Nigeria

Country Operational Plan (COP) 2022

Strategic Direction Summary

April 28, 2022

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Acronyms

AE	Adverse Events
AGYW	Adolescent girls and young women
AHD	Advanced HIV Disease
ANC	Antenatal Care
ARV	Antiretroviral Drug
ART	Antiretroviral Therapy
AYP	Adolescent and Young People
CLHIV	Children Living with HIV
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
FSW	Female Sex Workers
GBV	Gender-Based Violence
GF	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GoN	Government of Nigeria
HEI	HIV-Exposed Infants

HIS Health Informatics System

HIV Human Immunodeficiency Virus

HTS HIV Testing Services

IBBSS Integrated Biological and Behavioural Surveillance Survey

IIT Interruption in Treatment

IP Implementing Partner

IPV Intimate Partner Violence

KP Key Population

LMIS Laboratory Information Management Systems

MAT Medically Assisted Therapy

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

NDR National Data Repository

NEPWHAN Network of People Living with HIV/AIDS in Nigeria

NGO Non-Governmental Organization

NHRC National Human Rights Commission

NHLMIS National Health Logistics Management Information System

NISRN National Integrated Sample Referral Network

OI Opportunistic Infection

OU	Operational Unit
OVC	Orphans and Vulnerable Children
PrEP	Pre-Exposure Prophylaxis
PEPFAR	The United States President's Emergency Plan for AIDS Relief
PEEP	Patient Education and Empowerment Project
PITC	Provider-Initiated Testing and Counselling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PWID	People who inject drugs
RTK	Rapid Test Kits
S/GAC	Office of the U.S. Global AIDS Coordinator
SID	Sustainability Index and Dashboard
STI	Sexually Transmitted Infections
SNU	Sub-National Units
TB	Tuberculosis
TPT	TB Preventive Therapy
TLD	Tenofovir, Lamivudine, and Dolutegravir (HIV Drug Regimen)
UNAIDS	The Joint United Nations Programme on HIV/AIDS
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

Data from the Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS) in 2018 indicated that approximately 1.8 million people in Nigeria are living with HIV, and prevalence rates across the country vary from 0.3% to 4.8% by state. This data enabled the PEPFAR Nigeria team to implement a targeted national antiretroviral therapy (ART) surge, focusing on those geographic regions with high HIV burden and low ART coverage to move the country closer to epidemic control. PEPFAR Nigeria initiated the surge in fiscal year (FY) 2020, at the end of the Country Operational Plan for 2019 (COP19) implementation year, and continued it through COP 20 and COP 21. Nigeria made significant progress in finding and placing people on treatment, with over 643,000 people placed on treatment since the beginning of the surge – a 102% increase over pre-surge levels.

The current COP21 implementation is deploying evidence-based practices to increase case-finding, including strengthening index and key population testing, bringing HIV testing, care, and treatment services directly to patients in the community, incorporating family-centered care, and using multi-month dispensing to adapt services to client needs. The national, aligned response during COP21 implementation also includes on-the-ground technical and operational assistance to support the National Agency for the Control of AIDS (NACA) to scale-up HIV services in Abia and Taraba states, which were previously outside of PEPFAR's geographical coverage, and build the capacity of the Federal Ministry of Health through the National AIDS and STI Control Program (NASCP) to manage the HIV technical response through the design and implementation of the National Clinical Mentorship Program (NCMP). These successes drove Nigeria's progress towards achieving the UNAIDS 95-95-95 goals and laid a foundation for sustaining those targets long term. By FY 21 Q4 (September 2021), the country had increased the percentage of PLHIV who know their status (1st 95) from 92% to 93%, the percentage of known PLHIV on treatment (2nd 95) from 90% to 98%, and the proportion of PLHIV on treatment who are virally suppressed (3rd 95) from 59% to 95% (2021 UNAIDS Spectrum estimates). By the end of FY 22 Q1 (December 2021), Nigeria, with PEPFAR support, had placed 1,769,656 million people on ART. Per the revised PLHIV estimates 1,869,259 (2022 UNAIDS Spectrum estimates) provided in FY22 Q1, Nigeria's national progress towards the UNAIDS 95-95-95 goals resides at 89-97-95, extraordinarily close to epidemic control, but with a remaining need for additional case finding within age groups and geographic locations.

As national epidemic control is now within reach, Nigeria needs a targeted strategy to address the mixed epidemic and close coverage gaps. Thus, the theme for PEPFAR Nigeria's COP22 plan is "Equitable Sustainability": Leaving No Geography or Population Behind. It incorporates the four highlighted challenges noted by the Office of the Global AIDS Coordinator (OGAC) in the COP22 Planning Level Letter. First, PEPFAR Nigeria will aim to close the treatment gaps in the remaining states with ART coverage less than 81%. Second, PEPFAR Nigeria will plan a specific effort to close the treatment gaps for children and adolescents, particularly among females. Third, we will optimize the viral load (VL) diagnostic network to reach and sustain the UNAIDS 3rd-95 goal for all by addressing gaps in viral load coverage and sub-optimal viral load suppression among certain

populations, including children, youth, adolescents, and pregnant women. Fourth, PEPFAR will maintain forward momentum on the National Alignment in conjunction with the Government of Nigeria (GoN), civil society, and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) to implement a unified, efficient, and sustainable HIV response.

In COP 22, Nigeria aims to build on the surge successes to achieve and sustain national epidemic control, incorporating evidence-based strategies and equitable, person-centered services. Recognizing the need for greater efficiencies, Nigeria closely analyzed subnational data to design a targeted strategy that will bring 31 of 36 states to >81% coverage (based on 2023 PLHIV estimates) by the end of COP22 and bring the national ART coverage to 116%. This strategy will pivot case-finding efforts towards specific sub-populations in those states and populations already maintaining high adult coverage rates, and specifically target broader case-finding efforts towards subnational units (SNUs) that have low ART coverage across all age groups. Furthermore, on the SNU level, PEPFAR Nigeria will intensify the use of recency program data for rapid response to guide targeted community-based case finding and forestall community HIV transmission. Simultaneous with strategic case finding, PEPFAR Nigeria will aim to reach and maintain 98% continuity in treatment by addressing the root causes of interruptions in treatment and ensure accurate, de-duplicated data through scaled biometrics and electronic medical record (EMR) reporting.

In addition to this geographic focus, PEPFAR Nigeria will implement a focused surge to address poor ART coverage and viral load suppression (VLS) among children, key populations (KPs), and adolescent girls and young women (AGYW), to ensure no one is left behind. This targeted focus addresses Nigeria's persistent challenge with low ART coverage rates among persons younger than 15 years of age. At the end of COP21, ART coverage was only 38% among this population - as compared to 96% among those older than 15 years. To close the pediatric treatment gap, Nigeria will optimize case finding and linkage to treatment for children and adolescents by increasing access to safe and ethical index testing, integrating HIV testing into sexual and reproductive health services, strengthening linkages after HIV self-testing, and expanding use of social network strategies. The country will also increase support for the orphans and vulnerable children (OVC) program in alignment with pediatric care and treatment to maximize impact. In addition, PEPFAR Nigeria will reduce interruptions in treatment among children living with HIV (CLHIV), thus improving VLS rates in this population.

Key to this strategy– and to maintaining VLS among all PLHIV – will be an optimized viral load network. In COP22, PEPFAR Nigeria aims to reduce results turnaround time to 10 days or less for VL samples and 5 days or less for early infant diagnosis (EID) samples. It will do so by addressing the two major system challenges of extensive equipment downtime and supply chain disruptions that have affected laboratory reagents and commodities. To buffer against reagent and commodity stock outs, PEPFAR Nigeria will make greater use of the laboratory information management systems (LIMS) to track supplies, increase regular inventory on hand, and implement a vendor-managed inventory system for continuous replenishment. PEPFAR Nigeria will manage equipment downtime by phasing out old platforms, such as CAP/CTM, and replacing

them with higher throughput machines that can take up sample backlogs from other parts of the network. System resiliency will be an important element in COP22, to include mixed-method sample prioritization, improved quality management, and integrated testing across several disease platforms.

The foundation of a successful HIV response in Nigeria is extensive cooperation and coordination among key stakeholders, particularly with the GoN, civil society, and the Global Fund, under the National Alignment. This Alignment, initiated in COP20 during a fortuitous alignment of PEPFAR and Global Fund planning cycles, in addition to a commitment from NACA to place more patients on treatment, became a more unified national program during COP21. From the beginning, the National HIV Alignment has improved program synergies and resource efficiency by increasing transparency, preventing duplication of efforts, and harmonizing program standards. In COP22, PEPFAR Nigeria will continue this forward momentum through targeted growth of the national ART cohort while simultaneously scaling and optimizing care and treatment services and standardizing the service package for key populations based on the joint guidelines developed during COP21. An important focus for the National Alignment in COP22 will be in prevention of mother to child transmission of HIV (PMTCT). Through this united goal, GoN, PEPFAR, and the Global Fund will collectively support the establishment of Joint PMTCT/Pediatric HIV Incident Command Structures at state levels that will guide the expansion of GoN-supported PMTCT programs in facilities across the country. The effort is truly 'whole of Nigeria', as it will also link to both civil society-led case finding and linkage of pregnant women at the community level, policy development through GoN, PEPFAR, and Global Fund at the national level, and commodity investments through the private sector-managed HIV Trust Fund. The Alignment will continue to lean more on community-based efforts to meet patients' needs, and to drive the creation of enabling environments that address discriminatory policies, gender-based violence, and other inequities that stand in the way of progress and human rights. In COP22, PEPFAR Nigeria will contribute to this vision by continuing to support accountability through the scale up and transition of community-led monitoring, as well as the patient education and empowerment program, through the Network of Persons Living with HIV/AIDS in Nigeria (NEPWHAN).

