KPs who are currently being missed by the program. Also, PEPFAR Nigeria will build on lessons learned from the FY 20/21 Recency TRACE project and program implementation to scale up recency testing in FY 22. Heat maps of locations with recent infection generated from rapid test for recent infection (RTRI) data will be prioritized as additional key tool for targeted community testing, prevention interventions, timely provision of social network testing as well as safe and ethical index testing services.

More importantly, recency surveillance will take a center stage at OU and SNU levels in determining and monitoring rates of new infections in Nigeria. For example, a Rapid Response Team system will be established to quickly institute a public health response based on set recency data threshold triggers.

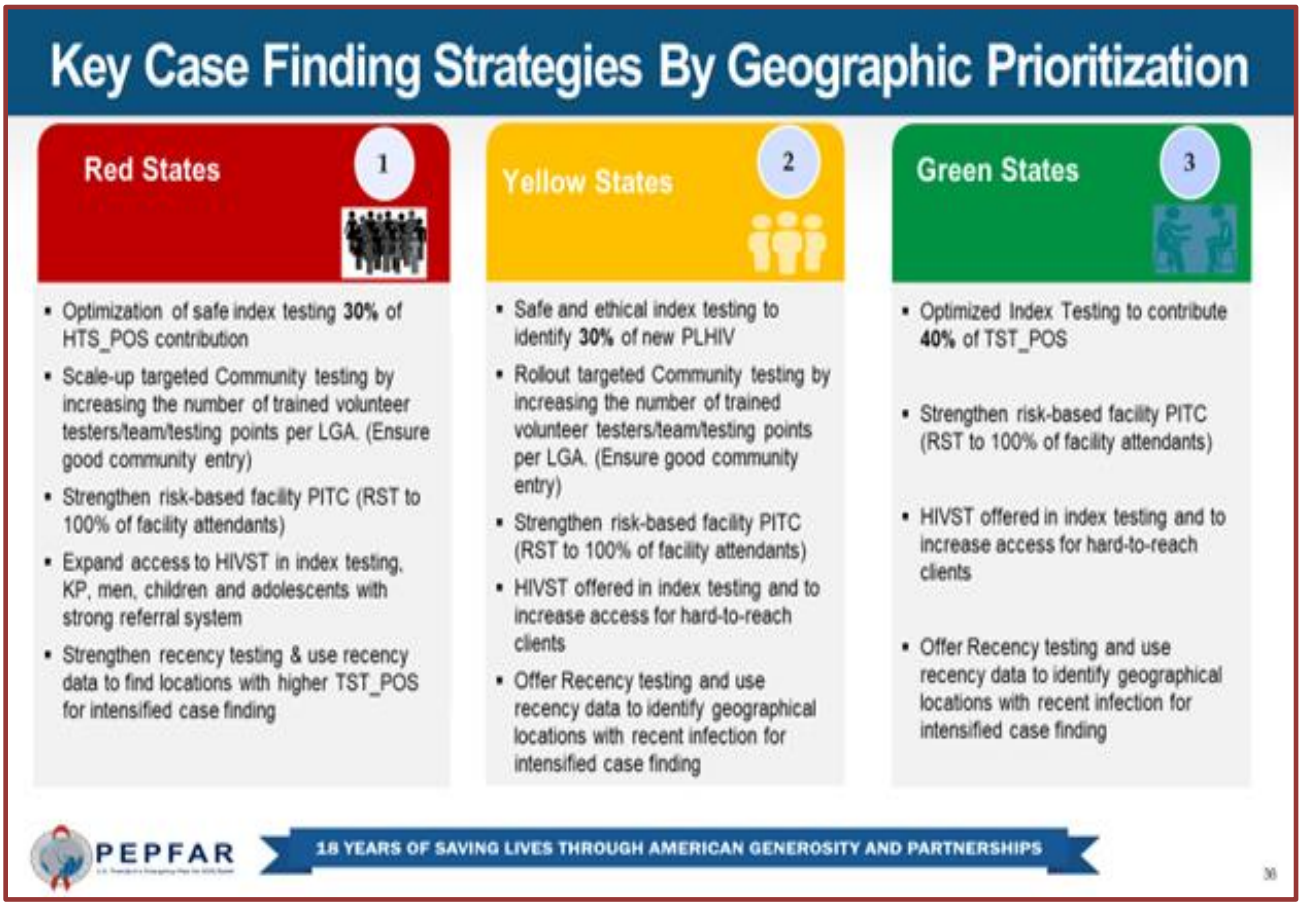


Fig 4.1.2 Case finding strategies by geographical prioritization

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 all states, targeted community testing will contribute between 36-89% of the new PLHIV identified as guided by maps of program data and recency data heat maps to determine testing locations.

The quality of interventions will be maintained and supported through ESM across all SNUs. Also, the RST will continue to be applied in the communities to improve testing efficiencies. Community "Moonlight and Sunrise" testing in coastal regions that continued to generate high yields in FY20/21 will be continued as well as intensified pediatric case finding in collaboration with OVC accelerated pediatric surge programs to improve case finding amongst children.

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.

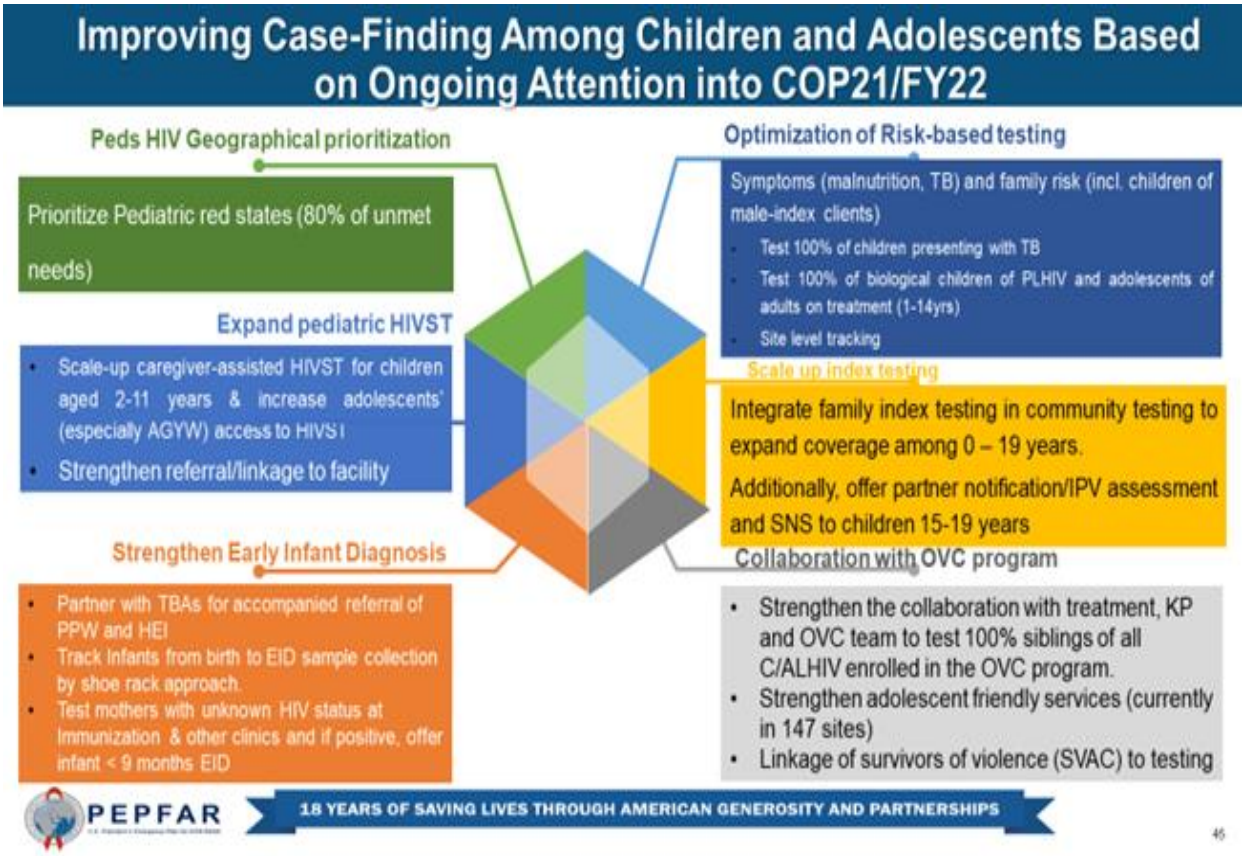


Figure 4.1.3 Pediatric Case finding strategies

In the Green States, strategic case finding strategies such as safe and ethical index testing, will be scaled up with fidelity, and 40% 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 have reached treatment saturation. The RST will be applied in Green States for facility and targeted community HTS to improve the yield.

As Nigeria nears saturation in most states, in COP21, ten (10) states with 80% pediatric unmet need will be prioritized as pediatric surge states to accelerate identification of pediatrics and bridge the treatment gap. In COP20, efforts were made to ensure 100% of all biological children (0-19 years) of adult index clients were tested for HIV but coverage remained sub-optimal. Consequently, in COP21 family index testing as an evidence-based strategy will be scaled up and further integrated into community testing as the testing program pivoted to the community because of poor facility attendance due to COVID-19. PEPFAR Nigeria will work assiduously to ensure that 100% of biological children (<19 years old) of parents diagnosed with HIV are offered safe and ethical HIV testing services if the biological child/adolescent has an unknown HIV status. The HIV Testing Services, Clinical Services, and OVC programs will work closely to ensure this while optimizing testing at all facility and community entry points to identify at-risk children, including biological pediatric and adolescent siblings of C/ALHIV. Index testing will be continued as a strategy to identify biological children of KPs who may be HIV positive, particularly among female sex workers, persons who inject drugs, and MSM living with HIV who have biological children who may require specialized approaches to engage with, and reach in a safe and ethical manner.

To improve testing efficiency among pediatrics in COP20, national RST were refined, and field tested by the FMoH and NASCP in collaboration with PEPFAR and other stakeholders. The final tools will continue to be applied in PITC to improve testing efficiencies during COP21 implementation. Risk-based PITC in high yield modalities, will be continued for all pediatrics with TB, malnutrition etc. to optimize pediatric PITC yields. EID was explored in non-PMTCT settings where children are being brought in such as nutrition/immunization, TB, and pediatric in-patient's clinics to ensure opportunities were not missed. This will be continued, as well as partnering with Traditional Birth Attendants (TBAs) for referrals, tracking of infants from birth to EID sample collection and testing of mothers with unknown HIV status. In line with COP21 guidance, formal relationships between treatment, KPs 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.

Based on WHO guidance, in COP21, PEPFAR Nigeria will expand care giver assisted pediatric HIVST for children 2-11 years whilst ensuring GBV screening is conducted and the principle of do no harm is upheld. HIVST will be targeted at adolescent girls and young women (AGYW) to increase access to HIV testing and case identification amongst them. For adolescents & young

persons (15-24 years), other strategies that will be continued include 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 GBV will be prioritized for HIV testing and positives actively linked to treatment.

4.2. Optimizing continuity in treatment and ensuring viral suppression

Leveraging on strategies outlined in section 2.2 above, PEPFAR Nigeria will continue to improve quality of patient care in COP 21 by optimizing continuity in care across all SNU in Nigeria. This 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. Pediatrics specific case managers will be scaled. 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, adherence 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. Newly identified clients will be evaluated for advanced HIV disease and managed accordingly.

Client already on ART: Appointment reminders by the case manager will be done at least a day or two in advance of 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. Effort will be made to align clinic and laboratory appointments.

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 (>98%) 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 all children weighing >3kg and 4 weeks old.,

4. Scaling 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.

PEPFAR Nigeria will continue to scale NDR predictive analysis capabilities to strengthen proactive management of continuity in treatment. Other approach will be the use of social media platforms for priority client groups to reinforce adherence and retention messages and provide dedicated peer to peer support.

PEPFAR Nigeria will scale use of geo-mapping to identify geographies with the highest IIT 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 virtual meeting 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 IIT will be determined through the application of the 'reason for IIT' checklist. A central collation and qualitative analysis of the reasons for IIT 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 full transition to pediatrics DTG. based regimens in line with revised recommendations to children weighing above 3kg or 4 weeks of age.

The treatment program will also leverage the OVC program to strengthen linkage, ART initiation and continuity in treatment for 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 continuity in treatment 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, MMD, 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 COP 20, PEPFAR Nigeria continued to prioritize the provision of life saving services to Children and adolescents in PEPFAR-supported sites for pediatric ART and OVC services. The program scaled up the enrollment of CALHIV into the OVC programs and strengthened the clinical community linkages and bi-directional referral processes. Case managers located in health facilities ensured that children who needed clinical services were provided with services, while continuing to work with their families to provide the needed OVC case managed services to support enrollment in care, continuity in treatment and viral suppression. This has resulted in an increase in the numbers of CALHIV enrolled in both OVC and pediatrics treatment. Additionally, in COP 20, 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 FCT with OVC program footprints.

As at SAPR FY21, the total OVC HIV STAT POS, proxy for CALHIV on treatment (TX_CURR <19) enrolled into OVC program increased from 32,378 to 37,077. (Figure 4.3.1) which is a 14.5% improvement from APR FY20. For Apr FY20, OVC represented 51% of total Children Currently on Treatment in all PEPFAR states (TX-CURR 0-19) and 64% in the states with OVC programs. However, this 64% includes individuals 18-19 who do NOT qualify for the OVC program. Therefore, while the OVC program continues to focus on enrolling all CALHIV and supporting care and treatment outcomes, it remains a challenge to align the OVC HIVSTAT POS indicator and the TX CURR (0-19) indicator because of the difference in the age disaggregation.

Funding Agency	***Indicator***	***FY20 Q4***	***FY21 Q2***
OU Total	*OVC_HIVSTAT_POS*	*32,378*	*37,077*
CDC	*OVC_HIVSTAT_POS*	*20,132*	*24,377*
USAID	*OVC_HIVSTAT_POS*	*12,246*	*12,700*

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

In response to this ongoing challenge, in COP20, the OVC program conducted a profiling exercise of all enrolled OVCs by the most vulnerable subpopulation groups. This allowed the program to better target services and interventions specific to enroll CALHIV, HEIs, SVAC, Children 9-14, Children of Commercial Sex Workers, etc. The profiling exercise originates from the national OVC database NOMIS which consists of client-level information that includes CALHIV on ART and the corresponding facility. Implementing partners will place a POC in each facility to harmonize client-level information in the NOMIS with the NDR specifically for HIV positive children. Non-HIV positive children will continue to be enrolled in the NOMIS alone. Furthermore, the pediatric TX CURR targets for COP 21 for the existing OVC states is 87,705 (and includes the ineligible 18-19 age bracket). Of this number, the OVC program purposes to enroll the eligible CALHIV (less than 18) and achieve a 90% coverage of TX_CURR <18.

To formalize shared implementation, PEPFAR continues to prioritize a greater alignment with the pediatric care and treatment program in COP 21. Trainings in OVC and clinical package of care will also be conducted for clinical and OVC staff respectively.

In COP21, the OVC program will expand to additional SNUs with high TX_CURR number but do not currently have an OVC program. This expansion will include an additional 13% program growth rate and is based on an analysis of pediatric program coverage and states with sub optimal outcomes for children and adolescents. In doing this, PEPFAR will prioritize SNUs that have low viral load coverage for pediatrics and areas with low viral suppression across age and sex groups for pediatrics (Fig 4.3.0).

Table 4.6.0 Targets for OVC and Linkages to HIV Services					
SNU	***Estimated # of Orphans & Vulnerable Children***	***Target # of active OVC***		***Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files***	
State		***(FY21 Target)*** ***OVC_SERV***	***(FY22 Target)*** ***OVC_SERV***	***(FY21Target)*** ***OVC****	***(FY22 Target)*** ***OVC****
Abia			8,537		6,177
Adamawa	97,817	36,696	36,696	27,522	27,522
Akwa Ibom	200,687	142,111	142,111	106,585	106,585
Bauchi	106,098	38,314	38,314	28,736	28,736
Bayelsa			4,050		3,037
Benue	316,276	131,765	131,765	98,827	108,420
Cross River	136,367	53,125	53,125	39,841	37,656
Delta	124,279	49,262	49,263	36,952	35,317
Ekiti			4,156		2,980
Edo			17,441		12,504
Enugu	94,445	34,752	34,752	26,066	25,617
FCT	117,840	47,911	47,911	35,937	33,824
Gombe	62,562	24,597	24,596	18,450	19,843
Imo	96,393	24,649	24,649	18,496	17,835
Kaduna	194,275	68,972	68,972	51,732	53,526
Katsina			5,112		4,079
Kano	345,541	118,994	118,994	89,242	94,948
Lagos	415,134	155,226	155,226	116,420	107,725
Kogi			10,175		7,061
Nasarawa	123,408	51,558	51,559	38,671	37,704
Niger			34,402		25,158
Ogun			9,430		6,544
Ondo			6,343		4,402

Table 4.6.0 Targets for OVC and Linkages to HIV Services					
SNU	**Estimated # of Orphans & Vulnerable Children**	**Target # of active OVC**		**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files**	
State		**(FY21 Target) OVC_SERV**	**(FY22 Target) OVC_SERV**	**(FY21Target) OVC***	**(FY22 Target) OVC***
Osun			3,860		2,679
Oyo			12,527		8,693
Plateau			20,695		15,134
Rivers	200,188	120,685	120,686	90,519	84,128
Taraba			6,093		4,603
TOTAL	**2,781,639**	**1,098,617**	**1,241,440**	**823,996**	**922,437**

PEPFAR Nigeria in COP21, is scaling up targeted pediatric HIV testing. Pediatric specific screening tools have been developed. 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. OVC partners will work with care and treatment programs to scale up pediatric case finding, particularly in areas with low coverage for pediatrics and SNUs which are experiencing significant treatment net new losses (figure 4.3.1). HIV self-testing will also be scaled up for eligible adolescent clients.

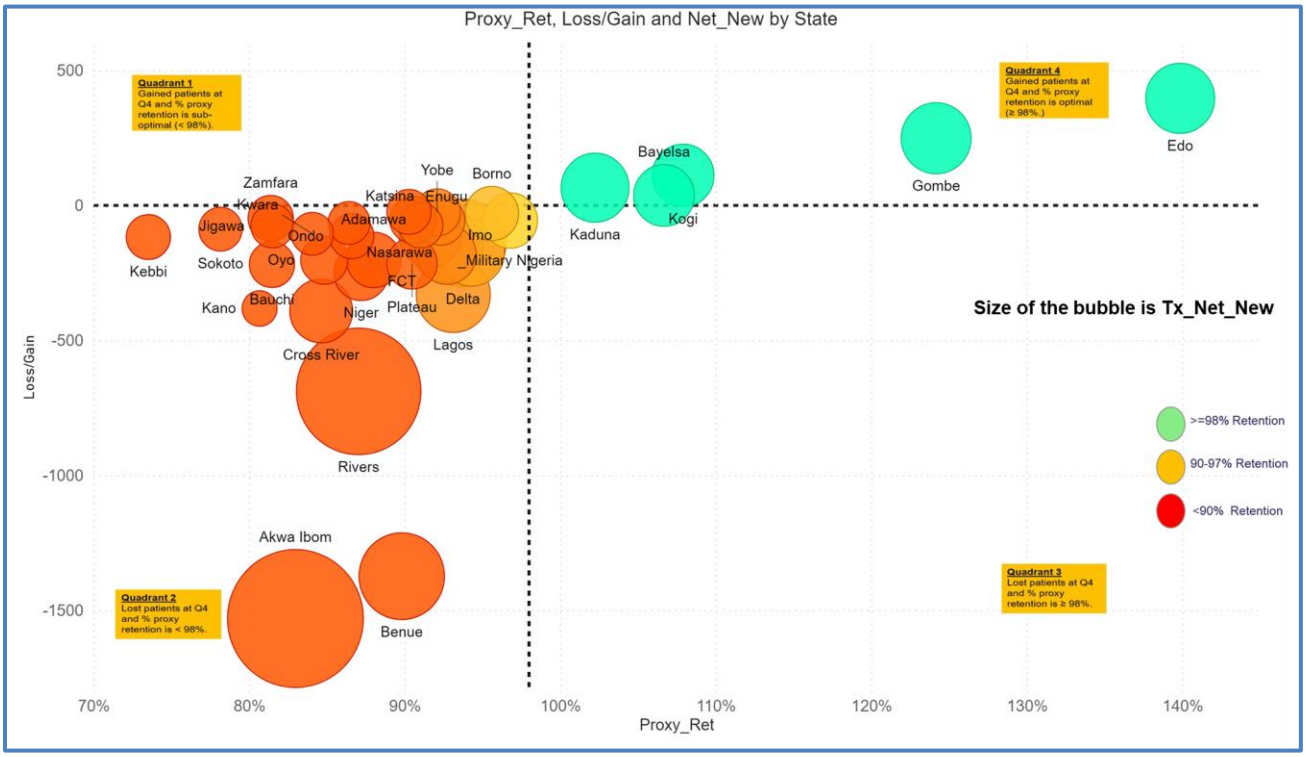


Figure 4.3.1 – Proxy retention losses and gains by state.

In COP 21, the Nigeria OVC program will scale up the Pediatric ART Saturation strategy (PASS) and strengthen integration with the pediatric care and treatment program. PASS will be extended to all sub national units and will be used to support, case identification, linkage, and retention in care. To ensure this happens, the Nigeria OVC program, will be implementing a hybrid model in all states currently not implementing the OVC program. The hybrid OVC program will focus on enrolling beneficiaries from 2 streams of children and adolescent living with HIV (CLHIV and HIV exposed infants (HEI).

In addition, SNUs who have a high burden of any other of the priority sub populations will be able to enroll them for OVC services. Also, evidence-based interventions which are targeted at the primary prevention of sexual violence and HIV to Adolescents aged 9-14 who live in high burden SNUs using three OGAC approved curricula have been adapted to be implemented in Nigeria - Families Matter Program (FMP), Coaching Boys into Men (CBIM) and IMPOWER will be brought to scale. 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, community groups and through referrals. 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 21. In addition, the Nigeria OVC program will continue to implement a program that meets the unlisted OVC minimum requirement by aligning 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 and 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.

To address the sub-optimal outcomes for AYPLHIV, PEPFAR Nigeria commenced implementation of Operation Triple Zero (OTZ) in FY19Q4 at 7 learning sites and commenced scale-up in FY20. As of Feb 2021, over 12,700 adolescents and young people (AYP) have been enrolled in OTZ across 112 PEPFAR-supported facilities in 18 states. Preliminary results from OTZ learning sites are promising having shown an increasing viral load suppression rate trend within a 12-month follow-up period (Figure 4.3.2).

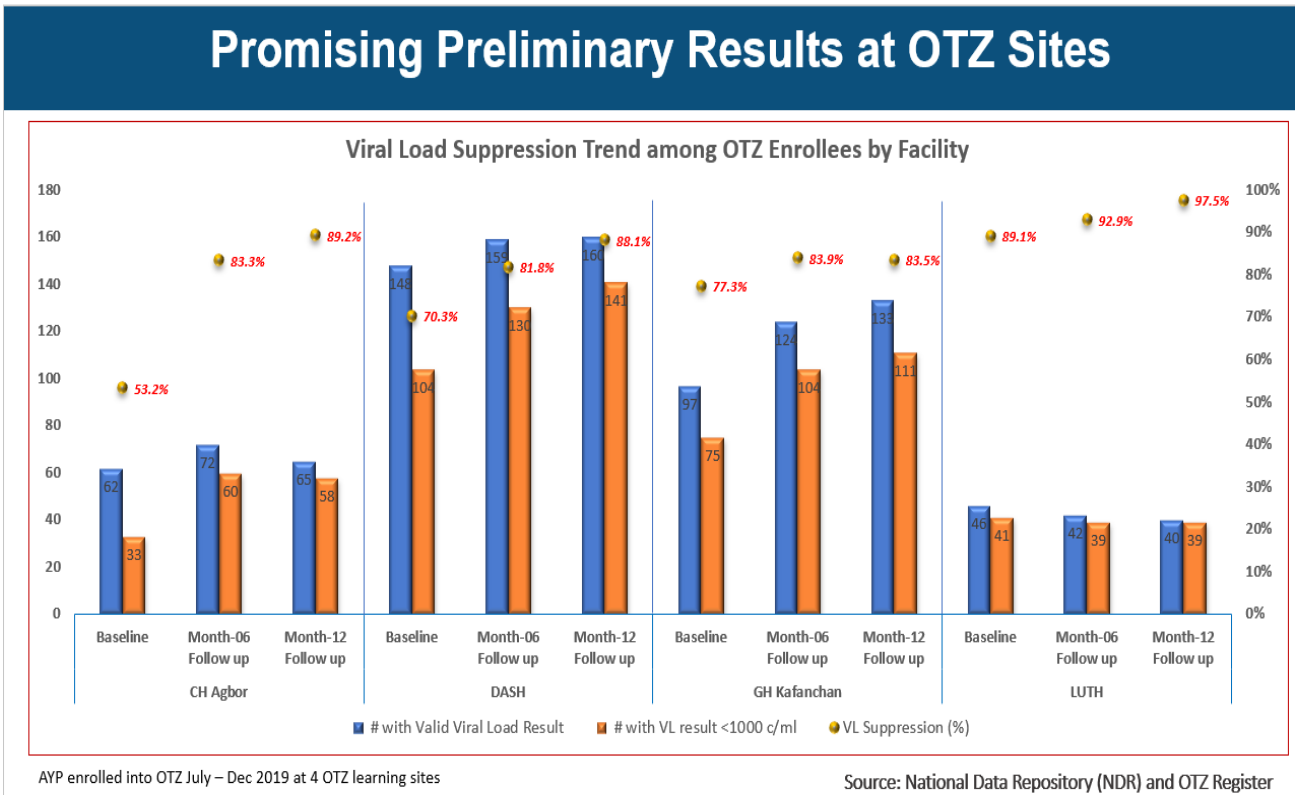


Figure 4.3.2: Viral Load suppression trend among OTZ enrollees

In FY21, OTZ underwent COVID-19 adaptations in response to the COVID- 19 pandemic and continued to motivate and support AYP to achieve the "triple zero outcomes" – zero missed appointment, zero missed drugs, and zero viral load. For COP 21, OTZ will be scaled up further with the goal of reaching 90% of ALHIV TX_CURR, and with a focus on fidelity in the roll-out of interventions.

b. Prevention of Mother-To-Child-Transmission of HIV

Nigeria has low antiretroviral therapy (ART) coverage among HIV-positive pregnant women, partially due to low uptake of facility-based antenatal care and hospital deliveries, therefore finding new approaches to implement evidence based PMTCT activities in community settings is necessary towards the achievement of the COP21 PMTCT targets. Utilizing individual faith and beliefs systems in increasing access to testing pregnant women for HIV as part of community-based interventions has been shown to be well accepted by the community, and effective in increasing male involvement in health issues including promotion of maternal and child healthcare services. The community approach to PMTCT will entail working with communities' structure such as churches, local health facilities and traditional birth centers, to form a network to recruit, test and link pregnant women identified with HIV into lifelong treatment and care.

The approach will engage the communities in the development, implementation, and evaluation of sustainable evidence-based interventions, focus on identification and training of community

partners such as church-based health teams, train health staff (including traditional birth attendants) on developing prevention programs and linking with community-based OVC programs for other socio-economic and welfare support for households. The plan will also include working with governmental agencies, traditional chiefs, community and religion leaders, policy makers and influencers, to adopt and scale-up successful interventions. In addition, this community level approach will focus on identification and training of community partners, church-based health teams, empower communities to take ownership in improving healthcare for members and helps to reduce stigma associated with single disease testing for HIV by using an integrated testing approach during planned baby showers which will target other health issues such as Hepatitis, TB, HBP and others. Community events will emphasize the importance of awareness and health screening in keeping families healthy with linkage of identified positives to a network of facilities for treatment and other related services.

Because of the COVID-19 pandemic and attendant challenges causing poor utilization of services in health facilities, PMTCT services will be directed on implementation of community PMTCT in four states - Akwa Ibom, Benue, Cross River and Rivers states with potential for expansion to PEPFAR yellow States- based on different considerations including lessons learned from surge activities, fertility rates, MCH facility utilization and other factors. It is expected that contribution to overall PMTCT target will be 80% from facilities and 20% yield from the community-based activities.

Pre-natal HIV and Syphilis screening and treatment

In 2010, WHO established elimination of mother-to-child transmission of HIV and syphilis goals for 2015, which has led to establishing the validation criteria. By 2017, 11 countries have been validated and more countries including Nigeria were expected soon. To help address these issues and support the WHO goal of dual elimination of mother-to-child transmission of HIV and syphilis in Nigeria, PEPFAR will be rolling out prenatal HIV and syphilis screening and address barriers to achieving dual elimination of mother-to-child transmission.

Going into COP21, testing at ANC will now be dual HIV/Syphilis test kits. So far, the necessary commodities have been included in the COP21 commodity calculation, Test kits validation concluded by GoN in collaboration with stakeholders, algorithm developed, pilot has been done and result disseminated, and national Training-of-Trainers will be held later this year.
It is expected that the dual elimination effort will enhance both HIV and syphilis case identification through collaborative service uptake mobilization and demand generation.

What we are continuing with:

1. PEPFAR Nigeria will continue to target 95% of ANC attendees to know their HIV status at supported facilities.
2. Target 100% identifies HIV positives for both maternal linkage and EID for HIE (90% Less than 2 months and 10% at 2-12 months).

These would be attained through different location specific innovative strategies.

c. Key Populations

The KP program strategy for COP21 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, it will also leverage on existing differentiated service delivery models at public and private facilities. 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 MMD; HIV viral load services that includes U=U services, VL demand creation and use of Dried Blood Specimen 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 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.

What's new in COP21?
Traditionally the Nigerian KP program has not been funded for harm reduction services under PEPFAR. In COP21, the program will collaborate with the Global Fund-funded KP program to support harm reduction services pilot in three (3) states yet to be selected. In addition, the PEPFAR Nigeria team will participate in the GF/UNODC pilot methadone study.

d. TB/HIV

In FY20, the goals 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 98% of co-infected patients were placed on ART. Over 87% of PLHIV were screened for TB with a positive screen rate of 1.7% and 2% among PLHIV already on ART and those new on ART respectively. Among patients with positive TB screen, 103% had their samples collected and tested for TB with 13% diagnosed with TB mostly by GeneXpert (92%). Of 344,213 ART patients started on TPT, 313, 816 completed treatment in FY 20, giving a TPT completion rate of 91.2%.

In COP21, PEPFAR Nigeria will further prioritize TPT scale up with the aim of achieving a 95% TPT coverage among eligible patients. This will be achieved by intensifying the sensitization of health workers on the importance of TPT and ensuring that they are involved in implementing the scale-up plan; ensuring that new PLHIV at the time of ART enrolment, are placed on TPT following confirmation of eligibility status, conducting folder audit to ascertain TPT eligibility for already enrolled PLHIV and flagging TPT-eligible clients to ensure they are offered TPT during their next clinic visit; leveraging different client tracking mechanisms such as viral load testing cohorts, index testing, OVC, KP, OTZ and contact tracing as opportunities to identify TPT eligible clients and 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 and monitoring of treatment adherence, adverse events and completion. In accordance with the updated National Guidelines for HIV prevention, treatment, and care, repeat TPT is not required in PLHIV who have previously received TPT and are currently on dolutegravir (DTG) as there is significant viral suppression with the use of DTG.

In COP20, TB screening positivity rate was 1.7% in PLHIV already on ART and 2% among PLHIV new on ART, while TB yield from testing of PLHIV who screened positive was 13%. TB case finding among ART patients can be further increased by the identification of sufficient numbers of TB presumptive clients. In COP21, PEPFAR Nigeria will increase TB case finding among PLHIV through improvements in intensified TB case finding efforts. This will require ensuring that TB screening occurs in all program areas and at all service delivery points including ART clinics, PMTCT/MCH, KP programs, adolescent health, OVC, Index Testing and DSD models. Emphasis will be placed on improving the quality of TB screening, proper sputum sample collection, storage and transportation, and utilizing diagnostic methods such GeneXpert MTB/Rif Ultra, chest x-ray, stool testing and TB LF-LAM for TB detection in patients with advanced HIV disease (AHD) and severe illness. The TB-LAM will complement early TB screening and will not replace GeneXpert for TB diagnosis. Furthermore, PEPFAR will sustain the gains of COP 20 by ensuring that at least 95% of TB patients have a documented HIV status and at least 95% 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. TB/HIV service provision will be closely monitored through complete documentation, reporting, and tracking of all elements of the TB service cascade for HIV infected patients diagnosed with TB in the patient care card, NMRS and other data alignment systems/dashboards.