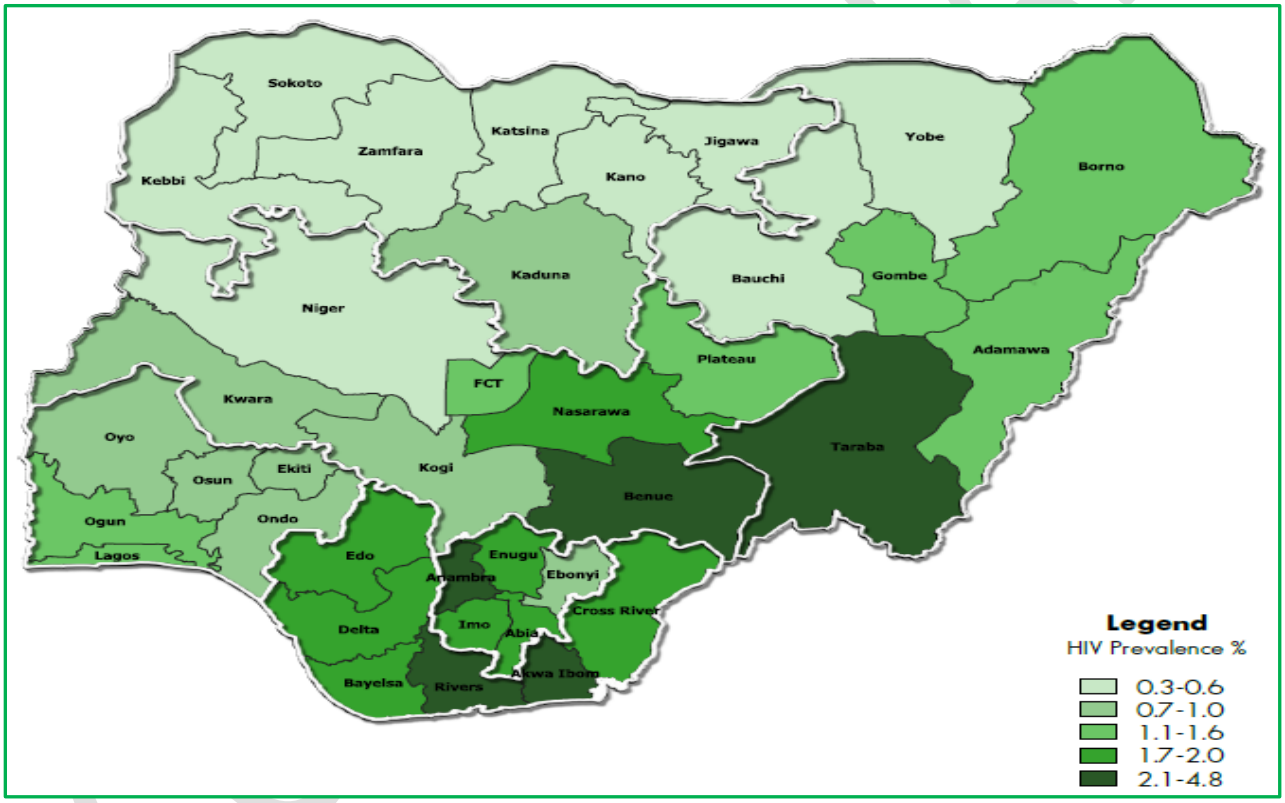
2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

Nigeria has an estimated demographic population of 219,243,344, of which 49% is female and 51% is male. Nigeria is a lower-middle-income country with a Gross National Income of 2,100 per capita.

Currently, an estimated 1,869,259 people live with HIV in Nigeria. The 2018 NAIIS estimated the national HIV prevalence at 1.4% among adults 15 years old and above, with a higher prevalence among women (1.8%) compared to men (1.0%). HIV prevalence varies across states with a range of 0.3% to 4.8%. Eight new infections per 10,000 population were reported by NAIIS.

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



Nigeria's HIV response made unprecedented achievements through the HIV Treatment surge efforts implemented from 2019 to 2021 and led to significant progress in achieving HIV epidemic control. The ART surge resulted in a 123% increase in the number of PLHIVs on treatment from 794,816 in 2019 to 1,769,656 as of December 31, 2021. With a projected treatment NET_NEW of 146,644, the number of PLHIVs on treatment is expected to further increase to 1,954,234 at the end of 2022. To date, 18 states have attained treatment saturation, defined as at least 81% treatment coverage but 22 states remain with a treatment coverage rate less than 81%.

The largest programmatic gap is in case finding among HIV positive children, adolescents, and pregnant women. In addition, HIV transmission amongst adolescents and key populations

remains high. About 41,000 of the estimated 150,000 pregnant women annually received antiretroviral drugs (ARVs). There are systematic challenges with achieving high PMTCT program coverage in Nigeria, as only 10-20% of antenatal care (ANC) sites offer PMTCT services to pregnant women. In addition, there are gaps in the uptake of ANC services, with only 67% of pregnant women receiving ANC from a skilled provider. These findings highlight the need for a more integrated approach to the delivery of reproductive health services in the country.

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. Additionally, a high HIV prevalence was reported in the 2020 Integrated Biological and Behavioral Surveillance Survey (IBBSS) among several KP typologies: brothel-based female sex workers (BBFSW; 17.1%), non-brothel-based female sex workers (NBBFSW; 15%); people who inject drugs (PWID; 10.9%) and men who have sex with men (MSM; 25%). The relatively higher prevalence among KPs is driven by stigma and discrimination, cultural beliefs and practices, societal and religious disapproval, 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, additional forms of stigma and discrimination, and operational issues such as patient flow challenges that result in long wait times in facility settings. The rollout of differentiated models of care has helped to mitigate these challenges to an extent, but even these efforts have been limited by the seeming resistance of health service providers to adopt longer periods between patient appointments, as well as entrenched drug prescribing and dispensing practices. That said, the program has managed to expand these programs significantly in the last FY.

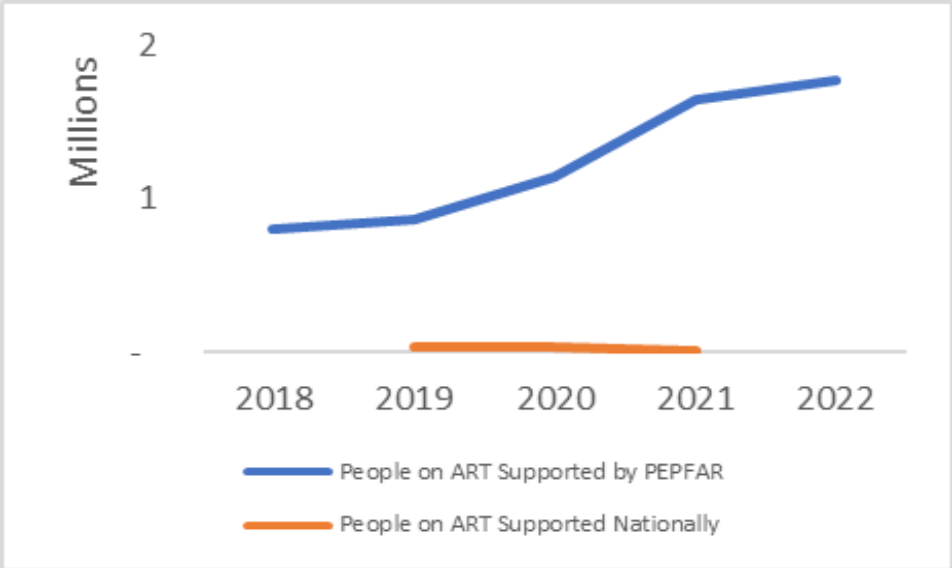
Table 2.1.1 Host Country Government Results																
	Total		<15				15-24				25+				Source, Year
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	221,534,703	100%	42,729,067	19%	45,404,977	20%	20,954,510	9%	22,242,589	10%	44,658,434	20%	45,545,226	21%	Spectrum, 2021
HIV Prevalence (%)		0.84		0.17		0.17		0.64		0.64		2.1		1.29	NAIIS, 2018
AIDS Deaths (per year)	46,066	100%	19,347, i.e. 42%				26,719. i.e. 58%								Spectrum, 2021
# PLHIV	1,869,259	100%	73,947	4%	78,929	4%	133,742	7%	74,463	4%	820,681	45%	633,711	35%	Spectrum, 2021
Incidence Rate (Yr)		0.03		0.02		0.02									NAIIS, 2018 (Preliminary)
New Infections (Yr)	66,908														Spectrum 2021
Annual births	8,071,509														Spectrum, 2020
% Preg. Women with at least one ANC visit		76.5%													NAIIS, 2018
Pregnant women needing ARVs	99,194														Spectrum, 2020
Orphans (maternal, paternal, double)	1,869,299														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
[1]% of Males Circumcised		98.90%													Morris et. al (2016)
[2]Size & Prevalence Estimates of MSM	387,842	22.9%													1. Nigeria KP Size Estimates Studies
Size & Prevalence Estimates of FSW	530,810	14.4%													2. IBBSS 2020
Size & Prevalence Estimates of PWID	200,522	3.4%													

[1] 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/

[2] 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			[3]HIV Testing and Linkage to ART Within the Last Year		
	[4]Total Population Size Estimate (#)	[5]HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	[6]Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	221,534,703	0.84%	1,869,259	1,821,434	1,514,567	81%	92.4%	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%								
		15%								
PWID	227,068	10.9%								

Figure 2.1.3 Updated National and PEPFAR Trend for Individuals currently on Treatment