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 starting in the FY19 and accelerating further in FY20 with an unprecedented growth in the ART program. The program expanded access to ART services and initiated 157,080 new PLHIV on treatment in FY19 and 347,374 new PLHIV in FY20 despite COVID-19. Going forward, from FY21 the program will use real-time recency testing to define, develop, and implement a public health investigation and

response capability to identify drivers of transmission and program direction. Additionally, index testing will be scaled with fidelity in low-rate states to help improve case finding yields across the age bands.

Furthermore, the program is creating an enabling policy environment that encourages access to ART by constantly engaging with government and key stake holders to update the national policy documents and standard operating procedures.

As states and SNUs make progress towards epidemic control there will be a concerted effort to sustain the program through advocacy and government engagement. Through high-level engagements with the US Mission Nigeria Front Office, including the Ambassador, Deputy Chief of Mission, and Consul General, governors in high-burdened states have made pronouncements eliminating all user fees that hinder access to same-day ART. However, more engagement and improvement are needed to implement client-centric care strategies and improve the quality-of-service delivery. Other key programmatic issues that will be addressed in COP 21 include:

- Maximize effective interventions to reduce treatment interruptions for clients—particularly client-centered and community-based strategies that have been successful in surge states and strive to re-engage clients who disengaged in previous quarters
- Encourage the use of risk stratification tool in low-rate settings and settings getting close to saturation to improve case finding
- Implement a harm reduction strategy for people who inject drugs (PWID), based on medically assisted therapy is needed to ensure they are retained in care to achieve viral suppression. Additionally, attention to children of PWIDs also need to be paid, linking them to OVC programs and ensure that their negative cohorts and follow up as part of a comprehensive strategy in KP strategy.
- Using virtual platforms (e.g., Project ECHO), the program will continue to improve on its capacity building reach while improving opportunities for sharing of best practices with PSNUs with sub-optimal results
- Sustain the low IIT rate at the OU level, striving for a maximum of 2% IIT
- Further strengthen 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 including the case management community-based strategies showing promising results
- Fully integrated into clinical care, the advanced HIV disease package develop routine system for assessing, monitoring, evaluating, and reporting efforts to prevent, detect, and intervene in advanced HIV disease.

Continuous quality improvement strategies pivoted on client-centered care is currently being implemented as part of PEPFAR Nigeria enhanced site management in all high-volume sites. PEPFAR will continue 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 order to sustain the testing yield and testing uptake of index testing, health care workers will intensify discussions around the benefits of index testing during post-test counseling.

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 minimum program requirements status as at end of FY20. The figure shows that PEPFAR Nigeria has virtually attained all MPRs. In COP 21, in addition to the MPRs already attained, PEPFAR Nigeria will be sustain the achievement and focus on expanding self-testing, scale up PrEP for the high-risk general/key population and complete the use of unique identifiers at all supported sites.

Progress Check	1st 95					2nd 95					3rd 95	Above Site		
	PrEP for KP	Index testing & adolescent case finding	OVC & CLHIV Alignment	Linkage	Test & Start	TLD Transition	Peds Optimization	DSD & MMD	TPT Scale Up	Monitoring Morbidity & Mortality	VL/EID Optimization	Indigenous IP funding	Removal of User Fee	EMR & Unique Identifier
OU	+75%	+85%↓	+75%	+95%↑	+95%↑	+95%↑	+90%↑	+90%	+75%		+85%↑		+75%	+80%↑
Surge	+75%	+75%↓	+90%	+95%↑	+95%↑	+95%↑	+90%↑	+90%	+90%	+75%	+90%		+90%	+75%
Red States	+75%	+60%↓	+75%	+95%↑	+95%↑	+95%↑	+90%↑	+90%	+75%		+90%↑	+90%↑	+90%	+85%↑
Yellow States	+75%	+75%		+95%↑	+95%↑	+95%↑	+90%↑	+90%	+75%		+80%↑			
Green States	+75%	+90%	+75%	+95%↑	+95%↑	+95%↑	+90%↑	+90%	+75%		+90%↑	+90%	+90%	+90%↑

90%-100% 75%-89% 50%-74% < 50%

Figure 4.4.1: Status of the Minimal Program Requirements at FY20 Q4

4.5. Commodities and Supply Chain Systems

Within the Supply Chain system strengthening scope, progress has been made, in collaboration with the GON and other donors, on the following technical areas:

Global Standards One (GS1): While this activity is currently chaired by the GON, through NAFDAC, the central objective remains to strengthen the governance structure that supports the traceability implementation. Several committees such as the NAFDAC GS1 TWG and the GS1 Steering committee have supported the development of the GSI results framework for Nigeria and definition of the KPIs for the traceability initiative. The National Traceability strategy, which was developed in 2019, was formally launched by the HMH in October 2020. There is continued engagement with NAFDAC to initiate the development of the Product Master Database or the National Product Catalogue in 2021.

Private sector management with regards to Lagos & Abuja warehouse: The Abuja Premier Medical Warehouse (APMW) and the Lagos Federal Medical Warehouse (LFMW) were successfully transitioned from an interim private sector operator to a GON coordinated private sector operator in 2020 through a successful Public-Private Partnership bid. This is the first step in the transition of all six Regional warehouses to a GON coordinated Private Sector operated system. Currently the two warehouses are managing several donor-funded commodities including PEPFAR, GF, UNESCO, PMI etc.

NHLMIS: The National Health Logistics Management Information System (NHLMIS) platform was successfully transitioned to the GON through NPSCMP in 2020. The transition also included capacity building for the GON points of contact at the national and state levels on key NHLMIS functions. The annual subscription for the platform was provided by the Global Fund in 2020 while additional features, as requested by the GON, are being developed for the NHLMIS platform based on a funding commitment made by UNFPA. This additional upgrade will be available to all health programs and users of the platform.

Additionally the PEPFAR Nigeria team plans to implement innovative decentralized drug delivery strategies through the expansion of Decentralized Drug Distribution especially the community-based approaches such as community-based ART refill groups (e.g. community pharmacies, private clinics and other community-based dispensing) by developing a coordinated supply chain strategies to support implementation across surge and red states which can then be replicated across the country by the implementing partners. This strategy will further strengthen client- centered supply chain Modernization with increased impact and efficiency for program commodities accountability across different models with the seamless reporting into the NHLMIS and EMR/NDR.

The team also plans to work with GON and the Global Fund to further optimize pediatric ARV regimens, including the rapid transition pediatric <20kg to DTG 10 mg dispersible tablets thereby simplifying the implementation of MMD3 for children 2 - < 5 years of age with adequate supply

chain system in place to monitor the progress of the transitioning to address any encountered challenge.

4.6. Collaboration, Integration and Monitoring – Update on the National Alignment Plan

The GON, Global Fund, and PEPFAR continue to work in partnership to explore new areas for collaboration and alignment in the HIV program. The National HIV Alignment was initiated in COP20 and is being implemented in in two phases.

Alignment 1.0 is the first phase of the National HIV Alignment. Alignment 1.0 resources between the GON, Global Fund, and PEPFAR for FY21 and FY22 are presented in Table 4.6.1 transitioning of 249 Healthcare Facilities and gap filling using resources (US$6.7M) provided by the Global Fund through the HIV primary recipient, FHI360.

Global Fund	PEPFAR	Government of Nigeria
FY21 – $73.4m **FY22 - $80.2m**	**FY21 - $371m** **FY22 - $426.5m**	**FY21 - $16.9m** **FY22 - $16.9m**
Commodity procurement for National program	Commodity procurement and logistics for National program	Commodity procurement for National program
Provision of High-Quality HIV C&T service in Ebonyi & Anambra	Provision of High-Quality HIV C&T service in all states except Ebonyi & Anambra	Coordinate National HIV program and support Abia/ Taraba in partnership with PEPFAR
KP programming (13 states); AGYW/AYP (2 states); Harm Reduction (3 states)	KP programming (12 states); ongoing discussions to scale up	KP Facility services in Abia and Taraba in partnership with PEPFAR
Invest in Health System Strengthening	Support National EMR/NDR platform	Support State Implementation Teams in Abia & Taraba
Support funding gap for governance in GON Coordination	Leverage & improve KP service package	Lead coordination of National Program Performance Framework
Support Capacity building for GON	Implement National ESM & ECHO program	Work towards sustainability

Table 4.6.1: Funding Envelop and Resource Alignment

Under the leadership of the GON and in partnership with HIV stakeholders, 1,189 stakeholders across 36+1 states were capacitated to conduct site assessments to identify gaps in state facilities. In total, 249 solar-powered inverters, 395 air conditioners, and 249 solar-powered deep freezers were installed under the supervision of FHI360 across 249 facilities transitioned to PEPFAR support. Additionally, 395 units of Dell laptops and 249 biometric fingerprint readers are in process of being delivered to IPs offices by FHI360 for onward distribution to IPs in the coming weeks. Fifty- nine (59) laboratories are also in the process of being transferred to PEPFAR support.

Alignment 2.0 is the second phase of alignment where service packages will be standardized and other areas for alignment are being considered as listed below.

1. Standardization of Service Packages for General Population and for KPs

For General Population, the National Guideline will be used to guide standardization and all partners will be required to adhere to the strategy requirements and standards across the 3 95s for optimal client care. Standardization of service package for KPs is finalized and enlists a new KP typology has been enumerated to include MSM, female and male sex workers, PWID, transgender persons and people in custodial and other closed settings. The package recognizes clients, partners, and children of key populations as critical in the national response and has developed packages for all KP typologies including KP mothers & caregivers including children and adolescent KP.

2. Abia & Taraba Alignment: Early conversations between the GoN (NACA and NASCP) to partner with PEPFAR in Abia and Taraba states have highlighted a 3-phased approach onboard and engage stakeholder; Surge implement for scaleup, acceleration and optimization of services; and the sustained support phase with a hybrid of DSD and Technical Assistance (TA) to the GoN to attain sustained epidemic control across subgroups in the states.
3. Laboratory Alignment will address two areas of laboratory functioning. The standardization of laboratory service package and enhancing laboratory performance. It will be mandatory for all laboratories to be linked to the LMIS, implement quality management systems, implement routine equipment management, and practice standard biosafety measures for staff, patients, and environment safety.
4. A consensus National M&E Framework where all partners will participate in joint performance reviews with clear modalities for regular review of program performance across all levels.
5. Coordination by the National response with clear delineation of roles and responsibilities of the distinct entities involved in the delivery of HIV services to engender accountability, clarity of requirements

The GON will continue to lead and facilitate open and honest discussions between all players while strengthening collaborations. PEPFAR will continue to discuss ways to strengthen the alignment and support the government develop one national HIV treatment program in Nigeria. All stakeholders are involved in the alignment process to build an all-inclusive and strong HIV program in the country.

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, with update global guidance, including "Test and Star," and widespread access to viral load assays, the gold standard for treatment monitoring, 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 using the newly approved point of care CD4 platform (VISITEC) or through sample referral to laboratories within the 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 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 cryptococcal meningitis preventive therapy and TPT 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 21, 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 21, 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. In COP 20, PEPFAR Nigeria supported high-volume ART sites across Nigeria in the implementation of cervical cancer screening using Visual Inspection with Acetic Acid (VIA) and have capacity for thermo-coagulation for identified women living with HIV between 25 and 49 years. The lessons learned from these demonstration sites will be scaled-up in COP 21. In COP21, this will strengthen to ensure all women of reproductive age l receive support for cervical cancer

intervention using the screen-and-treat approach and referral services to tertiary facilities with capacity for cervical cancer treatment. Service delivery will be by Visual Inspection with Acetic VIA acid and treatment for precancerous lesions using cryotherapy or thermal ablation.

Women having initial VIA negative screening result will have opportunity 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.

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 will be working with CHAI, GON, and other stakeholders in the roll out of the cervical cancer-training curriculum, data collection tools and reactivation of the cancer technical working group. 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's viral load and EID program has continued to make remarkable efforts at strategically sustaining increased access to viral load and EID testing services, while ensuring that package of services are patients centered and that no population is left behind. At the end of FY20Q4, the viral load testing coverage and viral-suppressions rates were at an impressive 88% and 92% respectively for PEPFAR Nigeria.

Despite the COVID-19 pandemic and its huge impact and limitations on service delivery and uptake in FY20, the country program has demonstrated un-usual resilience and sustained increasing viral load coverage across all sex and age-bands, including children and adolescents.

Key to these achievements were the implementation of the ART Surge strategy and community-based approaches for viral load sample collections, including the use of DBS for collection of samples among KPs and in hard-to-reach areas; sustained use of viral load champions to drive

demand and services uptake at the site levels; use of electronic system for generating line list of eligible patients; and granular management of program at site levels using performance data. On the service delivery part, the country program sustained high volume of testing while grappling with the challenge of lab equipment break-down and delayed response time, as well as disruptions in lab commodities supply due to COVID-19 and its impact on the global supply chain. NISRN was instrumental in re-directing samples to labs based on availability of reagents. Despite these challenges, the lab network collectively tested more than one million patients samples and returned their results in FY20.

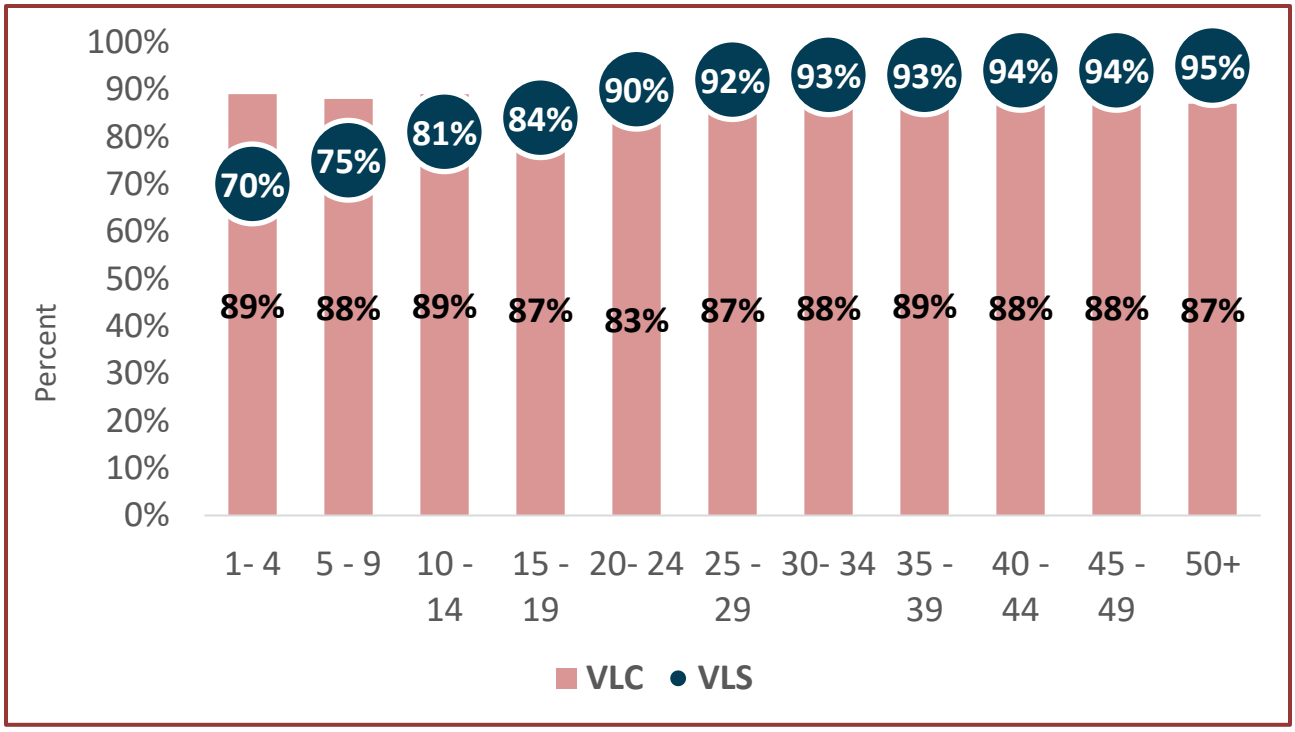


Fig. 4.9.1 - Viral load testing Coverage and Suppression rates across all age bands. FY20-Q4.