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

Figure 2.1.4 Updated Trend of New Infections and All-Cause Mortality Among PLHIV

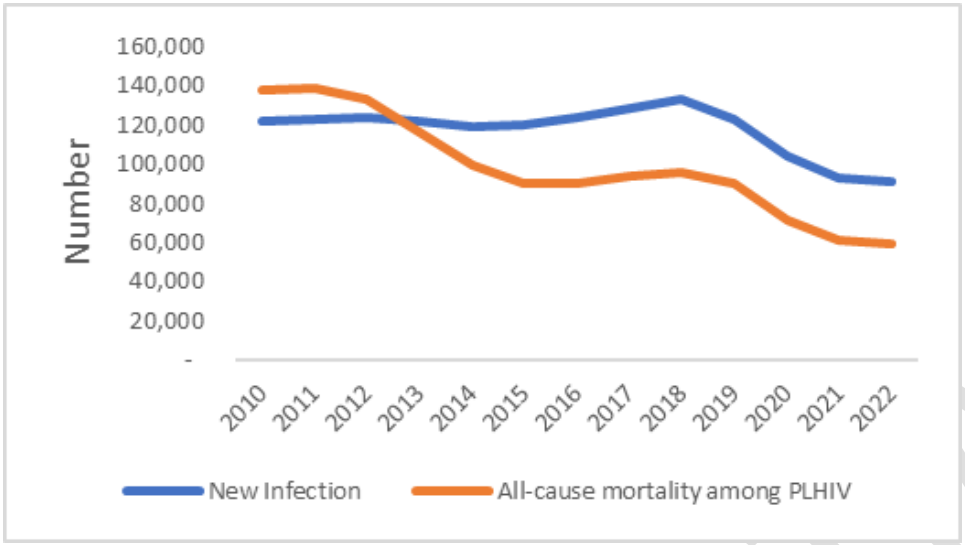


Figure 2.1.5 Assessment of ART program growth in FY21

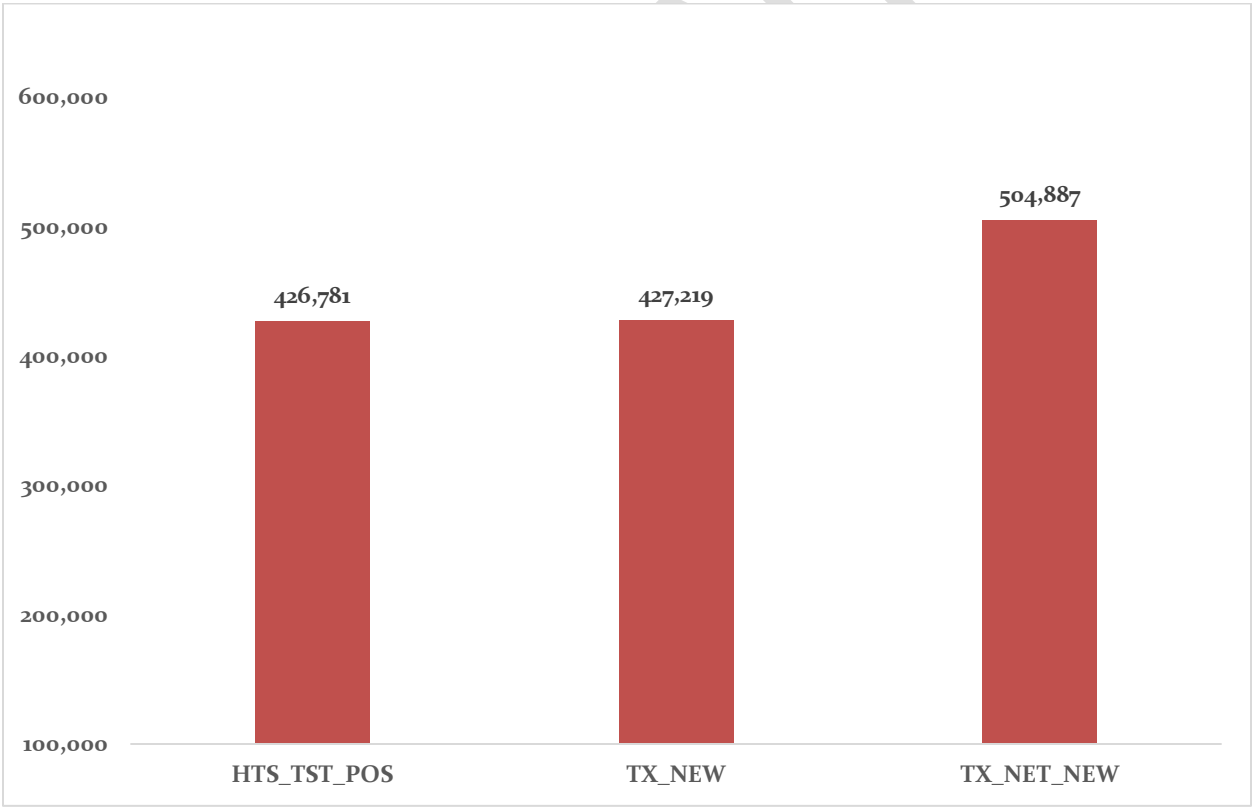


Figure 2.1.6.a Clients Gained/Lost from ART by Age/Sex, FY22 Q1

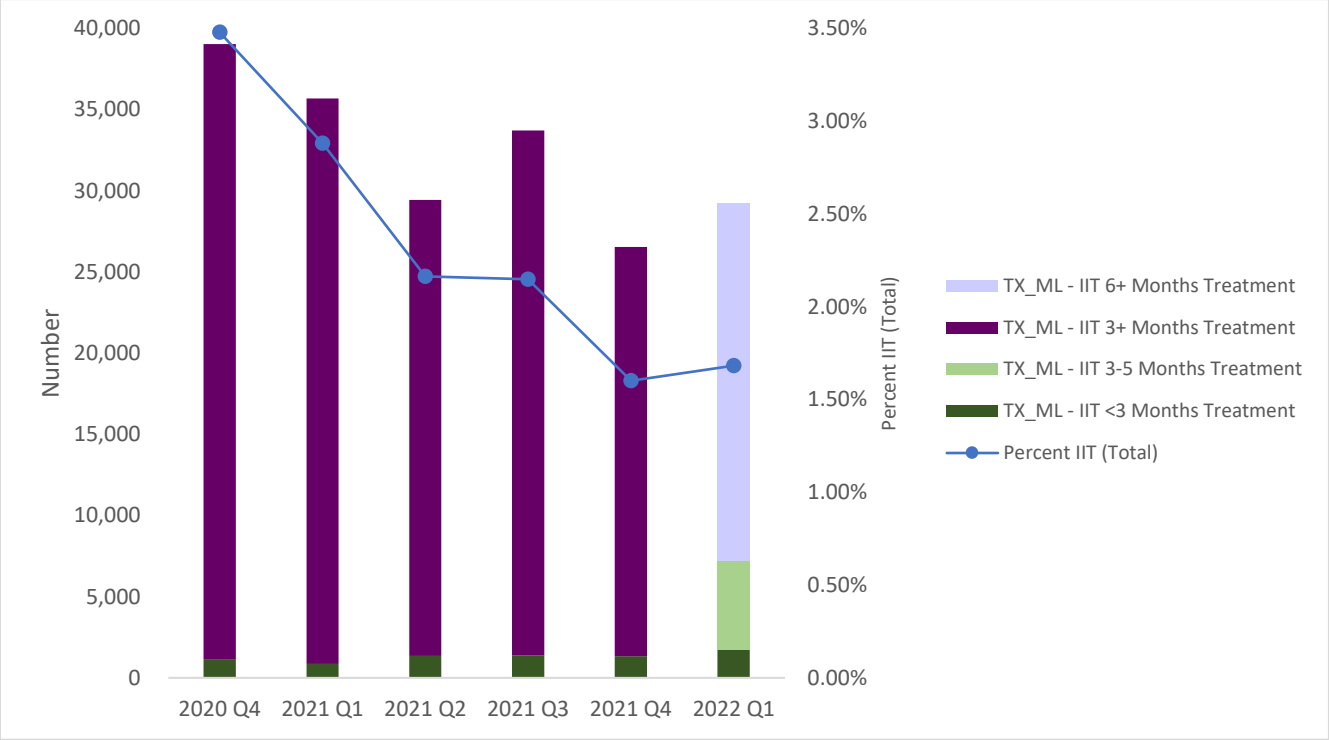


Figure 2.1.6.b Interruption in ART by Age/Sex, FY22 Q1

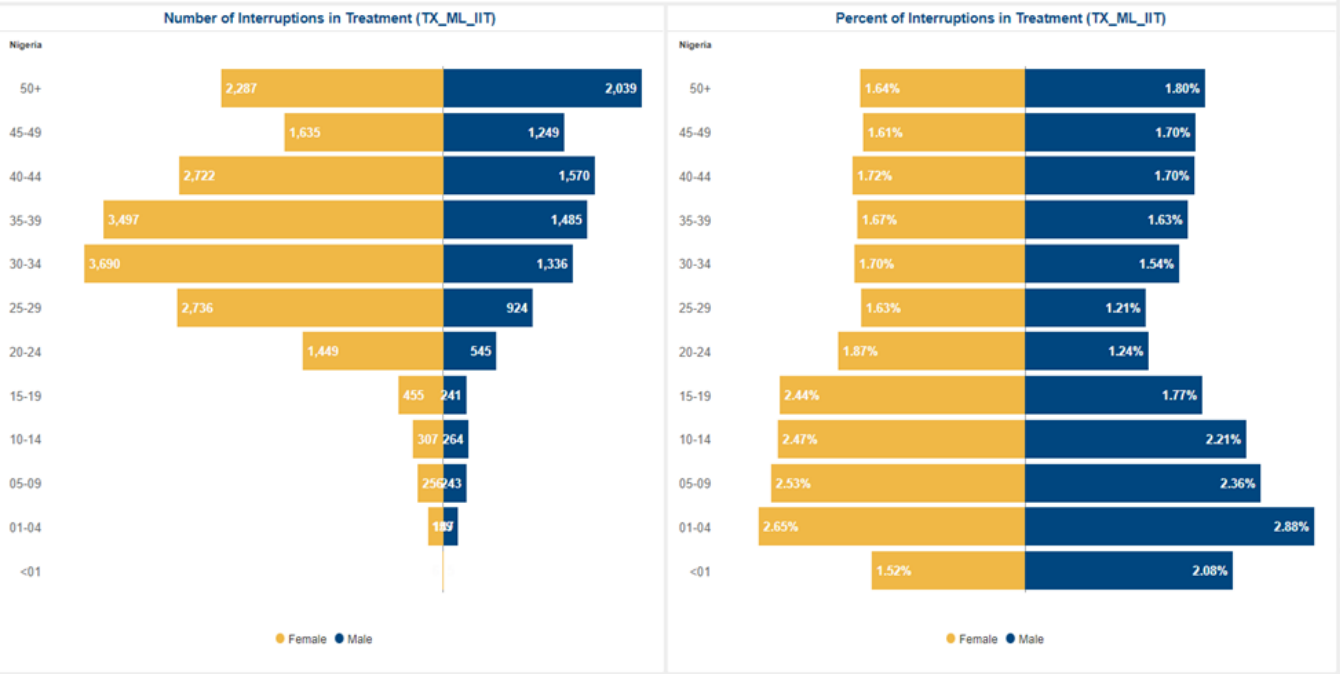


Figure 2.1.7 Epidemiologic Trends and Program Response for Nigeria

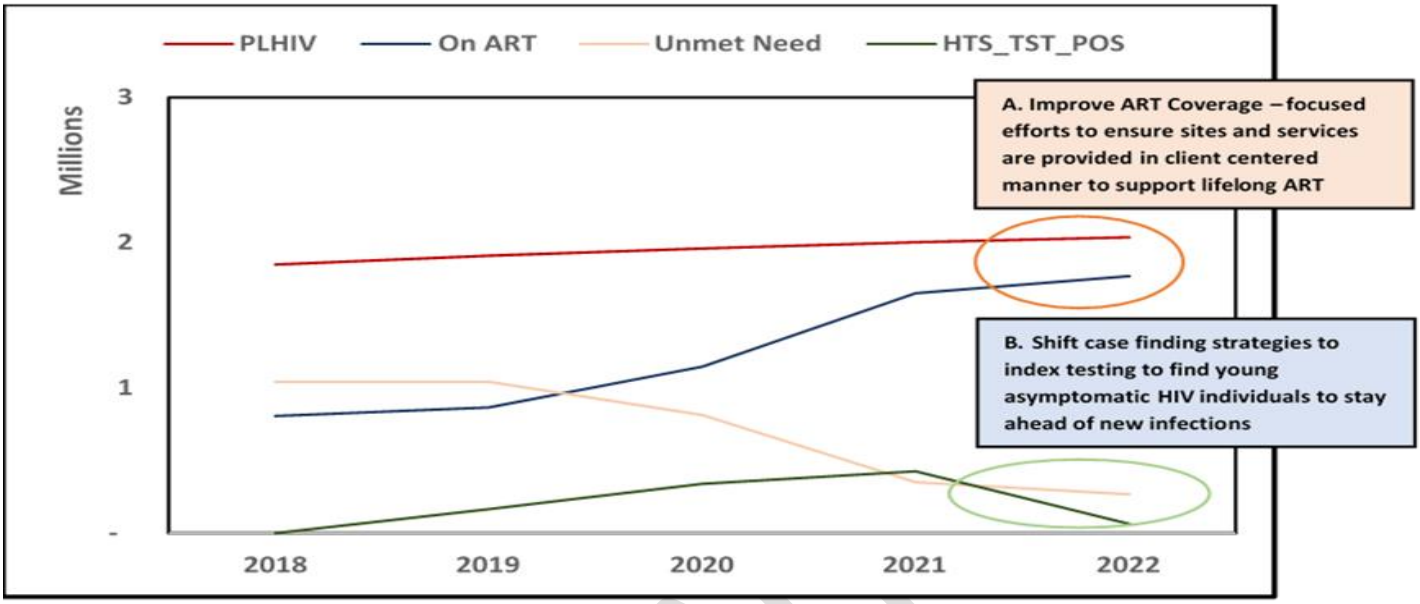
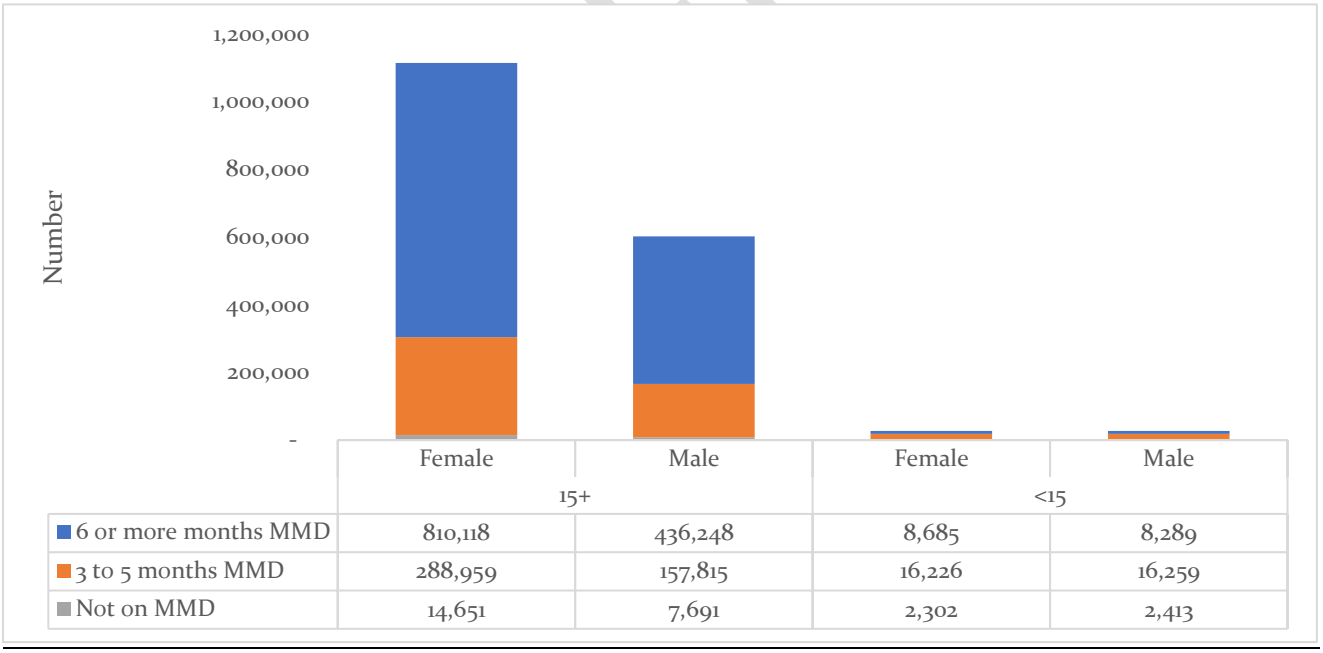
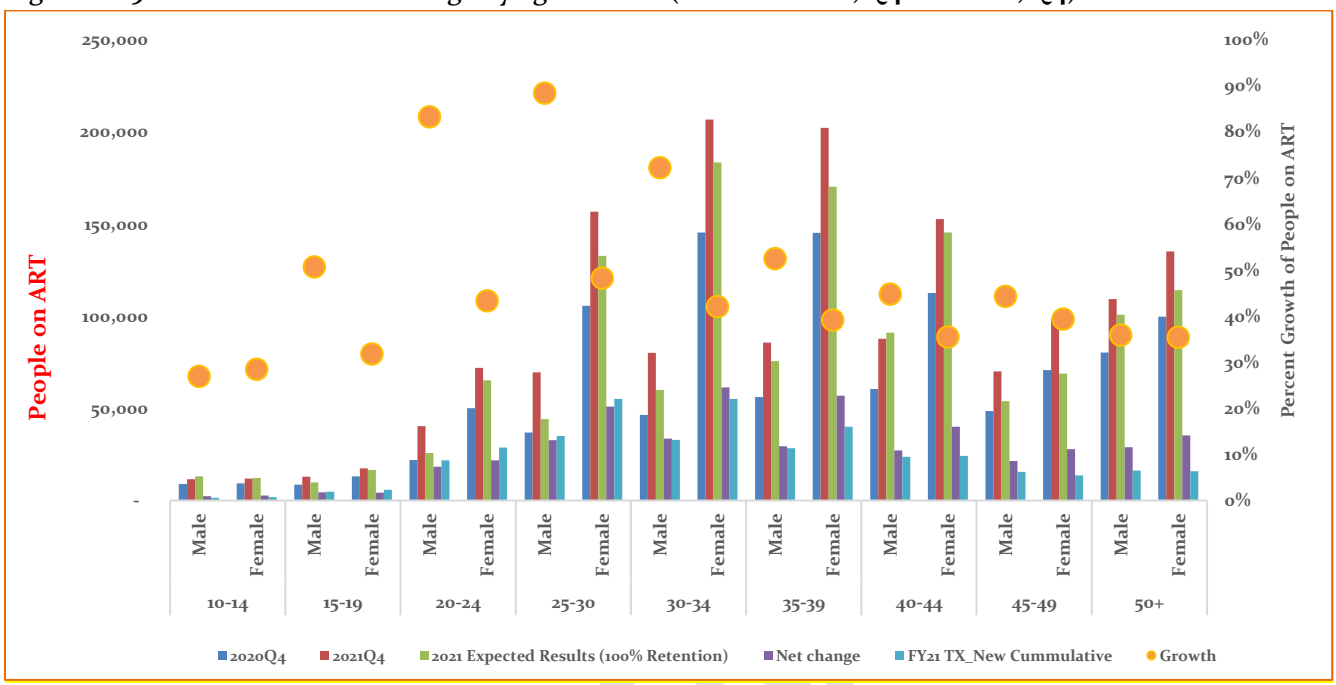


Figure 2.1.8 Net change in HIV treatment by sex and age bands 2020 Q4 to 2021 Q4



	Female	Male	Female	Male
	15+		<15	
6 or more months MMD	810,118	436,248	8,685	8,289
3 to 5 months MMD	288,959	157,815	16,226	16,259
Not on MMD	14,651	7,691	2,302	2,413

Figure 2.1.9 – Growth in ART coverage by age and sex (between FY20, Q4 and FY21, Q4)



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

Following a successful national HIV program alignment, the Nigerian HIV treatment program has become more efficient by deploying a combination of GIS mapping, community hot spot case finding, targeted KP case finding, index testing, and community centered care within a complementary framework across implementing agencies and partners. Additionally, the program showed resilience throughout the COVID-19 pandemic by deploying several mitigation strategies to protect PLHIV and health care workers. In COP22, PEPFAR Nigeria will leverage on COP21 gains in the program to scale up people-centered HIV prevention and treatment services and to address the inequity in specific populations. The goal of the national treatment program is to achieve ART coverage of greater than 81% in all states of the federation. Specific areas of focus will include closing the HIV treatment gap among children, KP, AGYW, and within MTCT; strengthening laboratory functionality and logistics management; and building on the achievements in SNUs with >81% ART coverage to achieve treatment saturation in the remaining SNUs with ART coverage <81% and optimize the use of biometrics for improved data quality and service delivery. Innovative approaches such as multi-month dispensing at six months and leveraging the OVC program to help find CLHIV implemented in COP21 will be further strengthened and mainstreamed.