In the current year (FY21) the program will sustain and take to scale the strategies and approaches that have shown to be successful in facilitating increased viral load services delivery and uptake. A key lesson learned during our current implementation is that approaches that reach-out to patients within the communities are critically important in increasing testing coverage – rather than waiting for patients to show up in the clinics. Incentivized off-clinic days appointments for viral load sample collection has also been seen to be instrumental in this regard. A major draw-back the program is grappling with is the prolonged downtime of aged PCR equipment. We have commenced the phased replacements of these machines and by FY21Q3 should have fully accomplished this intervention, toward boosting the laboratory network's capacity for sustained high volume testing. We have noted poor reporting of viral load testing coverage among pregnant and breastfeeding women and have prioritized this for urgent remediation in our current implementation. The planned roll-out of EID testing on GeneXpert to complement the conventional methods has commenced and will be completed this year and taken to scale in FY22.

In COP21, we have prioritized the use of "electronic solutions" to further increase laboratory testing efficiencies, including the full implementation of remote sample log-in at the ART/PMTCT site levels – to facilitate this, we will be rolling out the implementation of bar-coding system at all major hub-sites for efficient sample accessioning. We will rely heavily on the use of data at all levels for the routine review and interrogation of program performance. We will roll out the use of HIV drug resistance testing for patients on TLD regimen who are failing to achieve viral suppression. We will also be prioritizing patients with persistent low viremia (50 to 999 viral copies per mL) for drug resistance testing. These activities, coupled with the use of patient's data derived from the ERM/NDR, will facilitate identification of patients who are likely to fail on viral suppression, as well as inform clinical decisions, including switching ARV regimens.

We are encouraged by the resilience of the viral load program and have targeted to provide viral load test to all eligible patients in COP21, thus given us a viral load coverage target of 100% by end of FY22.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

Achieving and sustaining epidemic control requires strong key systems. PEPFAR invests in building local capacity for key systems through these above-site investments. These investments, while not being directly related to service delivery, are necessary to help create an enabling health system environment to support services. The PEPFAR's Above Site investments are housed in what is referred to as Table 6 and Surveys-Surveillance, Research and Evaluation (SRE) and is summarized in the "Systems Investment Table" in appendix C and are described in the narratives below.

S/N	Project Title	Status	Budget
1	Community-Led Monitoring/Ambassador's Small Grants	On-going, modified	$ 300,000
2	CSO Engagement Plan	On-going, continuing	$ 500,000
3	African Cohort Study (AFRICOS)	On-going, continuing	$ 500,000
4	Nigeria AIDS Indicator and Impact Surveys (NAIIS)	On-going, continuing	$ 440,572
5	National Data Repository (NDR)	On-going, continuing	$ 4,371,548
6	National Integrated Sample Referral Network (NISRN)	On-going, continuing	$ 3,000,000
7	NOMIS Upgrade	New	$ 350,000
8	Domestic Resource Mobilization	On-going, modified	$ 500,000
9	HIV ST - Total Market Approach	New	$ 250,000
10	OVC Situational Analysis	New	$ 250,000
	Total		**$ 10,462,120**

Table 5.1.1: Above site investments

1. **Community-Led Monitoring/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. PEPFAR and by the U.S. Department of State, Africa Bureau's Ambassador's Special Self-Help (ASSH) Program.

2. **CSO Engagement Plan**
   PEPFAR Nigeria will continue its collaboration with the local CSO community and will invest about $500,000 to continue the projects launched in COP20. The Patient Education and Empowerment Plan will be expanded to also address health literacy and human rights education of key populations accessing services in One-Stop Shops across the country. In addition, these funds will support the local CSOs "U equals U" campaign

and help to set-up structural capacity building interventions for Youth-Led CSOs and key population advocates and will support their collaboration with local human rights public institutions and organizations. Lastly, the funds will pay for the quarterly PEPFAR/CSO engagement meetings as well as the annual CSO accountability forum; an annual CSO-led conference which reviews the national HIV response with the intention to find opportunities for improved CSO collaboration with other stakeholders on the national HIV response.

3. **African Cohort Study (AFRICOS)**

Africos is a multi-country, multi-year cohort study managed by DOD. It is in the 8th 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 3,556 patients (comprising of 2,950 people living with HIV (PLHIV) and 606 HIV-uninfected participants as of December 1, 2020) globally, while Nigeria enrolled 383 patients (10.8%) and every 6 months collects clients' social, demographic, clinical and laboratory data as well as blood and other samples (as appropriate) 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, SARS-CoV-2, 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. Serologic testing for SARS-CoV-2 was recently added. In COP 21, Nigeria's participants' enrollment target will be maintained at 550 participants (consisting of 459 PLHIV and 91 HIV-uninfected participants). The Cohort will provide useful information regarding morbidity and mortality monitoring, HIV drug resistance patterns, non-infectious comorbidities, impact of COVID-19 on HIV pathogenesis and outcomes, effect of COVID 19 movement restrictions on patient care, effect of TLD transition on clinical outcome and understanding of persistent low-level viremia among other variables being monitored. This will guide our understanding of the disease progression to formulate policies that will improve clinical outcome.

4. **Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS)**

Following the completion of data collection activities in all states and the Presidential announcement of NAIIS results in March 2019, 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 resistance, and presence of antiretroviral drug metabolites, were completed. The staff at the National Reference Laboratory received training to manage the stored samples in the biorepository lab which was also set-up with NAIIS

funds. Data analysis and validation has been completed and the draft technical report underwent scientific review and clearance.

In 2020, the NAIIS technical report was cleared by CDC headquarter Science Integrity Branch and presented to the GON for dissemination to other stakeholders and the public. Other NAIIS information products, such as the revised State summary sheets, HIV Drug Resistance summary sheet and Lagos State NAIIS technical report, were developed and submitted for scientific review and clearance. In addition, the development of NAIIS public access data portal (NADA) began in 2020 and is ready to host NAIIS-related information products and survey datasets for public use. The NAIIS public dissemination package is currently undergoing scientific review, awaiting clearance before release to the public. With COP20 funds, the biorepository sample management system was upgraded to international standards to enhance quality assurance in the storage and retrieval of samples for further testing.

With COP21 funds ($440,571), NAIIS public access data portal (NADA) will be finalized, and general awareness created on access and use of NAIIS data for HIV epidemic monitoring, programming, and secondary data analysis.

5. National Data Repository (NDR)

The NDR contains records of over 1.4 million active clients in all 36+1 states in Nigeria, with data coming from all PEPFAR supported health facilities. There is also a robust analytics and visualization module that supports program implementation including viral load cascade monitoring and tracking, monitoring of IIT, weekly monitoring of the ART surge program, quarterly reporting of key indicators to DATIM via flat files, HIV case surveillance and recency. PEPFAR will focus on capacity building and implementing key data science approaches to improve Nigeria's HIV programming. This will include development of predictive models using the data on the NDR for predicting clients who have potentials for IIT, viral failure, etc. This will guide patient-specific interventions to improve the quality of patient care and the overall patient outcome.

In COP21, PEPFAR will strengthen health information systems by continuing support for the implementation of the NDR, development of patient unique identification system for accurate matching and deduplication as well as support other program initiatives, expanding interoperability and health information exchange as well as build the capacity of its partners to continue to support and develop HIS.

Currently, 70% of PLHIV clients in Nigeria have their fingerprint data on the NDR. In COP21, fingerprint capture shall be scaled up to and maintained at 100% of PEPFAR supported patients. Additionally, riding on the existing data, we will be expanding the NDR to include a client registry that will enhance the opportunities for implementing a National Patient unique identification system for the HIV program.

In COP19, HIV Recent Infection Surveillance was funded through two IPs, 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, in addition to military facilities supported by DOD across these states. While UMB has supported implementation three additional states and the military facilities supported by DoD. The COP19 total recency target in the eight surge states was 64,820 which represents 30% of HTS_TST_POS targets in the states. The recency surveillance data management system including a recency visualization dashboard for real-time reporting was set up on the NDR.

In 2021, activation of recency surveillance has been scaled up to 23 states and over 220 sites. The US DOD received ethical clearance and commenced training, and activation of recency surveillance activities in military facilities. Asante HIV-1 recent rapid test of 44,600 were available to support recency testing through COP20 funding Implementation continued through the comprehensive partners. Carryover of $673,617.54 was available through ICAP CDC-HQ TRACE award to support use of recency surveillance data for public health action and response and to procure additional 50,000 Asante HIV-1 recency rapid tests.

In COP21, PEPFAR Nigeria is preparing to procure 129,000 recency rapid test kits, implementation of recency surveillance activities and recency surveillance public health action and response system. No other source of funding has been identified to support Recent Infection Surveillance in COP21.

In COP 20, the case-based surveillance and mortality surveillance protocols were developed and approved, currently it is funded through the SHIELD award and implemented by UMB. About 25% of sites in 18 CDC supported states have been activated for case-based surveillance (CBS), national CBS committee inaugurated, and national policy documents have been drafted including implementation roadmaps. In COP 21, we are proposing scale-up to achieve national coverage, incorporate mortality status into CBS systems using identifiers with the ability to match sentinel events uniquely, securely, and confidentially for diagnosed PLHIV over time and services, and build national capacity for the use of CBS data for public health action across all levels. We will work with GON to come up with policies needed to scale the use of unique identifiers for clients that are linked across all service delivery sites.

We will continue to expand the country's health information exchange (HIE) between the different health information systems both within the HIV program (including the EMR, LIMS, NHLMIS) and across other programs including the TB program, OVC program etc.

6. **National Integrated Sample Referral Network (NISRN)**
One of the identified barriers to improved viral load uptake in Nigeria in COP17 was the absence of a national viral load scale up strategy, hence the need to establish a national integrated sample referral network. This need became more critical as the rationalization of

the PCR Lab network reduced the footprint of PCR labs in the country with the attendant increase in viral load testing needs.

NISRN became functional in FY18 and serves to pick-up samples from health facilities (using 3rd-party logistics providers) and moves these to the PCR labs and other referral labs in the network, and in turn, picks-up results from the referral labs back to the clinics. NISRN is operated by a PEPFAR implementing partner but is co-funded by the Global Fund and is currently the common system for all viral load and EID sample referral in the country, irrespective of donor or implementing partner. This is being expanded for TB and CD4 samples, as well as other emergent diseases. Recently, the country has been able to leverage the sample referral network to support COVID-19 sample transport in states with clear sample logistics constraints.

The efficiencies of NISRN have highlighted the need for improved lab services to increase testing output of the high throughput platforms and minimize wastages as well as ensure samples are not backed up in labs without being tested. The focus for NISRN in COP21 is to improve turnaround times at the different points of the network:

i) Facility: Turnaround time from when the test is requested by physician and the sample is collected and ready for pick up
ii) NISRN: Turnaround time from when the sample is ready for collection and when it is picked up and delivered to the Lab
iii) Laboratory: Turnaround time from when the sample arrives at the Lab and when it is tested with results ready for return to facility

7. **NOMIS Upgrade -** In 2020, PEPFAR Nigeria assessed the National OVC Management Information System (NOMIS) system in Nigeria to identify current system limitations. This assessment was a result of user feedback on the difficulties being experienced in using the NOMIS for data collection, reporting and programming within an increasing data need by PEPFAR. The key findings highlighted limitations of the current NOMIS architecture to support modularity in the software development life cycle (SDLC). This, in turn, limits scalability and interoperability of the system with other systems in the ecosystem. Poor system governance, e.g., a lack of health informatics protocols, technical documentation, or a robust community of practice (CoP) to manage and sustain the SDLC were other key findings of the assessment. In COP 21 PEPFAR Nigeria will work to address these challenges and make the NOMIS more functional and inter operable

8. **Domestic Resource Mobilization and Tracking -** In line with the PEPFAR Minimum Program Requirement (MPR) to demonstrate "evidence of host governments assuming greater responsibility of the HIV response," COP 20 domestic resource mobilization (DRM) efforts continue to focus on the integration of HIV services into national and state health insurance schemes and improving government expenditures on HIV through public budgets. Additionally, PEPFAR supported the NACA to develop a domestic resource mobilization

strategy (DRMS) and is supporting an assessment of the feasibility, potential benefits, and risks of local production of HIV commodities.

On World AIDS Day 2020, the Government of Nigeria formally adopted and launched the National Blueprint for Integration of HIV into State Health Insurance Schemes. The blueprint was developed by NACA, the National Health Insurance Scheme, and other HIV stakeholders with PEPFAR support and provides guidance to Nigeria's 36 states and FCT on how to integrate HIV services into their state health insurance schemes. Specifically, the document provides recommendations on the minimum package of HIV services feasible to integrate into insurance benefits packages, appropriate payment models for providers, and purchasing arrangements, among other key considerations. Each state will be required to adapt the blueprint based on their unique contexts.
At state level, PEPFAR further supported Lagos State to develop and implement a roadmap for integrating HIV into the state health insurance scheme (SHIS). This included the completion of the HIV integration roadmap and identifying and implementing necessary steps for HIV integration, including identification and empanelment of additional HIV facilities, accreditation and contracting with those facilities, mapping out mechanisms for referral and monitoring and evaluation for HIV integration, and commodity logistics. With PEPFAR support, Lagos State has empaneled 119 health facilities for provision of HIV services, enrolled over 300,000 into the Lagos SHIS, released funding for health insurance coverage and commenced HIV service delivery in 30% of empaneled health facilities.

In 2021, the Lagos State Government increased its HIV budget allocation by 7% (N605,101,737) and 31% budget expenditure was achieved in 2020 (N173,000,000). In FY21Q1, the Lagos State Government released N100,000,000 from the HIV budget and spent N49,000,000 for the procurement of 130,000 RTKs.

PEPFAR supported NACA to develop an updated DRMS (last developed in 2012) aimed at increasing domestic financing for the implementation of national HIV/AIDS programs in Nigeria and reducing dependence on donor funding for HIV control efforts. The estimated value of domestic resources to be mobilized from 2021–2025 could be as much as US$662 million, with most of the new funding proposed to come from increases federal and state government budget allocations and releases, the planned HIV Trust Fund, funds raised through the bond market, and philanthropic contributions. Implementation of the DRMS will help increase the government's commitment to HIV funding, reduce HIV funding gaps, and contribute to the achievement of HIV epidemic control in Nigeria. Currently, the DRMS is undergoing final reviews by NACA and Health Policy Plus (HP+), and will be disseminated for implementation before the end of April.

One of the major pillars and strategies proposed in the draft DRMS is local production of HIV commodities. PEPFAR is supporting the assessment of local production of HIV commodities feasibility, which will serve as a useful advocacy tool to set the stage for a more robust

investment case for local production of HIV commodities in Nigeria. It will also help to guide the GON and donors in identifying key issues to be considered to determine whether to launch local manufacturing of HIV commodities, and, if so, provide key steps for successful implementation.

In COP21, PEPFAR will continue to support efforts to improve government expenditures on HIV through public budgets and full integration of HIV into health insurance schemes with focused support in Lagos State. Emphasis will be placed on demonstrated coverage of HIV services within health insurance packages in Lagos State (to serve as a proof of concept for scale up to additional states), increased budget allocations and releases for HIV and increased state government purchase of RTKs.

9. **HIV ST - Total Market Approach** - Currently, Nigeria sub-optimal uptake of HIV self-testing services. Substantial evidence has shown that HIV self-testing (HIVST) is a critical strategy in reaching the first 95 of the UNAIDS' 95-95-95 goals. The convenience, privacy and anonymity of HIV Self testing allows users to test themselves in their homes or safe spaces and helps breaks down stigma and other structural barriers (i.e., distance to health facilities, wait times) that limit access to HIV testing, particularly among select sub populations (men, adolescents, and key populations). While much of PEPFAR's focus for HIV self-testing is on the public sector, it recognizes the need to strategically coordinate with/and support other sectors for successful scale up HIV self-testing in Nigeria. Scaling up access to HIVST in the private sector will contribute to increased case identification and linkage to treatment.

   A total market approach (TMA) to self-testing, which has been promoted by PEPFAR and adopted by the Federal Ministry of Health, provides a framework for stakeholders to optimize the use of the full range of public, private commercial, nonprofit, and donor resources in Nigeria to increase sustainable, equitable, and efficient access to HIV self-testing information, products, and services. With 50% of Nigerians seeking healthcare from private providers, the private health sector plays an integral role in health service delivery in Nigeria. Acceptability of HIV self-testing especially among Men, KPs and youths has been established. A recent study conducted in Nigeria showed that 47% of KPs prefer HIVST to traditional laboratory testing, and over 80% are willing to pay for HIVST (an average of N1,420 per test kit). The program is unable to significantly scale-up targeted use of HIVST due to price considerations (remains above $3/test kit). This highlights the need to speedily engage all stakeholders using the TMA to create a balance across the public, private and social markets to take self-testing to scale and ensure provision of client centered care.

   In COP 21 PEPFAR will work to increase private sector supply and distribution of HIVST, increase awareness and demand for HIVST, improve coordination with GON and other key stakeholders such as UNITAID (to avoid duplication and improve efficiency in service delivery) and work to lower the negotiated HIVST price.

10. **OVC Situational Analysis** – The Nigeria program prioritizes efforts to address the needs of OVC and mitigate the negative outcomes of HIV on this population. To achieve this, it is necessary to collect relevant data and information that will help to identify the gaps in policy and practice and to assist policy makers, program implementers and service providers to make evidence-based decisions about how best to fund and implement programs, to maximize positive outcomes for children and their caretakers. The OVC Situational analysis will help to achieve this. It is a nation-wide cross-sectional study targeting children and adolescents between the ages of 0–17 years. It will examine and document the overall situation of OVC in Nigeria and provide data on the state of vulnerable children. In addition, the study will help evaluate the impact of the OVC program on the health, safety, economic wellbeing and education of OVC.

    The study will assess the availability and relevance of services and help to identify opportunities for program improvement. It will help the program re-strategize and better target in line with PEPFAR priorities and emerging realities. Ultimately, study findings will be useful to other stakeholders, including the national OVC task force, NGOs and international partners working in this area.

6.0 Operations and Staffing Plan to Achieve Stated Goals

United States Agency for International Development (USAID)

In COP21, USAID plans to maintain its current management and operations inclusive of our cost of doing business ($13,300,000). Maintaining this CODB level, has enabled USAID to allocate 100% of our budget increase toward sustaining gains across our surge state while expanding our investment toward rapid scale up for epidemic control across our red and yellow states. In alignment with our approach to epidemic control, USAID will sustain our overall staffing footprint with three additional positions: Management and Operations Specialist, HIV and TB Project Management Specialist and a USPSC Strategic Information Advisor. Considering our pending transition to local partners, a review of our staffing matrix identified the need for additional management, technical and strategic information staff members who will provide necessary technical assistance and partner oversight with increased granularity across the USAID portfolio. Specifically, the SI advisor will coordinate and liaise directly with Care and Treatment implementing partners to provide site level monitoring and data analysis while also providing continuous training and support to strategic information points of contact. The HIV/TB project management specialist will provide technical and direct partner management across our key program areas. Management and operations specialists will liaise between our programmatic and finance team to ensure an integrated approach and accountability for programmatic and financial performance.

In addition to the three new positions, the team is actively engaged in recruiting five vacant positions four of which became vacant during COP20 primarily due to promotions to higher positions within and outside USAID (Office Manager/Secretary, PMTCT Program Manager, Care & Treatment Program Manager and Program Assistant-SI). The fifth position is a strategic information project management specialist which was approved in COP20. All five are currently at different levels of recruitment and expected to be filled by Q4 FY21. All positions previously reported vacant have been filled. Also, the TB Program Assistant position is planned to be repurposed to a Program Management Specialist position.

USAID's PEPFAR funded staffing footprint includes 51 positions (100%) dedicated to the PEPFAR portfolio inclusive of the PEPFAR Coordinator's position. Within the Office of HIV AIDS and TB there are 37 positions including one position (TB Program Manager supporting TB/HIV integration) funded by the Global Health TB portfolio. Across USAID there are 32 non-PEPFAR positions whose level of effort to PEPFAR programs range from 10- 50% of their time to PEPFAR programs.

USAID currently has a M&O funded mechanism dedicated to carrying out SIMS assessments site visits, and in COP 21 will be transitioning the SIMS activity to a new mechanism. We will strengthen our SIMS approach by combining it with the provision of robust routinized site level Data Quality Assessments (DQA) to compliment SIMS while at the same time getting more value for money. This will ensure that the implementing mechanism used for assessing SIMS from the

program quality perspective will additionally assess performance reporting quality, and thus allowing the implementing mechanism to lead triangulation efforts for SIMS, DQA and visualization of performance achievement data.

US Centers for Disease Control and Prevention (US 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 Team and PMT 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.

CDC continues to implement the Incident Command Structure (ICS) with Operations Chiefs, and the ART Surge and ESM strategies. ESM requires more intensified support and collaboration between State Government staff, implementing partners, 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. To ensure full impact of the surge site visits, all proposed site visits must have accompanying Scope of Work (SOW) with specific surge related issues to be addressed. Each visit consists of a mix of staff from different program areas to ensure programmatic balance and insight during the visits, and to provide amelioration for issues identified.

In COP20, CDC requested the addition of two new HIV Treatment Specialists positions to support the rapid scale up in its yellow states (under the ESM and Surge Strategies), and the repurposing an existing vacant LES position from Public Health Administrative Specialist to a Senior Program Specialist – Supply Chain Management position 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. All three positions have completed the classification processes. The Supply Chain Specialist position is filled, and the two Treatment Specialist positions are at the final stages of recruitment, with the selected candidates currently undergoing security clearances. Two positions previously reported vacant for over 6 months, the OVC Specialist and the Prevention Specialist, have been filled.

With the ART Surge implemented by CDC/PEPFAR Nigeria across all supported states in Nigeria, the program has been able to find and retain on treatment, greater than 80% of the estimated number of persons living with HIV (PLHIV) in the country. During the ART Surge implementation CDC has had to pivot from health facility centered HIV case-finding to a more proactive community-based case-finding approach that requires active engagement with both general and key population communities across the country to screen-in people eligible for HIV testing using our novel HIV risk stratification tool. This was occasioned by the lesson learned from the impact of the ongoing COVID-19 pandemic, which led to a sharp decline in health facility attendance, and the realization that over 90% of the newly identified PLHIV were asymptomatic and would otherwise have no reason to go to any health facility for HIV testing. For this reason, the CDC Prevention Branch has had to restructure its composition and organogram to allow for the creation of two teams – Clinical Services, and Community and Gender-Based Services Teams. While the Clinical Services Team will focus on facility-based case-finding and prevention services so as to optimize efforts within the health facilities, the Community and Gender-Based Services Team will spear-head our community case-finding and prevention services. To this end, CDC is adding a Senior Prevention Specialist position to serve as the Community and Gender-Based Team Lead.

CDC is also requesting one additional Public Health Management Administrative Specialist to effectively manage its PEPFAR extramural portfolio. This was a previously vacant position that was repurposed in COP20; however, the existing team of two Public Health Administrative Specialists and one supervisory Team Lead has proven insufficient to manage the CDC cooperative agreement portfolio. The Team Lead is providing supervision for the entire extramural portfolio including awards managed by the other two staff while also directly managing extramural awards. This has resulted routinely in the Team Lead working long hours on nights and weekends. This additional position will facilitate redistribution of direct award management to the three Public Health Administrative Specialists, thereby allowing the Team Lead to focus more robustly on supervision, quality management, strategic planning, and coordination for the cooperative agreement portfolio.

CDC currently has five vacant positions (one USDH position and four LES positions) – a USDH Behavioral Scientist (Prevention Advisor), PMTCT Program Specialist, Senior Surveillance Specialist, Quality Assurance Specialist, and Finance Assistant positions. All positions were recently vacated with none being vacant for up to 6 months. These positions are all at different stages of recruitment with recruitment actions expected to all be completed by FY21Q4.

The Cost of Doing Business (CODB) budget has been strategically planned to adequately support the implementation of the CDC COP21 program activities. For planned management and operations activities to be smoothly carried out, there is a 1.3% increase in the COP21 CODB budget over that of COP20. This increase is largely due to proposed addition of two new LES staffing positions described earlier and two public health fellows that are planned to be engaged

in FY22. The public health fellows will support CDC's monitoring, evaluation and data analytics efforts using CDC's monitoring strategies with heavy reliance on EMR and the NDR.

US Department of Defense/Walter Reed Army Institute of Research (DoD/WRAIR)

Major changes on DOD COP21 CODB comprises of proposed plan for the purchase of additional Government Armored Vehicles (2 units) to replace aging vehicles that have been subjected to long distance interstate trips across different sites in Nigeria. In COP 21, costs associated with travels and in-personal professional development will decrease with potential continued travel restrictions based on the COVID-19 pandemic and national insecurity, as well as a transition to increased virtual mentorship and training. However, these increased virtual meetings, as well as increased patient monitoring, necessitated an increase in the cost of IT to support the additional equipment and data needed to support databases and software.

DoD team's previous staffing analysis from COP19 showed the need to close identified gaps and strengthen the ability of the agency to improve case finding and retention. With the surge strategy and ESM continued from COP20, there is continued need to fill the approved one NSDD-38 and four LES positions that will ensure improvement in retention, weekly data analysis and review and ensuring un-interrupted supply of commodities to the sites. DoD's headquarters recently provided approval to increase headcount, and the four LES positions have entered the hiring process, with anticipated hiring by Q4 of FY21. The four LES positions include: (1) an HIV Testing and Counselling Specialist, to support the increased volume and efficiency of case finding; (2) an Adult Treatment Specialist, to provide support to enhancing the quality of care for adult patients, as well as serve as the key staff for both SIMS and continuous quality improvement; (3) a Monitoring and Evaluation Specialist to provide additional support for increased data collection, analysis, and reporting; and (4) a Supply Chain Management Specialist, to coordinate and monitor the pharmaceutical, commodity, and logistics aspects of the DoD program. Additionally, DoD also anticipates backfilling the recently vacated TB/HIV Specialist position by FY21Q4.

The 8% increase in the DoD CODB for COP21 derives mainly from the increased IT and telecommunications costs, the replacement vehicles, and hiring of the positions described above, which will continue to support data completeness and quality, as well as enhanced patient case finding, care, treatment, and retention.

Department of State/PEPFAR Coordination Office

There is no change to the cost of doing business for the PEPFAR Coordinator's Office. The office maintains current staffing levels with the five LES positions having successfully filled the Admin Assistant position which became vacant in the current fiscal year. No significant change is expected in the team 's travel budget has most of its engagement remain local and/or virtual.

APPENDIX A – How we are targeting by geography, age and sex to reach epidemic control in COP21/FY22

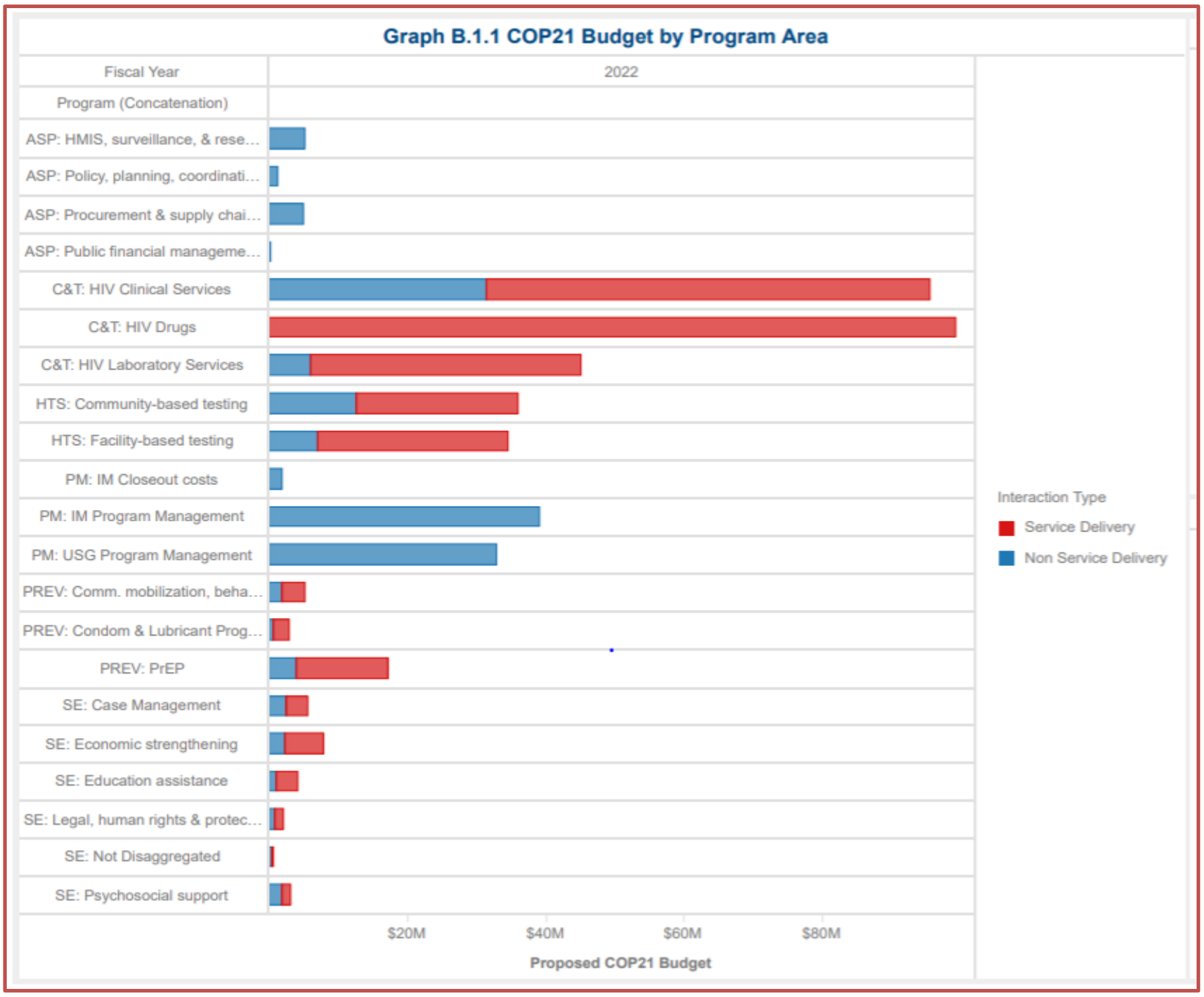
Prioritization	SNU	<1		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
		Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
Surge States	Akwa Ibom	90%	90%	90%	90%	90%	90%	90%	90%	93%	90%	94%	90%	97%	90%	98%	90%	99%	92%	99%	94%	99%	96%	99%	97%
	Rivers	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Red States	Delta	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	92%	90%	94%	90%
	Enugu	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	91%	90%
	Imo	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
	Lagos	90%	90%	90%	90%	90%	90%	90%	90%	90%	97%	96%	95%	99%	95%	100%	95%	100%	96%	100%	97%	100%	97%	100%	98%
Green States	Benue	90%	90%	108%	108%	100%	100%	100%	100%	90%	90%	91%	90%	96%	90%	98%	90%	99%	90%	99%	90%	99%	90%	99%	92%
	Gombe	90%	90%	90%	90%	93%	93%	90%	90%	96%	100%	92%	99%	95%	96%	97%	95%	99%	97%	99%	98%	99%	98%	99%	99%
	Nasarawa	90%	90%	90%	90%	90%	90%	90%	90%	90%	95%	96%	98%	99%	99%	100%	99%	100%	99%	100%	100%	100%	100%	100%	100%
Yellow States	Adamawa	90%	90%	90%	90%	92%	92%	90%	90%	90%	90%	94%	90%	97%	90%	98%	90%	99%	90%	100%	90%	100%	90%	100%	94%
	Bauchi	90%	90%	90%	90%	92%	92%	98%	98%	95%	90%	96%	90%	98%	90%	99%	90%	100%	90%	100%	90%	100%	90%	100%	90%
	Bayelsa	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	92%
	Borno	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
	Cross River	90%	90%	90%	90%	90%	90%	95%	95%	90%	90%	95%	91%	98%	95%	99%	97%	99%	98%	99%	99%	99%	99%	99%	99%
	Edo	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	96%	90%	98%	90%	99%	90%	99%	90%	99%	90%	99%	90%	98%	90%
	Ekiti	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
	FCT	90%	90%	90%	90%	99%	99%	100%	100%	90%	90%	90%	92%	96%	97%	98%	99%	99%	99%	99%	100%	99%	100%	99%	99%
	Jigawa	821%	769%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	94%	90%	97%	90%	98%	90%	99%	90%	99%	90%	99%	90%
	Kaduna	90%	90%	90%	90%	90%	90%	90%	90%	96%	90%	97%	90%	98%	90%	99%	91%	100%	95%	100%	97%	100%	98%	100%	98%
	Kano	90%	90%	90%	90%	90%	90%	90%	90%	94%	90%	90%	90%	94%	90%	97%	90%	99%	90%	100%	90%	100%	90%	100%	90%
	Katsina	90%	90%	90%	90%	90%	90%	90%	90%	91%	90%	92%	90%	96%	90%	98%	90%	99%	90%	99%	90%	100%	90%	100%	90%
	Kebbi	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
	Kogi	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	95%	90%	97%	90%	98%	90%	99%	90%	99%	90%	98%	90%
	Kwara	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	95%	90%	98%	90%	99%	90%
	Niger	1000%	1000%	111%	111%	100%	100%	100%	100%	100%	90%	100%	91%	98%	97%	90%	99%	90%	99%	92%	100%	96%	100%	98%	100%
	Ogun	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	91%	90%	95%	90%	96%	90%	97%	90%	97%	90%	96%	90%
	Ondo	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	91%	90%	95%	90%	96%	90%	97%	90%	97%	90%	96%	90%
	Osun	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
	Oyo	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	91%	90%
	Plateau	90%	90%	90%	90%	90%	90%	90%	90%	90%	94%	97%	95%	99%	98%	100%	99%	100%	100%	100%	100%	100%	100%	99%	100%
	Sokoto	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	91%	90%	93%	93%	93%	95%	92%	95%
	Yobe	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	95%	93%	98%	90%	99%	90%	99%	90%	99%	90%	100%	95%	99%	99%
	Zamfara	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
	Abia	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
	Taraba	90%	90%	90%	90%	98%	98%	90%	90%	91%	90%	90%	90%	95%	90%	98%	90%	99%	90%	99%	90%	99%	90%	100%	93%