PEPFAR Nigeria will improve on the strategies for identifying PLHIV, linkage to care and continuity in treatment that enabled successful quarter-on-quarter growth in TX_CURR in COP21. As of Q1 COP21/FY22, the program has achieved a TX_CURR of 1,769,656, providing access to an additional 73,182 (4%) PLHIV more than the COP21/FY22 target. Furthermore, COP21 Q1 program data indicated a 98% continuity on treatment. The focus in COP22 will now be on

sustaining growth of the treatment cohort, continuity of ART among all clients, and closing the emerging sub-population interruptions in treatment (IIT) gaps through adaptive, people-centric interventions that will leverage technology and predictive analysis to minimize client losses. Emphasis will be placed on optimizing the differentiated service delivery (DSD) models for ART initiation/delivery; strengthening virtual platforms for enhanced adherence; scaling up six-month multi-month dispensing of ARVs (MMD6), especially for pediatric patients; full ARV optimization, including among children and adolescents (e.g., dolutegravir-based regimens); deploying case management accountability systems and integrated care; and surveillance and real time monitoring of IIT data at the facility and implementing partner (IP) situation room(s).

Focus on Client ART Continuity

Based on lessons learned in COP21, PEPFAR Nigeria will ensure continuity in treatment of all clients, by institutionalizing MMD6, ensuring patients tracked back to care are placed on DSD models based on their need. Additionally, the program will continue to leverage patient-level data centralized in the NDR to strengthen continuity in treatment through machine learning and predictive analysis. A prevention package of optimized appointment scheduling layered on structured pre-appointment programs, such as appointment reminders and risk profiling based on antecedents or demography, in the early phase of continuity of treatment will be provided, listing the identified early defaulters and a generated list-serv 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 for 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, mapping root causes and client pain points; and routine collection of patient satisfaction surveys during visits to support continuous quality improvement of services.