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

APPENDIX B – BUDGET PROFILE AND RESOURCE PROJECTIONS

B.1 Planned Spending in COP 2021

B.1.1 Total Funding Level				
Applied Pipeline	**New Funding**	**Total Spend**		
$6,784,214	**$437,240,786**	**$444,025,000**		
Table B.1.2 Resource Allocation by PEPFAR Budget Code				
PEPFAR Program Area	**Budget Code Description**	**New Funding**	**Applied Pipeline**	**Total Amount Allocated**
C&T	Care and Treatment	$234,501,655	$5,194,015	$239,695,670
PM	Program Management	$40,826,730	$0	$40,826,730
PREV	Prevention	$25,069,492	$0	$25,069,492
HTS	Health Testing Services	$70,442,554	$0	$70,442,554
ASP	Above Site Program	$11,635,298	$53,321	$11,688,619
SE	Social Economy [OVC]	$23,399,064	$0	$23,399,064
M&O	Management and Operations	$31,365,993	$1,536,878	$32,902,871
TOTAL		**$437,240,786**	**$6,784,214**	**$444,025,000**
***Central Funding - $0.00**				



B.2 Resource Projections

The resource projections for COP21 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 COP21 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 carefully designed strategy in line with the surge plans.

A new strategy of utilizing interventions was introduced. More interventions were used for partner budget allocations to allow for some level of specificity that were missing by reason of the removal of budget codes from the financial classification.

APPENDIX C – Systems Investments Table for Section 6.0

Table 6: Above Site Investments							
Funding Agency	**Prime Partner**	**Activity Budget**	**COP20 Activity Description**	**Relevant Indicator or Measurement Tool (How do you intend to measure progress on this activity?)**	**COP21 Baseline Data (What is the current status of the indicator?)**	**COP21 Benchmark (Where do expect the indicator to be at the end of COP21 implementation?**	**Notes (Add any additional notes or clarifying descriptions here)**
DOD	Henry Jackson Foundation	$ 500,000	SI17 RV 329 Study (Africos)	1. # of clients enroled in the study cohort. 2. % of clients on ART that are virally suppressed dissaggregated by age & sex.	397 clients have been enrolled as at April 19, 2021 comprising of 325 HIV positive and 72 HIV negative participants	To enroll 550 clients comprising of 459 HIV positive and 91 HIV negative participants	The cohort has already started enrolling 15 years and above to provide better understanding on the clinical outcome in these population
DoD	Henry Jackson Foundation	$ 500,000	CSO Engagement Plan/ Community Systems Strenghtening	1. # of stakeholder engagement meetings 2. # of trainings for PLHIV and KP clients on Patient Education and Rights Knowledge 3. Implement and track outcomes of U=U campaign	1. Quarterly engagement meetings ongoing 2. No trainings conducted so far 3. UequalsU national strategic framework yet to be developed.	1. Four meetings to be conducted annually 2. One ToT and 6 regional trainings to be conducted	
STATE	Ambassador's Small Grants	$ 300,000	Ambassador's Small Grants/ Community-Led Monitoring	1. Grants awarded and implemented 2. Number of CLM visits conductd by CSOs 3. Number of sites covered in CLM ctivities	No CLM visits have ben conduct	1. 15-20 grants awarded 2. Atleast 200 visits conducted by CSO 3. 150 sites covered by CLM activities.	PEPFAR CLM efforts till date have been focussed on the process of developing the appropriate policy framework and tools for the process.
USAID	Chemonics	$3,000,000	Sample Referral Network (NiSRN)	1. Number of Samples collected from sites and results returned 2. Reduced turnaround time for sample pickup and results returned. 3. Reduced sample rejection rates 4. Efficiency of cost per sample transported"	1. Transported a total of 1,089,626 samples and returned 856,235 hard copy results in FY20. 2. Median viral load sample to results turnaround time was 25.8 days. 3. Sample rejection rate was 0.04% 4. Maintained 77.9% reduction in average costs compared to pre-NISRN era. 5. Developed e-lab for real-time sample tracking and result dissemination	1. Reduced cost of sample transport via integration across sample types. 2.Optimal utilization of available equipment capacity 3. Improved commodity management /Minimized wastages and expiries of lab commodities 4. Reduced TAT for laboratory results 5. Increased access to VL/ EID testing	NISRN addresses numerous challenges to VL service delivery in Nigeria by: increasing referral network efficiency, expanding VL coverage and reducing TAT for results (and mitigating LTFU). It is also a crucial part of ensuring VL swards ensuring sustainability of an integrated VL sample referral logistics. Over time, it is envisioned that GON and the private sector (3PLs) will take on increased support of NISRN, further bolstering sustainability. It is important to note the broader impact of NISRN on Nigeria's health system and its applicability to other health services (i.e. current support to Nigeria's COVID response).
USAID	Palladium International, LLC & TBD	$ 250,000	Domestic Resource Mobilization	1. Increase in budget allocations and releases for HIV 2. Proportion of health facilities empanelled for HIV service provision through state health insurance scheme 3. Number of additional people enrolled in the state health insurance scheme 4. % of empanelled health facilities offering HIV services 5. Number of HIV test kits purchased by the state government	1. Official inclusion of HIV services into health insurance package 2.Commencement of HIV service provision within Lagos State Health Insurance Scheme 3. National DRM Strategy developed 4. 30% (2019 – 2020) budget allocation increase for HIV; 7% for 2020 - 2021 5. N100m released in Lagos State in 1st quarter 2021 6. State Govt procurement of 130,000 RTKs	1. Demonstrated coverage of HIV services within health insurance packages in Lagos; 2. Increased budget allocations and releases for HIV; 3. Increased state govt purchase of RTKs	• DRM is critical to achieving and sustaining HIV epidemic control in Nigeria. • User fees remain a major barrier to access and insurance helps to alleviate the out of pocket burden to clients. • GON is committed to funding SHIS and it is important that HIV is not only included but operationalized. • GON must also be pressed to commit to increased funding of the HIV response, including the provision of RTKs. • Increased funding for HTS helps us meet testing targets needed to achieve epidemic control. • In 2021 alone, Lagos State intends to enroll 2.3million people into SHIS and 73,000 into BHCPF. • Additionally, increased host country funding reduces the cost to PEPFAR and helps free up already stretched resources to other priority areas. • Ensuring all enrollees have access to HIV services not only lowers costs to PEPFAR but promotes sustainability. • COP 20 $250k was not sufficient to program for entire year.
USAID	TBD	$ 250,000	Domestic Resource Mobilization				

Table 6: Above Site Investments							
Funding Agency	**Prime Partner**	**Activity Budget**	**COP20 Activity Description**	**Relevant Indicator or Measurement Tool (How do you intend to measure progress on this activity?)**	**COP21 Baseline Data (What is the current status of the indicator?)**	**COP21 Benchmark (Where do expect the indicator to be at the end of COP21 implementation?**	**Notes (Add any additional notes or clarifying descriptions here)**
USAID	Palladium	$ 350,000	NOMIS Upgrade	1. NOMIS infrasctructure re-designed . 2. Upgraded NOMIS platform beta version lauched for pretesting 3. Final platform version released 4. NOMIS Community of practice established to manage periodic back-end upgrades	1. Survey of current NOMIS users to identify need and gaps has been completed. 2. A bootcamp held to commence review and update of the exisiting infrastruture. 3. Design of upgraded infrastructure has commenced.	Enhanced NOMIS for management of OVC data	This activity will overhaul NOMIS in line with current stakeholder needs so that data can be more easily analyzed to strengthen targeted services/approaches.
USAID	Pact Inc	$ 250,000	OVC Situational Analysis	1. Data collection and analysis completed 2. Preliminary study findings released in time for COP 22	1. Preliminary work on scope and data collection instruments has commenced in concert with the appropriate MDAs, USG, IPs and stakeholders. 2. Study data collection yet to commence.	The Situation Analysis will provide a better understanding of the recent OVC landscape in Nigeria to support targeting, deployment of appropriate strategies for optimal prevention, care and treatment results, and to improve overall outcomes for vulnerable children and C/ALHIV, and fast track progress towards epidemic control.	This is a cross sectional study targeting 0-17-year-old using quantitative and qualitative methods to understand factors responsible for orphanhood and vulnerability among children, aged 0-17; derive estimates of OVC aged 0-17 in households, institutions and street children, and their spatial distribution; assess the health, nutrition, educational, psychosocial and protection needs of OVC; identify areas of PEPFAR interventions in treatment, OVC and care to improve outcomes for vulnerable children, including C/ALHIV
USAID	Heartland Alliance	$ 250,000	HIV ST - Total Market Approach	1. Increase in # HIVST service delivery points/outlets in the private sector 2. Increased # of HIVST kits issued/sold in the private sector 3.Increase in # of target populations self-testing 4. Decrease in HIVST pricing in Nigeria 5. Increased coordination among all stakeholders/sectors in Nigeria 6. Increased support to GON to implement TMA to HIV self testing in Nigeria 7. Increased use of [especially, online/web based/digitalHIVST reporting platforms] HIVST reporting tools to ensure effective follow up and linkage to confirmatory testing and care for those who test positive 8. Number of individuals reached via social media platforms (Analytics)	1. Over 150,000 HIV test kits distributed through in private sector through sole Oraquick market authorization holder in Nigeria (Mozuk) in 2020 2. 506 community pharmacies trained for HIVST (KP CARE 1, PSM, TO2) 3. 194 pharmacies providing HIVST services (KP CARE 1, PSM, TO2) 4. HIVST kit price currently ranging from $3.40 to $4.00/kit	1. Increased private sector supply and distribution of HIVST 2. Increased linkage to care through private sector referrals 3. Increased # of hard to reach populations being diagnosed for HIV; 4. Improved coordination with other partners engaged with HIVST (i.e. CIFF, UNITAID, GF, etc.) and work to lower the negotiated HIVST price	• COP 21 guidance also states that TMA is key to sustaining HIV epidemic control. The private sector is often the first point of call for clients in Nigeria. Experience with condoms in Nigeria suggest that the private sector will be critical in driving access to HIVST and decreasing donor dependency. • In fact, an SFI/PSM market assessment estimated the potential national market for HIVST at private pharmacies to be 1.4m kits/yr. • A price subsidy at the start with gradual weaning off to full cost recovery could be targeted at KPs and other priority populations (segmented pricing) who are willing to pay (WTP). SFI WTP showed >60% WTP for HIV services; KP CARE 1 WTP showed 84% of FSWs and 74% of MSM WTP for HIVST.
CDC	University of Maryland	$ 440,572	Nigeria HIV/AIDS Indicator and Impact Survey	Public access use of NAIIS data on (NADA) platform to support HIV programming, epidemic monitoring and secondary data analysis.	•Obtain clearance on public access to NAIIS data •Set up NAIIS public access data (NADA) platform	•Provide public access to use of NAIIS data on (NADA) platform •Conduct workshop trainings on the public access to use of NAIIS data (NADA) platform	
CDC	University of Maryland	$ 463,881	National Data Repository	Health Information Exchange across data systems to optimized data use for quality of care of PLHIV, program quality and epidemic control monitoring.	•Number of supported healthcare facilities linked to NDR •Completeness of key output indicators for monitoring 95:95:95 and reporting from NDR •Completeness of LIMS data on NDR for monitoring laboratory management •Completeness of health facilities with PBS uploaded to the NDR	•Functional Predictive Analytics module that includes the following predictive models - Treatment interruptions - Viral suppression •Automated Data Exchange between the EMR systems and the NDR •Established data exchange between the NDR and the NHLMIS •Improved user experience with data access and utilization on the NDR	
CDC	TBD	$ 3,907,667					
		$10,462,120					

APPENDIX D– Minimum Program Requirements

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

	MRP	***Updates***
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.[18]	The Test and Start policy have been in operation in Nigeria since 2016. The program had progressively increased its proxy linkage rate since adopting the policy. In FY 2021 Q2, the program reported a linkage rate of 100%. Strategies such as same day ART initiation, accompanied referrals and use of referral coordinators facilitated high linkages.
	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.[19]	PEPFAR Nigeria has optimized TLD at 95% plus achievement as at FY21 Q1 for all eligible PLHIV weighing greater or equal to 30kg (including adolescents and women of childbearing potentials). The effort will be sustained throughout FY21 and in COP21.
	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.[20]	The PEPFAR Nigeria team will continue to scale up the implementation of the differentiated service delivery models across all PEPFAR supported facilities including 6-month multi-month scripting and dispensing with FY21 Q1 achievement of 34% on MMD6 and 62% on MMD3-5. Furthermore, the decentralized drug delivery models will be scaled -up to improve ARV coverage for all populations. This strategy will further strengthen client-centered supply chain Modernization with increased impact and efficiency for program commodities accountability across different models with the seamless reporting into the National Health Logistics Management Information System (NHLMIS) and EMR/NDR.
	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.[21]	In FY21 Q2, PEPFAR Nigeria rapidly scaled up TPT reaching a coverage of over 80% with a TPT completion rate of 96.7%. PEPFAR Nigeria will sustain this momentum through COP20 and into COP21 with the aim of reaching a TPT coverage of at least 95% by the end of COP21. 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 was completed in COP18. As part of the DNO, the country program activated 6 Mega PCR laboratories. 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.[22]	In FY20 index testing was scaled up across all geographical prioritization zones which resulted in an average Index testing yield of 22% and a percentage contribution of index testing to HTS_TST_POS from 18%-21% between Q1 and Q4. Sites-self assessments were conducted to assess compliance with safe and ethical index testing standards set by OGAC. This was followed by the implementation of remedial plans such as training and re-training of service providers, ensuring adherence to the WHO 5Cs and conducting IPV screening for partners of index clients and setting systems to monitor adverse events. Efforts were made to ensure biological children of HIV positive mothers <19 were tested for HIV in line with OGAC guidance and will be intensified to ensure 100% coverage. In FY 21, TA was provided to government to develop HIVST standard operating procedures, data capturing tools and demand creation materials in partnership with UNITAID and CRS/FASTER. PEPFAR FY21 targets are 149,192. However, UNITAID is distributing 235,000 through PEPFAR mechanisms while an additional 100,000 is being distributed through CRS/FASTER. HIVST kits for distribution in-country will focus on hard-to-reach partners of index clients, AGYP, Key Populations, and children 2-11years in line with WHO's guidance.
Prevention and OVC	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)[23]	In FY 20, individuals that tested HIV negatives, who had substantial risk of contracting HIV were provided with prevention services including PrEP. Additionally, consenting HIV negative PBFW in discordant relationships, partners of index clients and high-risk HIV negative KPs were initiated on PrEP, and monitored for seroconversion.