2.3 Investment Profile

Nigeria is on track to achieving epidemic control across all states through an aligned HIV program. The HIV response in Nigeria remains heavily dependent on international donors with PEPFAR and the Global Fund accounting for 71% and 27% respectively of the $799m reported HIV spending in 2021 (Table 2.3.1). Of this amount, $308.4m (39%) was spent on Care and Treatment, $76.9m (10%) on HIV testing services, 32.9m (4%) for HIV Prevention and $77.8m (9%) on Program Management. Of the total spending on care and treatment, 73% was through PEPFAR support, 24% from the Global Fund and 3% was from Country Government. PEPFAR also funded 92% of the HIV testing services and 72% of the Prevention investments while the Global Fund was responsible for 6% and 24% respectively of the HIV testing and Prevention investment.

Table 2.3.1 Investment Profile (Funding Landscape) for HIV Programs

	Total	Domestic Government	Global Fund	PEPFAR	Other Funders
	$	%	%	%	%
Care and Treatment	$ 308,482,160	2.8%	24.0%	73.2%	NIL
HIV Care and Clinical Services					
Laboratory Services incl. Treatment Monitoring					
Care and Treatment (Not Disaggregated)					
HIV Testing Services	$ 76,932,769	2.7%	5.7%	91.6%	NIL
Facility-Based Testing					
Community-Based Testing					
HIV Testing Services (Not Disaggregated)					
Prevention	$ 32,997,177	3%	24%	72%	NIL
Community mobilization, behavior and norms change					
Voluntary Medical Male Circumcision					
Pre-Exposure Prophylaxis					
Condom and Lubricant Programming					
Opioid Substitution Therapy					
Primary Prevention of HIV & Sexual Violence					
Prevention (Not Disaggregated)					
Orphans and Vulnerable Children	$ 30,166,102	0.0%	7.1%	92.9%	NIL
Case Management					
Economic Strengthening					
Education Assistance					
Psychosocial Support					
Legal, Human Rights, and Protection					
OVC (Not Disaggregated)					
Above Site Programs	$ 13,915,045	13.2%	27.3%	59.4%	NIL
Human Resources for Health					
Institutional Prevention					
Procurement and Supply Chain Management					
Health Mgmt Info Systems, Surveillance, and Research					
Laboratory Systems Strengthening					
Public Financial Management Strengthening					
Policy, Planning, Coordination and Management of Disease Ctrl Programs					
Laws, Regulations and Policy Environment					
Above Site Programs (Not Disaggregated)					
Program Management	$ 77,801,523	0.2%	9.8%	90.0%	NIL
Implementation Level					
Donor Level					
Program Management (Not Disaggregated)					
Total (incl. Commodities)	**$ 799,013,079**				
Total Commodity Only	**$ 258,718,303**				
% of Total		**2.7%**	**26.8%**	**70.5%**	

2.3.2 – National Procurement of Key HIV Commodities

Commodities accounted for about a third, $258.7m, of total HIV investments for 2021 (Table 2.3.2). The Global Fund accounted for $113.9 (44%), PEPFAR $136.8m (53%) and the government $8.0m (3%). The government contribution is an 18% increase from the previous year ($6.8m). The government has committed to increasing its ARV commodity contribution in FY23 while leveraging on the HIV Trust Fund for additional test kits.

Table 2.3.2 Investment Profile (Funding Landscape) for HIV Commodities

	Total	Government	Global Fund	PEPFAR	Other Donors
	Current Year $	%	%	%	%
Antiretroviral Drugs	$ 205,302,539	3.9%	53.0%	43.1%	NIL
Condoms and Lubricants	$ 2,587,237	0.0%	47.8%	52.2%	NIL
Female Condoms					
Male Condoms					
Other					
Condoms and Lubricants (Not Disaggregated)					
Rapid Test Kits	$ 16,750,554	NIL	14.3%	85.7%	NIL
Laboratory Supplies and Reagents	$ 26,351,269	NIL	5.1%	94.9%	NIL
CD4					
Viral Load					
Laboratory Supplies					
Laboratory (Not Disaggregated)					
Medicines	$ 4,551,986	NIL	NIL	100.0%	NIL
Essential Medicines					
Tuberculosis Medicines					
Other Medicines					
Consumables	NIL	NIL	NIL	NIL	NIL
VMMC Kits and Supplies					
Other Consumables					
Health Equipment					
Health Equipment					
Service and Maintenance					
PSM Costs	$ 3,174,717	NIL	NIL	100.0%	NIL
Total Commodities Only	**$ 258,718,303**				
% Contribution		**3%**	**44%**	**53%**	**NIL**

Analysis of reported data indicates that 86% of the reported above site investments were from PEPFAR and Global Fund[1]. These funds mostly cover stipends for almost all the adhoc staff (data clerks, peer educators, lay counsellors, and case managers) in the HIV program, accounting for the considerable investments. The figures for the government above site investments for 2021 are incomplete and a significant drop from the figure reported in National AIDS Spending Assessment (NASA) 2019, which attributed 89% of the HRH investments in 2018 to the host country government. Unfortunately, the NASA report which has been a source document for reporting the national HIV spending has not been produced since 2019 and domestic spending for the Nigeria HIV response is not readily available. The delay in obtaining data from the government resulted in non-completion of the COP22 HIV Resource Alignment Profile for Nigeria. Given the importance of this data for planning and decision-making, PEPFAR and the Global Fund programs will support the GoN to develop an updated NASA to improve tracking of funding flow for the HIV response from the source, through the different agents, and to the beneficiaries.

Ninety- two percent (92%) of the investment for the OVC program was borne by PEPFAR with 8% attributed to the Global Fund investment. Considering that the Global Fund does not support OVC programming but investments in 3 states for Adolescent Girls and Young Women (AGYW), understanding the scope and scale of this investment will be beneficial.

2.2.3 - US Government health-sector investments outside PEPFAR

Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration					
Funding Source	**Total USG Non-PEPFAR Resources**	**Non-PEPFAR Resources Co-Funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
USAID MCH	$32,000,000*	$0	$0	$0	End preventable child and maternal deaths
USAID TB	$14,000,000*	$0	$0	$0	Accelerate case-finding and increase national case detection rate.
USAID Malaria	$74,000,000*	$0	$0	$0	Reduce malaria burden under the PMI.
USAID Family Planning	$25,000,000*	$4,000,000	$0	$1,000,000	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*	$0	$0	$0	Reduce malnutrition among women and children.
USAID Economic Support Fund (ESF) COVID relief funding	$38,300,000	$0	$0	$0	USG COVID-19 objectives 1 and 2
CDC (Global Health Security)	$3,104,913	$0	$0	$0	Strengthening of International Health Regulations core capacities to promote global health security through: 1. Workforce development through frontline, intermediate and advanced training programs for field epidemiologists through the NFELTP Program. 2. Establishment and operationalization of Emergency Operations Centers. 3. Development/ improvement/ strengthening of Real-Time Surveillance and Border Health Security. 4. Development/ improvement/ strengthening of Information Systems and GHSA Reporting Development of Public Health Emergency Management programs. 5. Zoonotic Disease Human and Animal Surveillance. 6. Infectious disease research.
CDC / DGHP – ARPA Funds	$175,002	$0	$0	$0	Establishing a pan-respiratory disease surveillance systemin Nigeria.
CDC / DGHP CARES Act Funds	$10,161,228	$0	$0	$0	1. Create a crosscutting communicable disease sentinel surveillance network. 2. Support the expansion of the existing AEFI surveillance system in Nigeria. 3. Regional Hub for Genomic Sequence-Based Surveillance for SARS CoV-2. 4. Lab Systems Strengthening for SARS-CoV-2 testing. 5. IPC Sustainability and Expansion. 6. Strengthening Port Health Services (PHS) operations and coordination with POEs across the country. 7. Public Health Emergency Preparedness, Response and Recovery Fellowship.
CDC / DGHP ITF Funds	$775,000	$0	$0	$0	1. Develop IPC Programs in PEPFAR facilities 2. Create PH Emergency Management training program 3. Support NCDC to strengthen national IPC programs
CDC GID	$20,137,386	$0	$0	$0	Work towards: 1. Sustaining certification for wild polio type 1 (WPVV1) free status in Nigeria. Note that Nigeria eradicated WPV1 in August 2020. 2. Halting the spread of WPVs and circulating vaccine derived polio viruses (cVDPVs) and improving surveillance activities across states with CDC/AFENET presence. 3. Improving the quality of polio SIA campaigns and outbreak responses efforts in response to cVDPVs. This will increase the uptake of IPV and sustain management support teams (MST) deployment.

Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration					
Funding Source	**Total USG Non-PEPFAR Resources**	**Non-PEPFAR Resources Co-Funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
					4. Strengthening the collaboration with GoN (and other partners) on the transition of polio resources and structures to support broader surveillance, routine immunization, and PHC services. 5. Improving routine immunization coverage from 33% to 80% by 2028 through Z-drop strategy, supporting states to develop implementable strategies for chronically missed children, working with states to integrate their SCALES micro plans, implementing the optimized integrated routine immunization sessions, and other RI strengthening strategies and activities. 6. Supporting states in improving their uptake of COVID-19 vaccines and working with implementing partners to develop studies that will provide information on vaccine effectiveness, efficacy, factors that affect vaccine uptake etc. in order to develop strategies with the GoN to overcome vaccine hesitancy and improve vaccine uptake. 7. Measles elimination: through supporting measles campaigns and outbreak responses, increase measles coverage across all 36 states and FCT, support the deployment of MSTs and consultants, strengthen measles surveillance, and support the states to develop a system to align lab tests with outbreaks 8. Strengthening surveillance and testing of vaccine preventable diseases such as measles, yellow fever, and congenital rubella syndrome
DOD COVID-19 Biobanking (Africa CDC)	$1,540,000	$0	$0	$0	Multinational study on the biobanking and characterization of positive COVID-19 samples in Africa
DOD Biosecurity (DTRA)	$300,000	$0	$0	$0	Strengthening of outbreak response systems
DOD Lassa Surveillance	$1,278,000	$0	$0	$0	Zoonotic Disease; Human and Animal Surveillance
DOD Lassa Vaccine Trials (IAVI)	$2,400,000	$0	$0	$0	Development of Ph2a and Ph2b Lassa vaccines
DOD Acute Febrile Illness (JWARG)	$425,000	$0	$0	$0	Acute febrile illness surveillance study and testing of point of care equipment for lung ultrasounds
DOD Malaria (PMI)	$0	$0	$0	$0	Increasing capacity in malaria microscopy and quality assurance for diagnosis; establishment of a national malaria slide bank through an award from USAID
DOD Monkeypox (DTRA)	$650,000	$0	$0	$0	Tropical medicine training on monkeypox; training on the safe handling and transport of monkeypox samples.
DOD AFRICOS Science	$60,000	$0	$0	$0	Back end scientific support for the PEPFAR-supported AFRICOS longitudinal study.
Total	**$231,306,529**				

2.4 National Sustainability Profile Update

For the 2021 Sustainability Index and Dashboard (SID), a conscious effort in the spirit of the national alignment to situate the SID as key central activity for reviewing the status of national health systems components critical to the success and sustainability of the country's HIV response efforts. The process was led by NACA's Policy, Planning and Coordination (PPC) department with the intention to complement and align the findings from the SID and Responsibility Matrix (RM) review with other ongoing health review activities to fully understand

the key areas of needed focus in the next planning cycle. The PEPFAR and UNAIDS country teams supported NACA by providing technical assistance.