[18] *Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization, September 2015*
[19] *Update of recommendations on first- and second-line antiretroviral regimens. Geneva: World Health Organization, July 2019*
[20] *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Geneva: World Health Organization, 2016*
[21] *Latent Tuberculosis infection: Updated and consolidated guidelines for programmatic management. Geneva: World Health Organization, 2018*
[22] *Guidelines on HIV self-testing and partner notification. Supplement to consolidated guidelines on HIV testing services. Geneva: World Health Organization, 2016* https://www.who.int/hiv/pub/self-testing/hiv-self-testing-guidelines/en/
[23] *Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization; 2015* (http://www.who.int/hiv/pub/guidelines/earlyrelease-arv/en).

	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, 3. Reducing risk for adolescent girls in high HIV-burden areas and for 9-14-year-old girls and boys regarding primary prevention of sexual violence and HIV.	PEPFAR Nigeria has aligned the OVC program to support pediatric care and treatment outcomes. Case managers administer the revised assessment tool at the households to identify children and adolescents at elevated risk for HIV. Those eligible for testing are referred for testing and followed up by a case manager domiciled in the health facilities to ensure access to care and treatment services as needed. Case managers also follow up and support continuity in treatment and viral suppression at the household level. The implementation of the OVC preventive curricula (IMPOWER, FMP) supports risk reduction among 9–14-year-old girls and boys and has been rolled out across select PEPFAR Nigeria SNUs
Policy & Public Health Systems Support	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.[24]	PEPFAR Nigeria has engaged state governments on the abolishment of user fees that affect the three 90s. In FY 20, there was an increased number of states that augmented the supply of test kits to government supported facilities.
	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.[25]	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.
	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 is collaborating with the Network of People Living with HIV (NEPWHAN) and the Federal Ministry of Health (FMoH) to roll-out the Patient Education and Empowerment Plan (PEEP), a CSO capacity building effort which focuses on Health Literacy and Health Rights for clients accessing services in health facilities, with the expected result to have a "pool of experienced PLHIV across the country who understand personal responsibility, know their rights and the package of care they should be accessing" and use this information to improve their health outcomes. While in the current FY, it focuses on PLHIVs in health facilities, in COP21, it while also be extended to included Key Population clients accessing services in health centers and OSSs. The program is also working with CSOs and the National Agency for the Control of AIDS (NACA) to develop a national strategic framework to guide the scale of "UequalsU" campaign which was launched in 2019. Building will support local CSO actors to implement activities in support of this campaign.
	4. Clear evidence of agency progress toward local, indigenous partner direct funding.	**USAID** - In alignment with our OVC and KP portfolios, USAID will completely transition its entire portfolio inclusive of all care and treatment partners to indigenous partners by end of FY22. **CDC** – All CDC OVC, KP and Care and Treatment partners in Nigeria are currently local indigenous partners.
	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, the Government will invest funds to cover the treatment needs of 100,000 PLHIV yearly for FY2021 and FY2022 (estimated $16.5 million yearly). In addition, the GoN has redeemed part of its $12 million pledge to the Global Fund 6th Replenishment. The pledge for the 6th replenishment was a 20% increase from the pledge for the previous replenishment cycle. The GoN paid the sum of $10.167,052.50 to the Global Fund early 2021 with assurance that the balance of $1,832,947.5 will be paid within the year. The government also plans to pay off the balance ($419,000) from the 5th replenishment. The shortfalls in the amounts redeemed were due to exchange rate differences. The GoN is expected to pay the total outstanding amount of $2,251,947.5 within 2021.
	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.	PEPFAR Nigeria systematically monitors HIV positive clients throughout their clinical care and ensure appropriate public health action. The PEPFAR Nigeria team has scaled up use of patient unique identification with implementation of biometric identification in all SNUs. In FY 21 Q2, over 980,458 clients of a total 1.4 million PLHIV on ART (68%) had their biometric details captured in the National Data repository. PEPFAR Nigeria will continue to scale up scale up case-based surveillance and unique identifiers for patients across all sites, with the goal of achieving use of unique identifiers in 95% of clients on ART in COP 21.

[24] *The practice of charging user fees at the point of service delivery for HIV/AIDS treatment and care. Geneva: World Health Organization, December 2005*
[25] *Technical Brief: Maintaining and improving Quality of Care within HIV Clinical Services. Geneva: WHO, July 2019*

APPENDIX E – Feedback on CSO Input for COP21

Specific Request	Response
Standardize renumeration packages for CSO/LIPs staffs/volunteers in accordance with the institutional polices of local implementing partners (LIPs).	• PEPFAR will ensure an appropriate categorization and standardization (by expected level of effort and time commitment) of community field workers recruited by IPs and set a baseline and parameters for how we compensate community HCW. • Current IP workplans will be scrutinized and we will ensure proper measures are/have been taken to properly compensate community staff. • We will set up appropriate feedback mechanism for complaints on this and other related issues.
We propose to PEPFAR and its IPs to allow CSOs to design our program interventions by ourselves (especially programs around human rights violations and other interventions) that is specific to our context, while the IPs can provide oversight.	CSOs are currently able to design their proposed interventions in the Small Grants applications. The local partner transition process addresses this to the extent possible within USG grant management policies and guidance. (Add update on local partner transition from MPR updated)
We ask for a sustained system strengthening programs and standardize framework that would be coordinated by the CSOs.	The Nigeria CSO Engagement Plan is our framework for prioritizing and budgeting for CSO Community Strengthening activities. It is developed in collaboration with the cohort of CSO leaders we engage and is reviewed at the quarterly CSO engagement meetings. Please reference this in SDS.
CSO's ask for a stated commitment to wider array of biomedical prevention. Whilst there is a robust intervention around oral PrEP, there is the need to begin active planning for other biomedical prevention interventions such as Dapivirine ring and injectable PrEP.	In line this request, both the Dapivirine ring and the long-acting ARV, Cabotegravir will be procured as additional options for PrEP.
Train OSS staff on the specific psycho-social support of transgender persons. Ensure that medical ART care takes on board drug interactions with hormonal treatments; ensure that GBV and CLM data collection is sensitive to non-binary gender identities.	Clinicians at all facilities are trained to screen for drug-drug interactions of all sorts. GBV and CLM data collections systems are optimized to capture data for these populations.
CSO requests that the scope and funding for CLM should be expanded to include oversight of structural issues, program compliance and operational program delivery, including "ghosting" i.e., data falsification.	CLM is designed to evolve to address emerging needs and will be modified as it progresses to address emerging information and data needs. This request aligns with our plans. The program has several layers of data validation to minimize risks of data error, duplication and/or data falsification.

APPENDIX F – Summary of COP21 Program Targets

Treatment			
Indicator	**Pediatric**	**Adult**	**Total**
TX_CURR	84,143	1,612,297	1,696,440
TX_NEW	15,800	222,881	238,681
TX_NET NEW	22,919	117,551	140,470
PVLS (Denom.)	65,663	1,525,891	1,591,554

OVC	
OVC_SERV (Active)	1,241,439
OVC_HIVSTAT	817,789
PMTCT	
PMTCT_STAT (Denom.)	1,744,424
PMTCT_STAT (Num.)	1,726,986
PMTCT_STAT (newly tested)	1,696,099
PMTCT_STAT POS	37,571
PMTCT_ART	35,629
PMTCT_EID	37,571
< 2 months	33,818
2-12 months	3,753

HTS	
PMTCT_STAT (newly tested)	1,696,099
TB_STAT (newly tested)	46,700
Pediatric HTS_TST	494,071
Adult HTS (excludes, EID, PMTCT, TB)	8,893,367
Key Population HTS	440,834
HTS_SELF (KP)	89,211
KP	
KP_PREV	503,899
KP_PREV MSM	222,813
KP_PREV FSW	233,878
KP_PREV PWID	27,154
TB	
TB_STAT (Denom.)	54,511
TB_STAT (Num.)	54,511
TB_STAT (newly tested)	46,700
TB_STAT POS	380
TB_ART	8,191
TX_TB (Denom.)	1,697,102
TB_PREV (Denom.)	407,315
TB_PREV (Num.)	366,608

APPENDIX G: COP 21 COVID Funding: American Rescue Plan Act COVID-19

COP 21 COVID Funding: American Rescue Plan Act COVID-19								
Category (from list above: eg. I-A for IPC)	**How support will be used**	**Relevant Estimated targets (N/A if appropriate)**	**Proposed Agency**	**Proposed IM**	**Requested Budget**	**Brief Budget Justifcation**	**Brief description of gap or need**	**Explanation of how this activity supports and complements national COVID-19 plans**
I-A. Infection Prevention and Control Programming (IPC)	Support and TA for improved IPC practices among health care workers in PEPFAR supported sites	USAID treatment clients (over 500,000) and USAID-supported HCWs (over 6200) at USAID-supported sites (over 483)	USAID *(note the proposed budget reflects expected cost-share from USAID HPN)*	All 8 TX partners - RISE, SIDHAS, TO1, TO2, TO3, KP CARE 1, KP CARE 2, EPIC	$1,304,125	This will cover the training and mentoring of health workers in the area of IPC with baseline assessments and follow up monitoring for quality improvement. IPs will also work with Breakthrough Action to integrate a risk communication module into the trainings and will participate in TOT to be provided by BA	IPC remains a major gap in Nigeria's health system and with major infrastructural issues such as lack of running water and electricity, hygeine and other IPC practices are a challenge. Additionally, many health workers lack training in the appropriate use of PPE. These all contribute to the spread of COVID.	Improved IPC practices among health workers and within health facilities helps slow the spread of COVID
I.B. Services supporting COVID-19 vaccination access for staff at PEPFAR-supported sites and beneficiaries. AND I.C. Testing PEPFAR-supported staff and beneficiaries for COVID-19 and to inform both IPC practices and epidemiologic surveillance	Support production and disemination of evidence-based COVID 19 prevention messages and tools using multiple medium e.g IPC, radio to ensure access to information which addresses stigma and discrimination, directs individuals to available vaccination spots, and emphasizes the importance of vaccnation for immuno-compromised individuals	PEPFAR treatment clients (over 1,406,000) and PEPFAR-supported HCWs (over 10,110) at PEPFAR-supported sites (over 1400)	USAID *(note the proposed budget reflects expected cost-share from USAID HPN)*	Breakthrough Action Nigeria	$1,250,000	Funds will support message development, with a focus on the importance of vaccination for immunocompromised individuals, and production, capacity building of community health workers and monitoring and evaluation of message impact (integrate risk communication module into IPC and other relevant trainings for COVID - training curriculum/tool development and TOT for treatment partners). Strategies for dissemination of materials developed.	Just 964,387 (24%) of the 4 million doses issued on March 2, 2021 had been administered as of April 6, 2021 and despite having an estimated population of over 200 million, only 1.8 million COVID tests have been conducted to date. Recent polls show that many Nigerians remain skeptical of COVID testing and vaccination. Targeted SBC is critical to Nigeria's COVID 19 response	This activity will be intrumental in generating much needed demand for COVID testing and vaccines and will support testing and vaccine uptake.
1-B. Services supporting COVID-19 vaccination access for staff at PEPFAR-supported sites and beneficiaries.	1) Leverage supply chain logistics to support vaccine rollout (distribution)and monitoring of the COVAX (and other donated vaccines) at the state level. 2) Ongoing sample Transport support using NISRN to ensure long term integration of COVID testing	PEPFAR treatment clients (over 1,406,000) and PEPFAR-supported HCWs (over 10,110) at PEPFAR-supported sites (over 1400)	USAID	Global Health Supply Chain - Procurement and Supply Chain (PSM) Chemonics	$2,500,000	Supply Chain support for Vaccines: The roll out of hundreds of millions of adult vaccines in Nigeria is an unprecedented feat. This will require support for logistics, cold chain, quantification, coordination, planning, and training. Funding will cover coordination and planning with NPHCDA and other partners, coordination with manufacturers on shipment quantities, timelines and locations for delivery to ensure smooth roll out (i.e. no need to deliver SW commodities to Abuja), establishment of hub sites for distribution, support for quantification of needs per state/site, freight and third party logistics (3PL) from hub to last mile, storage, reverse logistics for accountability and waste management. NISRN: This will cover continued support for NCDC and state govts to transport COVID samples from sample collection centers to designated labs for testing.	The African Union plans to give an estimated 40million vaccine doses to Nigeria and J&J has agreed to donate an additional 70 million doses. This is all in addition to the already 16million doses commiteed through COVAX. While Nigeria has a experience in childhood vaccine rollout (which are distributed in cohorts), it has limited expertise in mass rollout of adult vaccinations. Once the large shipments of vaccines come in, the vaccine distribution and storage system will be severely constrained, especially at the state levels. USAID's GHSC-PSM mechanism has demonstrated expertise in cold storage and last mile delivery of lab reagents and lab samples for HIV and has access to infrastructure across the country to leverage for vaccine storage and distribution	PEPFAR has significant expertise in distribution and transport of HIV commodities as well as blood specimens. NPHCDA will struggle to roll out a mass adult vaccine exercise without support. Building on lessons learned from the roll out of COVID testing in the country that eventualy had to be decentralized (and even expanded to the private sector), PSM would work closely with targeted states (to be determined) to support gaps building on the robust PEPFAR supply chain including cold chain capacity.

COP 21 COVID Funding: American Rescue Plan Act COVID-19								
Category (from list above: eg. I-A for IPC)	**How support will be used**	**Relevant Estimated targets (N/A if appropriate)**	**Proposed Agency**	**Proposed IM**	**Requested Budget**	**Brief Budget Justifcation**	**Brief description of gap or need**	**Explanation of how this activity supports and complements national COVID-19 plans**
A. Extraordinary logistics and commodity costs associated with COVID-19. AND II. C. "Repair of Program Injury" i.e., support for programmatic acceleration and recovery from adverse impacts on program performance due to COVID-19.	Scale up and improve DDD systems and MM6 reducing client exposure to COVID within health facilties (including partnering with private sector actors to leverage investment)	USAID treatment clients (over 500,000) and USAID-supported HCWs (over 6200) at USAID-supported sites (over 483)	USAID	All 8 TX partners - RISE, SIDHAS, TO1, TO2, TO3, KP CARE 1, KP CARE 2, EPIC	$2,004,125	MMD: scale up of MMD 6 should be relatively straight forward and primarily entail sensitization of stakeholders of the change, staff time at facility level to establish tho clients to be moved to MMD 6 and communication to clients of the change. Perhaps also logistics arrangement within facilities not already implementing to accommodate fast track refill clients at facility level. DDD: Currently, % of TXCURR participating in DDD (i.e. in community ART refill) ranges from approximately 0 - 45%. This funding will work to scale up DDD among all IMs to at least 30% of TXCURR. This will include coordination and planning with GON at state and site levels. Specifically, sensitization of GON, providers and PLHIV on DDD bouquet of options (Community Pharmacy, Community ART Refill Group/Club, Home delivery, drop in centers/pick up points, etc). IP assessments of DDD sites to determine eligibility for participation, selection of sites and execution of MOUs (this will include community ART refill groups who usually identify and expert client who will be responsible for drug pick up and distribution to other clients - MOUs will clearly outline roles and responsibilities), establish stable ART clients eligible for DDD, communication to obtain consent from clients to be devolved, engagement of private sector for logistics support (especially for home deliveries). Coordination between hub facility and DDD sites and training on data reporting requirements.	Nigerian secondary and tertiary health facilities are often overcrowded and overburdened. This is especially true of most high volume PEPFAR sites and increases risk for COVID transmission. Health worker to client ratios are suboptimal, further straining the system. Many PEPFAR supported sites are also COVID treatment centers	Scale up of DDD and MMD helps to decongest often over crowded and overburdened health facilities. Additionally, it reduces COVID risk for PLHIV who won't need to come to health facilities as often
1-B. Services supporting COVID-19 vaccination access for staff at PEPFAR-supported sites and beneficiaries.	Ensure USAID beneficiaries have access to COVID 19 vaccines at targeted sites. Coordinate the prioritization of vaccination for PLHIV with the NPHCDA and NCDC as well as at state levels	USAID treatment clients (over 500,000) and USAID-supported HCWs (over 6200) at USAID-supported sites (over 483)	USAID	All 8 TX partners - RISE, SIDHAS, TO1, TO2, TO3, KP CARE 1, KP CARE 2, EPIC	$500,000	This will cover communication, training, joint coordination and planning with GON as well as close monitoring at state and site levels. Specifically establishment of no. of clients eligible for vaccination by state/site; coordination with NPHCDA to ensure adqueate quantification and monitoring support	Health authorities strongly recommend that everyone living with HIV receive a COVID-19 vaccine to protect themselves against SARS-CoV-2. Just 964,387 (24%) of the 4 million doses issued on March 2, 2021 had been administered as of April 6, 2021. Ensuring PHIV have access to vaccines will not only benefit PLHIV but help support the roll out of vaccines nationwide	This will support GON vaccine rollout efforts
1-C. Testing PEPFAR-supported staff and beneficiaries for COVID-19 and to inform both IPC practices and epidemiologic surveillance	Ensure USAID beneficiaries have access to COVID 19 testing at targeted sites. Technical support for continued screening, case identification and testing for COVID. Coordinate the prioritization of testing for PLHIV with the NPHCDA and NCDC as well as at state levels.	USAID treatment clients (over 500,000) and USAID-supported HCWs (over 6200) at USAID-supported sites (over 483)	USAID	All 8 TX partners - RISE, SIDHAS, TO1, TO2, TO3, KP CARE 1, KP CARE 2, EPIC	$750,000	This will cover joint coordination and planning with GON, health worker training on screening and testing protocols, and communication at both state and site levels to ensure prioritization of hotspots. Coordination with NISRN and testing centres to ensure efficient sample movement and timely collection of results	Despite having an estimated population of over 200 million, only 1.8 million COVID tests have been conducted to date. Testing remains integral to the COVID 19 response and coverage is very low. While the main thrust of COVID support should be on vaccines, it may take up to a year of more for vaccines to be rolled out completely. In the interim people will still continue to contract COVID and even need critical care. COVID case identification remains a major gap in Nigeria's COVID response. While vaccines offer rays of hope in the global fight against COVID, as long as COVID cases outpace vaccine roll out, new variants will continue to emerge and we risk new outbreaks and waves. Therefore, COVID case identification remains integral to the COVID response.	This will support increase in COVID testing. By helping to slow the spread of COVID, we are helping buy time for vaccine rollout, prevent the emergence of new variants.
USAID					**$8,308,250**			