As with prior iterations, 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 from the expert panel was reviewed by a Stakeholder group in November 2021, where additional inputs were gathered and incorporated. A final draft of the SID documents was subsequently disseminated in January 2022 before it was finalized and published.

As seen from the dashboard (Figure 2.4.1 below), improvements have been observed in a most of the health systems elements, but a few others continue to lag, and some have even reversed.

Figure 2.4.1 – The Nigeria 2021 SID Dashboard

Sustainability Analysis for Epidemic Control: Nigeria

Epidemic Type: Mixed
Income Level: Lower middle income
PEPFAR COP 19 Planning Level: $371.135m

SUSTAINABILITY DOMAINS and ELEMENTS	2015 (SID 2.0)	2017 (SID 3.0)	2019 (SID 4.0)	2021
Governance, Leadership, and Accountability				
1. Planning and Coordination	8.17	9.67	9.67	10.00
2. Policies and Governance	5.44	6.57	5.55	6.16
3. Civil Society Engagement	6.33	8.33	7.71	6.54
4. Private Sector Engagement	4.93	7.42	5.81	8.21
5. Public Access to Information	7.00	5.00	6.56	6.56
National Health System and Service Delivery				
6. Service Delivery	2.50	6.06	4.90	6.01
7. Human Resources for Health	4.92	6.09	6.09	5.99
8. Commodity Security and Supply Chain	5.73	6.18	4.72	6.32
9. Quality Management	6.24	7.38	3.86	5.48
10. Laboratory	4.44	5.83	5.94	6.89
Strategic Financing and Market Openness				
11. Domestic Resource Mobilization	3.06	5.71	5.56	5.99
12. Technical and Allocative Efficiencies	4.51	8.00	7.58	9.00
13. Market Openness	N/A	N/A	9.20	8.59
Strategic Information				
14. Epidemiological and Health Data	3.75	5.71	5.99	6.18
15. Financial/Expenditure Data	5.00	8.33	7.50	8.33
16. Performance Data	3.74	6.23	5.84	7.00
17. Data for Decision-Making Ecosystem	N/A	N/A	0.67	3.00

The narrative below summaries some of the observed health system-related sustainability strengths and weaknesses of the country's HIV response in 2021.

A. Sustainability Strengths:

Planning and Coordination (10.0, Dark Green, previously 9.67, Dark Green): Nigeria's HIV response is guided by an inclusive multi-year National Strategic Framework (2021-2025) with associated state-level health and HIV strategic plans. The engagement of civil society organizations (CSOs) and the private sector has improved over time and is reflected in the diverse national strategy development processes. The increase in this year's SID iteration is attributed to the routine tracking of civil society and private sector by government. NACA hosts a database for CSOs and IPs which includes their GPS coordinates, along with priority areas of focus. This improvement responds to the associated recommendation made in SID 2019. Stakeholders noted that although this database was in place to track service providers, there was a gap in the frequency of updating.

The group recommended that Government improve the frequency of updating the database to guide planning, coordination, and accountability.

Private Sector Engagement (8.21, Light Green, previously 5.8, Yellow): The scoring in this sub domain also experienced fluctuation over the various iterations of the SID. The resurgence of cooperation among private business noted in the previous SID was sustained. Stakeholders applauded the improvement in the formal channels for private sector partnerships (PPP) and the opportunity for private sector engagement.

One high point in the element of private sector engagement is the establishment of an HIV Trust Fund. This is an innovation by the Federal Government initiated under the Domestic Resource Mobilization effort and is solely private sector driven and funded. Launched in February 2022, the fund is expected to increase domestic resources pertaining to PMTCT. Discussions are advanced regarding the timeline for the launch of the Fund.

Linkages and referral networks between onsite workplace programs and public health facilities were recognized however the need for strengthening of these mechanisms was acknowledged. Lack of efficiency in the legislation of pharmaceuticals was also flagged. It was noted that application of these legislations is limited due to insufficient awareness and poor utilization of legal information.

Even with an increase in the score, stakeholders recommended that Nigeria must sustain the tempo of the effort thus far.

Technical and Allocative Efficiency (9.0, Dark Green, previously 7.58, Light Green): Has been an area of strength over the years with even more progress recorded this year. The Revised National Strategic Framework 2019-2021 divided the country into high, medium, and low burden states and most investments for HIV (especially by donors) reflect this prioritization. Standard processes like Spectrum and Mode of Transmission (MOT) Surveys inform the understanding of

the epidemic in Nigeria. For example, the MOT 2021 report states that the focus of the program should be geared toward AYP and PMTCT while the spectrum data was used as the basis for expansion of PEPFAR into the new states. In addition, policy on the integration of HIV/AIDS into the sub-national insurance schemes will improve strategic purchasing for HIV services. NACA aligns its procurement processes with the procurement Act while commodities are purchased at international benchmark prices through the WAMBO platform thereby improving efficiency in the HIV response.

The gap remains that sub-national health insurance schemes have not become fully operational, and this may threaten the sustainability of the response. Priority in terms of allocation should be given to higher burden areas.

Stakeholders recommended that government prioritize resource allocation to commodity supply and high burden states.

Performance Data (7.0 - Light Green previously 5.84, Yellow: Nigeria boasts the necessary guidelines and structures for the collection, analysis, and dissemination of performance data. The NDR, which captures patient level data for all HIV service delivery areas, is fully operational. There is a current drive to integrate the NDR with the DHIS2 system.

Stakeholders expressed concern regarding the sustainability of this national data reporting platform given that it is largely supported through donor programming. Gaps were also flagged in the coordination of non-health sector data.

The group recommended that the plans to review the non-health sector data tools be fast tracked along with the reactivation of the eNNRIMs reporting platform. It was also recommended that the timeliness of data reporting and validation from the states be addressed by NASCP and NACA.

B. Sustainability Vulnerabilities:

Civil Society Engagement (6.54, Yellow, previously 7.71, Yellow): The sustainability scoring across SIDs for this element fluctuates as CSOs insist on improved engagement at all levels. The Government was commended for its engagement with CSO (through The Coalition of Civil Society Networks – CoCSNHAN), in the development of national strategies and on accountability platforms. The Faith-based Community is actively engaged and has proceeded to develop its own strategy on HIV/AIDS and other related diseases derived from the National HIV and AIDS Strategy 2021-2025. The private health sector contributes to the process through the Nigeria Business Coalition Against AIDS (NIBUCAA). NIBUCAA is the coordinating entity for organized private sector.

Consistent with the previous SID, CSOs reported their limited or non-involvement in financial planning and allocations including in Government budgeting and the HIV Trust Fund initiative. Stakeholders recommended that the Government and partners create space for meaningful involvement in budget advocacy and budget tracking beyond sittings on boards.

Data for Decision-Making Ecosystem (3.00, Red previously 0.67, Red): Though there is some improvement, this element is still a vulnerability for the country. The Government of Nigeria has commenced the collection of biometric data (fingerprint) from all PLHIV as part of patient-level data from health facilities to the NDR for deduplication of records. There is a plan to introduce a national, unique ID system, to be derived from a system that may include each patient's unique fingerprint data. However, IPs in the country are currently using various unique IDs for their programming. The NDR serves as an HIV/AIDS data warehouse, but it is not integrated with any administrative data and does not currently incorporate other disease conditions.

Stakeholders reported sub-optimal performance of the Civil Registration and Vital Statistics system.

Considering this and other gaps it was recommended that the Government fast track the implementation and rollout of the national unique ID system, including its critical and essential National Client Registry component. The unique identifier conversation should be robust in consultation with deliberate efforts to harmonize across other disease programs.

Conclusion: There is a general improvement across most of the domains and elements of the SID and it is obvious that these improvements have contributed to the recent programmatic success in the national HIV treatment program. The Government is investing more and supporting the development of policies and systems to improve and sustain the HIV response. Stakeholder coordination has improved under the National Alignment Program, a joint agreement between the three principal funders of the HIV program in Nigeria; PEPFAR, the Global Fund and the Government of Nigeria, to prioritize their organization's investments and efforts in their unique areas of comparative advantage.

The central role of NACA in this year's iteration of the SID is a commitment by the agency and on behalf of GoN to use the products of these engagement, to guide future efforts to prioritize health systems investments, and to ensure that the Country is increasingly empowered to advance and sustain its HIV program goals and objectives.

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 2021, there were 1,769,656 PLHIV currently receiving ART across all SNUs, bringing the country's treatment coverage to 91%. Figure 2.5.1 shows the maps of Nigeria by SNU for treatment coverage above and below 81%. PEPFAR's investment over the past six years has been aligned to provide more support to SNUs with the highest unmet needs. Moving forward, PEPFAR's resources will be utilized to achieve treatment saturation in the remaining SNUs that are yet to achieve 81% treatment coverage.

Nigeria has achieved significant progress in in the past few years. For example, as of FY22 Q1, the previous surge states of Rivers and Akwa Ibom now have treatment coverage well over 81%. Similarly, high HIV burdened states like Benue, Delta, Lagos, Enugu, and Imo are on their way to

achieving epidemic control. In COP 22, PEPFAR will achieve at least 81% treatment saturation across all SNUs in Nigeria

The historic COP20 National Alignment Plan sought to unlock the country's ability to access care across all geographies optimally by engaging the major stakeholders of Government of Nigeria, PEPFAR, and Global Fund. The Alignment is geared towards epidemic control by optimizing pooled resource allocation, standardizing programming, expanding best practices, and deepening innovations and learning at all levels. In COP 22, PEPFAR will continue to support 35 of 37 states, including Taraba and Abia. Global Fund will continue to play a critical role in leading the surge efforts in Anambra and Ebonyi.

2.5.1 Nigeria's Antiretroviral Treatment Coverage by states (as at Quarter 1, 2022)

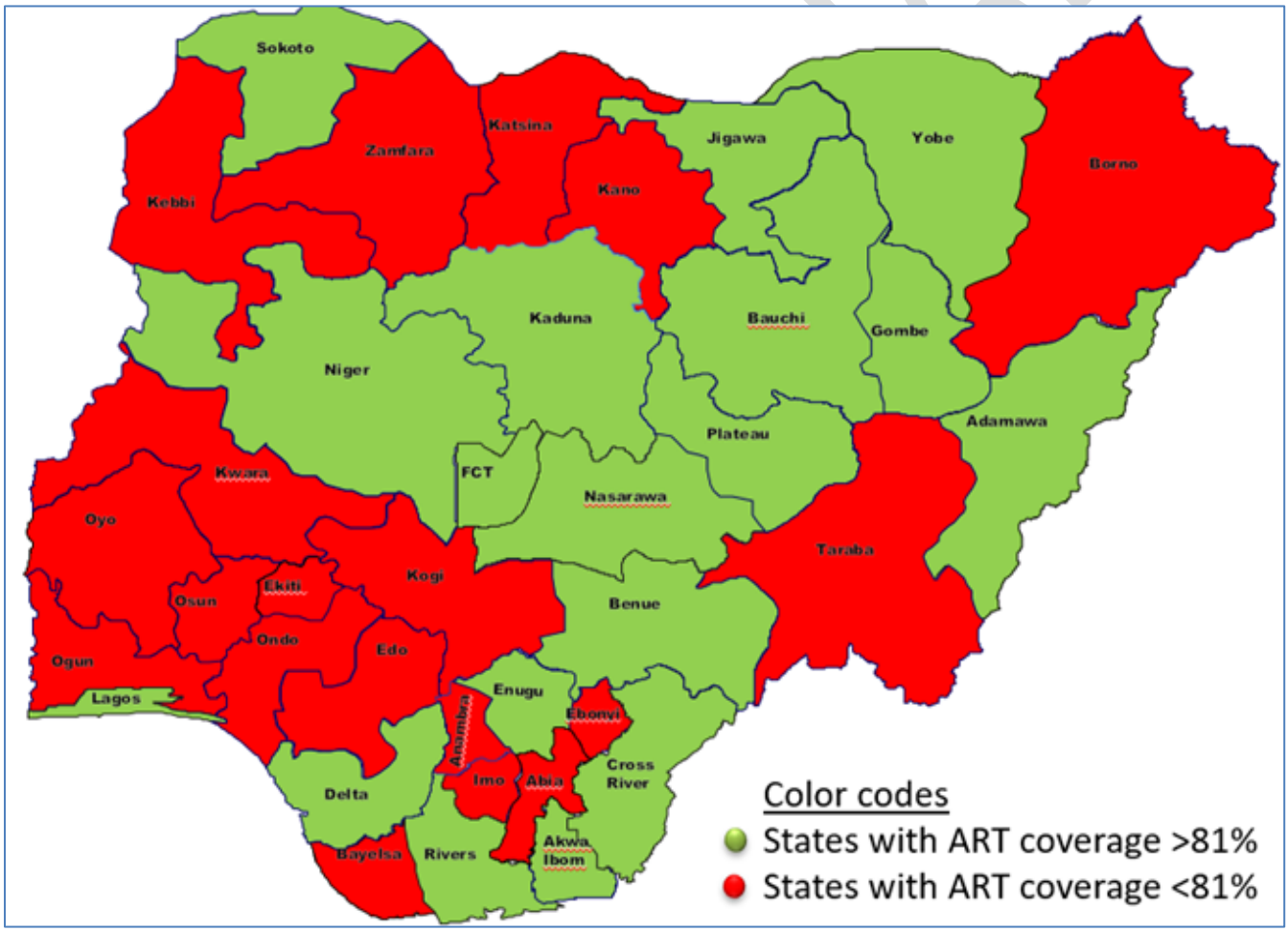


Figure 2.5.2 Nigeria's Total PLHIV Population by SNU using FY22 Spectrum PLHIV

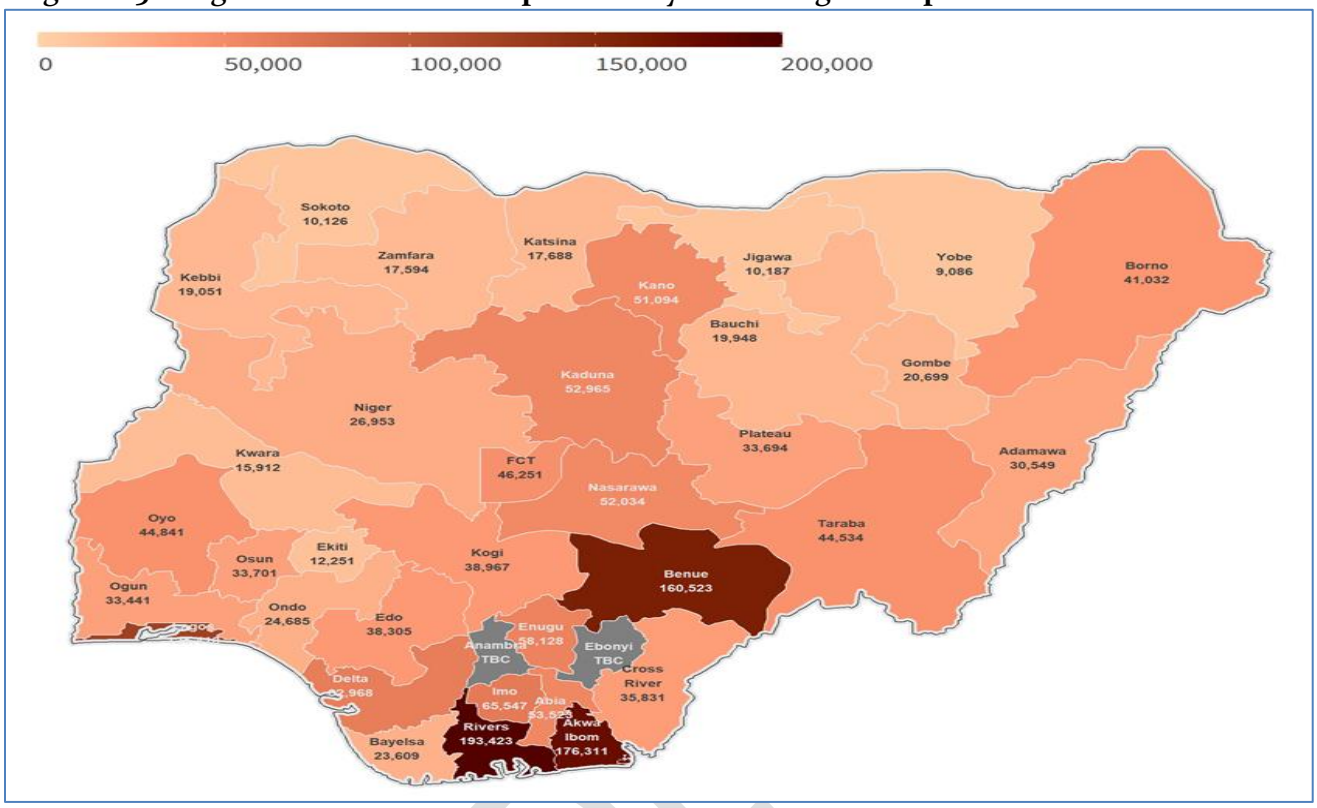


Figure 2.5.2 depicts the SNUs in Nigeria by treatment coverage and contribution to unmet need. In COP21, PEPFAR will achieve treatment saturation (81% treatment coverage) in 29 states with 6 states having treatment coverage of 60% including programing in Abia. Concurrently, the Global Fund will scale 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

Nigeria's national HIV/AIDS program alignment initiated in the COP20 development process continues to be the guiding framework for planning, implementation, and review of the country's program. The COP22 planning process presented a major opportunity to evaluate the progress made so far and to strategize for the next phase of the alignment.

Stakeholder engagement for COP22 was formally commenced during the week of the Country Strategic Retreat (January 31st-February 4th, 2022) during which the PEPFAR country team hosted several internal and external virtual meetings with country stakeholders in Government; led by the Director General of the National Agency for the Control of AIDS, Dr. Gambo Aliyu and the National Coordinator of the National AIDS/STI Control Program in the Federal Ministry of Health, Dr. Akudo Ikpeazu; the Global Fund Country team, the Joint UN team on AIDS and local Civil Society leaders.

During these meetings and several others culminating in the Virtual Planning Meeting (VPM) in March, the country team shared the tremendous success of the national alignment approach and the country's HIV program Surge in the last two years, which has seen the country make major progress with regards to the 95-95-95 UNAIDS targets. The meetings also presented an opportunity for stakeholders to reflect on outstanding program gaps and to initiate discussions on how to prioritize investments to address these gaps in the current and future operational year.

One major challenge that the funding partners had to contend with was the fact that the country had significantly overachieved in HIV treatment coverage and had ended the previous fiscal year with far more people on treatment than had initially been planned for. From this emerged the need to find additional resources to fund the national HIV treatment program (beyond what was initially envisaged).

In addition to this, stakeholders had to agree on a national strategy to address the continuing gaps in national PMTCT coverage which had appeared to persist despite the progress reported in reaching women of reproductive age with HIV care and treatment services. A national PMTCT scale-up plan which will see the country aim to provide HIV testing services to about 95% of all the estimated 8 million plus pregnant women in the country annually by FY2023, was agreed on. This plan presented additional funding challenges.

These gaps and others identified in the need to also scale-up pediatric case-finding and treatment as well as expanding program coverage for key populations, were ultimately resolved through a consensus to mobilize additional funds through the Country's Global Fund grants and potentially also through additional funding which may become available to the country as part of the country's Priority Above Allocation Request (PAAR). Another potential funding source was identified in the recently launched National HIV Trust Fund, a private sector led resource mobilization initiative of the Nigeria Business Coalition on AIDS (NIBUCCA), which has committed to provide new funding opportunities for the national PMTCT scale-up efforts.

Stakeholders also agreed that the national HIV alignment program should be extended to all others areas of the national HIV program including the areas of health systems investments and community systems support, so that the country would in the next round of PEPFAR, GON and Global Fund program planning process, be in a position to plan and deliver a fully integrated, fully leverage, single national HIV program that would form the basis for deeper understanding of what the sustainability agenda for the country would look like. Several groups were tasked to

begin consultations towards this, and it was agreed that country stakeholders would need to commence engagement later this year in preparation for the next year's planning process. While noting the need for continued improvements in domestic resource mobilization, stakeholders also proposed that it was time to commence efforts to significantly streamline the operational costs of the program to begin to identify activities that can be transitioned over to the state and national Governments without significant risks to current program gains.