COP 21 COVID Funding: American Rescue Plan Act COVID-19								
Category (from list above: eg. I-A for IPC)	**How support will be used**	**Relevant Estimated targets (N/A if appropriate)**	**Proposed Agency**	**Proposed IM**	**Requested Budget**	**Brief Budget Justifcation**	**Brief description of gap or need**	**Explanation of how this activity supports and complements national COVID-19 plans**
I-A. Infection Prevention and Control Programming (IPC)	Support and TA for improved IPC practices among health care workers in PEPFAR-supported sites	1,000 DoD HIV HCW across 32 military health facilities	DoD	HJF (70225)	$300,000	Strengthen Infection, Prevention and Control (IPC) among HCWs. This will build on the results of the IPC study among HIV HCW, to include training of over 1,000 health care workers across 32 military health facilities. The training will be in two phases with ToT and step down at each facility. Disinfectant such as Sodium Hypochlorite, Medical Grade Alcohol-based Hand sanitizer, Automatic Sanitizer Dispenser, etc. will be procured to improve supplies at the sites for the trainings, and to ensure some buffer stock is available on site.	IPC remains a major gap in Nigeria's health system and with major infrastructural issues such as lack of running water and electricity, hygeine and other IPC practices are a challenge. Additionally, many health workers lack training in the appropriate use of PPE. These all contribute to the spread of COVID.	Improved IPC practices among health workers and within health facilities helps slow the spread of COVID
1-B. Services supporting COVID-19 vaccination access for staff at PEPFAR-supported sites and beneficiaries.	Ensure DoD HIV HCW have information on and access to COVID 19 vaccines at targeted military sites.	1,000 DoD HIV HCW across 32 military health facilities	DoD	HJF (70225)	$100,000	COVID-19 vaccine sensitization of 1,000 HCW in 32 Military facilities. This activity will leverage the materials and messages used in the sensitization activities carried out for civilian population, and will include tracking of numbers of HCW vaccinated in the supported DoD facilities.	Data has shown that Nigeria still experiences extreme vaccine hesitancy, with just over 1.4million people vaccinated for COVID-19 as of April 21, despite a tranche of 3.9million vaccines received the first week of March. Critical among these, the prioritized HCWs are some of the most hesitant to receive COVID-19 vaccination, with only 17% of HCWs vaccinated nationally as of April 6. This trend is also seen in military health facilities.	Contributes to increase national vaccine coverage, particularly among priority populations.
II-B. Mitigate COVID-19 Impact on PEPFAR programs and beneficiaries and support PEPFAR program recovery from the impacts of coronavirus (Laboratory).	Ensure sufficient capacity for testing of both HIV and COVID-19 among military HCW and PLHIV at PEPFAR-supported sites	3 military facilities	DoD	HJF (70225)	$100,000	Strengthening military-supported COVID-19 laboratory testing platforms to primarily serve the HCWs that have been more prone to getting infected with COVID-19 when caring for PLHIV, and to provide confirmatory testing in the event of inconclusive results on the COBAS 8800 or GeneXpert systems. This includes purchase of ancillary supplies for open PCR platforms (Roche LightCycler and ABI 7500), including RNA extraction kits, that are not included in the procurements by the GoN or Global Fund, and permits utilization of previously donated open platform test kits.	The military is sensitive about its data on a per-patient level, and has seen a regular number of HCW infected in their PEPFAR-supported facilities. The GeneXpert platforms at the facilities cannot perform this task as it is at 100% utilization for TB/HIV samples. Therefore, two sites in Lagos have negotiated with the Lagos State Commissioner of Health for inclusion of their Light Cycler and ABI 7500 systems in the lab network for Lagos. For Abuja, the Defence Reference Laboratory is one of the three national mega-labs for PEPFAR and runs both viral load samples and COVID-19 samples on its COBAS 8800 machines. DRL will be leveraging its existing ABI 7500 machine as extra capacity in the event of significant volumes of viral load samples received or machine breakdown.	Supports testing and data collection as part of the national COVID-19 lab network.
DOD					**$500,000**			

COP 21 COVID Funding: American Rescue Plan Act COVID-19								
Category (from list above: eg. I-A for IPC)	**How support will be used**	**Relevant Estimated targets (N/A if appropriate)**	**Proposed Agency**	**Proposed IM**	**Requested Budget**	**Brief Budget Justifcation**	**Brief description of gap or need**	**Explanation of how this activity supports and complements national COVID-19 plans**
I-A	Strengthen infection prevention and control (IPC) programming at CDC PEPFAR-supported sites	Over 10,110 HCW; over 800,000 CDC PEPFAR clients on HIV treatment; over 1,700 sites in 18 CDC-supported states	CDC	APIN ($589,474); CCFN ($336,842); CIHP ($336,842); IHVN ($336,842)	$ 1,616,750	Funds will support strengthening IPC among PEPFAR Nigeria beneficiaries and staff. As of December 2020, there were more than 770,000 people living with HIV (PLHIV) receiving CDC PEPFAR-supported treatment at over 1,700 sites. Additionally, CDC PEPFAR Nigeria is increasingly providing community-based testing and treatment services, potentially increasing risk of infection outside of facilities. Funding is needed to build capacity of all PEPFAR staff, including: training on IPC protocols, correct use of personal protective equipment (PPE), and IPC monitoring (e.g., through site-level IPC committees). Strengthened IPC will minimize the risk of COVID-19 and other infections among PEPFAR beneficiaries and staff.	Sustained and strengthened IPC capacity building is needed to ensure that staff are protected while they continue to provide essential, life-saving services. Further, in Nigeria, fear of COVID-19 exposure has negatively impacted hospital attendance rate, including for HIV/TB services; strengthened IPC is needed to improve confidence in services provided.	This activity will strengthen IPC, which is a MoH national priority, toward preventing new infections and avoiding a third wave of COVID-19. This activity complements ongoing COVID-19 prevention efforts among PLHIV and TB/HIV patients, which could be at risk at poor outcomes following COVID-19 given potentially compromised immunity.
I-C	Increase COVID-19 testing among CDC PEPFAR beneficiaries and staff	Over 10,110 HCW; over 800,000 CDC PEPFAR clients on HIV treatment; over 1,700 sites in 18 CDC-supported states	CDC	APIN ($780,000); CCFN ($370,000); CIHP ($370,000); IHVN ($480,000)	$ 2,000,000	Funds will support increased testing among CDC PEPFAR Nigeria beneficiaries and staff, aligned with NCDC's "National Strategy to Scale Up Access to Coronavirus Disease Testing in Nigeria." This will include: deployment of high throughput GeneXperts, patients triaging using antigen-based tests, sample collection among PEPFAR staff and beneficiaries as well as other costs associated with COVID-19 testing and linkage to PEPFAR laboratories with COVID-19 testing capacity, as well as laboratory platforms, maintenance, and consumables. Following NCDC COVID-19 guidelines, a testing algorithm will be developed, taking into consideration COVID-19 symptoms and exposures. Testing results will be documented in patient electronic medical records (EMR) and the National Data Repository (NDR), leveraging existing PEPFAR investments that facilitate program and clinical management. All positive specimens will be reported centrally to NCDC, supporting national epidemiologic surveillance. Additionally, data will also inform IPC practices at PEPFAR-supported sites.	Currently, COVID-19 testing in Nigeria is extremely limited, with under 1.9 million tests conducted since the beginning of the outbreak despite a population estimated at almost 200 million. Important barriers to testing include costs, which is a minimum $100 at private facilities (GDP per capita in 2019 = $2,230). Limited testing has constricted the ability to conduct essential COVID-19 epidemiologiv surveillance, COVID-19 clinical management for PEPFAR-supported PLHIV, and implementation of mitigation efforts (e.g., quarantine, contact tracing, etc).	This activity will directly address Nigeria's priority to increase routine laboratory-based surveillance of COVID-19, aligned with Nigeria CDC guidelines and strategic planning (e.g., "National Strategy to Scale Up Access to Coronavirus Disease Testing in Nigeria"). This activity is needed to increase testing capacity among PEPFAR beneficiaries and staff, which will also support national epidemiologic surveillance.
II-B	Enhance COVID-19 laboratory capacity for genotyping to track COVID-19 variants of concern	Support activities in 3 CDC-supported PCR laboratories with capacity for SARS-CoV-2 sequencing using HIV Drug Resistance Testing platforms (Asokoro, JUTH, NRL) and NRL linked labs (NIMR and ACEGID)	CDC	APIN ($760,000); IHVN ($1,140,000)	$ 1,900,000	Funds will support genotyping of samples positive for SARS-CoV-2 taken from PEPFAR beneficiaries and staff. Genotyping will enable appropriate, targeted emergency public health response activities, expanding Nigeria Centre for Disease Control (NCDC) ability to identify and respond to variants of concern. Funds will be used to strengthen the PEPFAR-supported laboratories capacity, supporting more sustainable dual-use capacity, and may include: laboratory personnel, reagents, consumables, and higher capacity instruments. Following NCDC COVID-19 guidelines, all testing results will be centrally reported, supporting the national response to COVID-19.	Currently, Nigeria CDC's ability to detect COVID-19 variants of concern is extremely limited, with non-systematic testing of a small number of samples. As of February 14, 2021, sequencing has identified 55 strains of COVID-19, circulation of variants of concern, including two variants of concern: B1.1.7 and B.1.525. Expanded genotyping is needed to have appropriate COVID-19 emergency public health response activities, epidemiologic surveillance, and global tracking of COVID-19 variants of concern.	This activity will leverage existing HIV laboratory capacity in order to provide important data on the COVID-19 variants circulating in Nigeria, aligned with the national strategic plan to conduct sequencing to identify variants of concern and implement appropriate emergency public health response activities. This will also benefit global COVID-19 tracking of variants, toward the early identification of variants of concern coming out of Nigeria/West Africa.

COP 21 COVID Funding: American Rescue Plan Act COVID-19								
Category (from list above: eg. I-A for IPC)	**How support will be used**	**Relevant Estimated targets (N/A if appropriate)**	**Proposed Agency**	**Proposed IM**	**Requested Budget**	**Brief Budget Justifcation**	**Brief description of gap or need**	**Explanation of how this activity supports and complements national COVID-19 plans**
II-B	Enhance COVID-19 laboratory capacity for serologic testing, including to understand evidence of previous SARS-CoV-2 infection among PEPFAR beneficiaries and serologic testing of HIV viral load remnant samples	Support for SARS-CoV-2 antibody testing at the Multiplex Bead Assay (MBA) laboratory at the National Reference Laboratory (NRL), as well as viral load sample management activities in 7 CDC-supported PCR laboratories	CDC	APIN ($514,287); CIHP ($342,858); IHVN ($1,042,855)	$ 1,900,000	Funds will support serologic testing of samples from PEPFAR beneficiaries and staff to identify presence of antibodies against SARS-CoV-2. Serologic testing can help understand previous exposure, inform clinical decision-making, and help explain responses to vaccination. Further, serologic testing of remnant HIV VL samples, which are collected as part of routine clinical care for PLHIV, represents a feasible, low-risk opportunity to conduct additional laboratory testing to support COVID-19 public health response activities. Systematic serologic testing will support understanding SARS-CoV-2 seroprevalence among PEPFAR beneficiaries, complementing non-systematic national reported data based on virologic testing (e.g., PCR).	Given the high rates of asymptomatic COVID-19 infection and other factors influencing COVID-19 testing (e.g., patient health-seeking behaviors; health system constraints), reported surveillance data alone provides an extremely limited view on the COVID-19 epidemic in Nigeria. Serologic testing is needed to better understand previous infection among PEPFAR-supported PLHIV, toward supporting clinical decision-making, epidemiologic surveillance, and COVID-19 emergency publich health response activities.	This activity will provide important data on detection of COVID-19 antibodies to complement and supplement national epidemiologic surveillance activities, which are almost exclusively based on virologic testing (e.g., PCR). Regular antibody testing provides important evidence of previous infection toward improved patient clinical management, and provides information on the estimated number of people who have been exposed to COVID-19, regardless of symptomatic status or surveillance limitations. Use of remnant viral load samples already at laboratories will provide robust data on COVID-19 while minimizing risk of exposure and lowering cost needed by avoiding additional sample collection.
II-C	Expand virtual telecommunications to allow for continued PEPFAR program management during ongoing COVID-19 mitigation efforts (e.g., lockdowns)	1 National Situation Room; 3-6 regional sub-hubs	CDC	TBD SHIELD Follow-On ($500,000); APIN ($285,424); CCFN ($102,123); CIHP ($154,882); IHVN ($257,572)	$ 1,300,000	Funds will be used to build and expand alternative approaches to program management using virtual platforms. Prior to COVID-19, PEPFAR Nigeria invested in state and site-level telecommunication platforms, including the launch of Project ECHO in December 2019. These platforms supported partner and site-level management throughout the epidemic, allowing for PEPFAR Nigeria to continue to increase the number of PLHIV on ART despite COVID-19. Further, enhanced virtual platforms are aligned with a request from the National AIDS Control Association (NACA) Director-General to support the establishment of "situation rooms" for continuity of services during COVID-19 and other disruptions. Funds may be used for: staffing, infrastructure, and telecommunication equipment and internet capacity.	COVID-19 mitigation efforts have limited PEPFAR's ability to provide continuous program management, including at the SNU- and site-level. Currently virtual telecommunication capacity is also limited.	This activity is aligned with the national strategic vision for increasing the management and operations of HIV services, including during COVID-19, through alternative approaches to program management using virtual platforms.
CDC					**$8,716,750**			
				Total:	**$17,525,000**			

APPENDIX H: Digital Health Investment Inventory

Agency	Investment Type	Mechanism ID	Partner	Status
USAID	National OVC Management Information System (NOMIS)	81865	TBD	Implementation planned in COP21
USAID	Electronic Medical Records - Lafiya Management Information System (LAMIS)	100222	FHI	Implementation planned in COP21
USAID	National Health Logistics Management Information System (NHLMIS)	18442	Chemonics	Implementation planned in COP21
USAID	NiSRN Information Management System (NIMS)	18442	Chemonics	Implementation planned in COP21
USAID	E-Labs for the National Integrated Specimen Referral Network (NISRN)	18442	Chemonics	Implementation planned in COP21
HHS/CDC	Data interchange interoperability and accessibility	18439	UNIVERSITY OF MARYLAND	Expires in COP21
	Electronic medical records			
	Health Management Information System (HMIS)			
	Laboratory and diagnostics information system			
	Shared Health Record and health information repository			
HHS/CDC	Data interchange interoperability and accessibility	160512	TBD	Implementation planned in COP21
	Electronic medical records			
	Health Management Information System (HMIS)			
	Laboratory and diagnostics information system			
	Community-Based Management Information System			
	Shared Health Record and health information repository			