As with prior years, Civil Society engagement for COP22 was deep and inclusive. This time, eight CSO leaders were selected by community members to represent their interests in the COP planning process. Following an initial 3-day orientation meeting with the PEPFAR country team, the CSO received support from the UNAIDS Country team to organize community dialogues sessions with all the major sub-communities including PLHIV, youth groups, faith-based advocates, sex workers, MSM, transgender persons, advocates for drug users and incarcerated persons. The outcomes of their discussions and their specific recommendations and demands were presented to the PEPFAR country leadership to initial considerations as the COP22 plan was being developed and later again at the Virtual Planning Meeting at which point several consensus points had been established with the CSO leaders.

In general, several of the recommendations are already being addressed within the framework of the CSO engagement plan and the PEPFAR-supported community-led monitoring plans (see section 5.0). Others fall into the category of adjustments and additions that need to be reflected on the activities of the different PEPFAR and national program areas. The last set of recommendations reflect the need for broader stakeholder engagement to address systemic and structural challenges which limit the ability of Nigerian citizens to access HIV/AIDS services and the planned interventions to these are addressed in the section below. Also, the detailed response to the CSO demands presented at the VPM is presented in **Appendix F** – as has been done in prior years. This is presented to allow for easy tracking of progress on these demands.

2.7 Stigma and Discrimination

Following the initial exercise conducted in 2011 and a second in 2014, Nigeria completed a third Stigma Index Survey[7] in 2021. The study, which led by the Network of People Living with HIV/AIDS in Nigeria (NEPWHAN) saw data collectors administer a questionnaire-based survey tool to 1,240 PLHIV in 16 states of the Country and the Federal Capital Territory, Abuja. These included 763 females, 418 males, 9 transgender and 3 self-identified non-binary individuals. Overall, about 25% of the respondents identified with key populations communities, 161 being Female Sex Workers (FSW), 81 being Men who have sex with Men (MSM) and 57 being people who inject drugs (PWIDs). 63.5% of those surveyed were between the ages of 25 and 44 years.

Findings show that while there has been a steady decline in the reported experience of being denied access to healthcare services because of their HIV status or being forced to submit a HIV

[7] Network of People Living with HIV/AIDS in Nigeria (2021), "Stigma Index Survey 2.0 Report".

test before a medical procedure. Despite these positive findings, there remains some significant concerns about the experience of stigma and discrimination in the recent report. Twenty-five percent of respondents reported that personal experiences of unauthorized disclosure of their HIV status and the same proportion of respondents reported being pressured to take a HIV test. The general experience of stigma and discrimination was reported by 22% of respondents. Only a small proportion reported these experiences to have occurred within the healthcare setting, so it is more of a community phenomenon.

Regarding the experience of human rights abuse, 10.9% reported experiencing this. Of these, only a quarter of them reported taking any follow-up action to mitigate the rights abuse afterwards, while a good number of those who did not take any such actions reported not being aware of how and where to seek redress.

Stigma and discrimination for reasons such as gender identity, sexual identity, sex work and drug use, has emerged as a growing concern and appears to be most prevalent in the 18-44 years age band. More of these were reported as recent experiences suggesting trends in this regard.

To address these issues, the report recommended the need to improve community-level awareness creation efforts on HIV transmission and treatment outcomes as captured in the on-going national U=U campaigns which was launched in 2019. It also points to the need for health and human rights knowledge building amongst PLHIV and key population communities. Lastly, it speaks of the need for community engagement to disseminate this knowledge more broadly to the Nigeria public as well as the need to strengthen the existing legal framework to respond to issues of human rights violation and abuse for all Nigerians, irrespective of the HIV status, sexual and gender orientation.

These recommendations alignment with the objectives of the Patient Education and Empowerment Project (PEEP), a nationwide health and human rights literacy education program that the PEPFAR Nigeria has funding since 2020 and implementing in collaboration with the NEPWHAN, the National Human Rights Commission (NHRC), NACA, NASCP and UNAIDS. So far, an integrated health and human rights curriculum for PLHIV has been developed and disseminated through a seven training of trainer workshops for PLHIV community leaders at national, regional, and state level. The more than 130 community leaders trained so far are already disseminating the information through their informal channels but will be supported in the current implementation period to host annual state level workshops for PLHIV support group leaders, peer educations, case managers, adherence counsellors and others who have access to many PLHIV in the community to empower them with the information.

Also, as part of the PEEP, stakeholders have prioritized the need to set-up a NEPWHAN-led grievance communication and redress system in collaboration with the NHRC and other stakeholders. This system will receive, track and follow-up on reported cases of human rights violation and abuse of PLHIV and others and will ensure that appropriate redress actions are implemented. Over time, the system will increasingly serve as deterrent for perpetrators of such

injustice. PEPFAR will also support the NHRC to develop and disseminate a human rights manual to assist law enforcement and legal officers in the discharge of their duties especially with regards to the specific rights of PLHIV and key populations as guaranteed by Nigeria'S Patient Bill of Rights[8] and other related human rights protection tools in the country.

To improve community awareness about treatment outcomes, PEPFAR will also continue to support the ongoing national U=U campaign, this time through a Civil Society led effort that will not only give the community an opportunity to further disseminate the message but also to play a more central role in tracking and document the related actions of other stakeholders in support of the campaign.

In addition to these investments, the Nigerian Government has submitted a concept note to the Global Fund for structural interventions to address gender and human rights issues[9] in the country. In the spirit of the national alignment, PEPFAR will seek to work with UNAIDS, NACA, NHRC, Civil Society and the Global Fund Country Coordinating Mechanism (CCM) to ensure that these interventions speak to a broader integrated agenda to meaningfully address stigma, discrimination, human rights violations, and gender-based violence.

[8] Consumer Protection Council (2019), "Patient Bill of Rights (PBoR): Illustrated guide".
[9] NACA (2022), "Draft Concept Note on Gender and Human Rights Interventions".

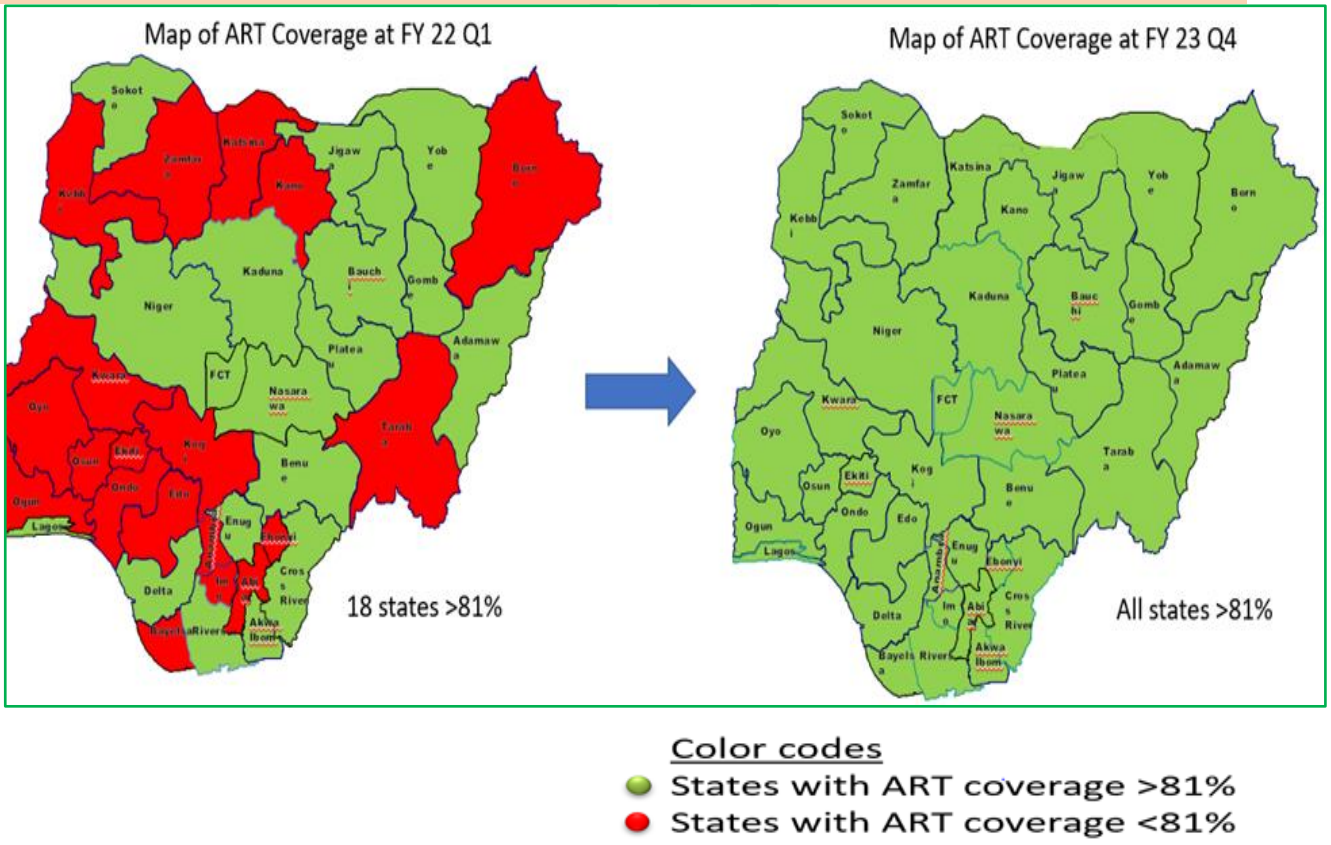
3.0 Geographic and Population Prioritization

3.1. Geographic Prioritization

At the end of FY22 Q1, 18 SNUs had achieved at least 81% ART coverage. However, inequality in the percentage of ART coverage persists across SNUs and by population. At the end of FY 2022 Q1, the treatment coverage among children (<15 years), adolescents (15-19), and adults (>20 years) were 33%, 46%, and >95% respectively. Moreover, uptake of antenatal services and consequently, PMTCT services, varies by region and between rural/urban residents.

In COP22, PEPFAR Nigeria will further expand on the HIV response gains of previous COPs with the aim of achieving at least 81% ART coverage in all states in Nigeria as shown in figure 3.1. To improve on current situation, PEPFAR Nigeria will launch a surge program to accelerate access in pregnant and pediatric populations. This will be advanced by unlocking the determinants, drivers, patterns of the epidemic and micro-epidemic hot spots, and achieved through equitable, people-centered mechanisms aligning with the UNAIDS 95-95-95 global goal for 2030. Leveraging off the recalibrated epidemiology defined through 2018 NAIIS, the updated 2022 HIV spectrum projections, continuously generated program data, trends, and analytic derivatives from NDR.

Figure.3.1: Anticipated SNU ART Coverage change between FY 22 Q1 and FY 23 Q4



In COP22, PEPFAR will continue to support 35 of 37 states, including Taraba and Abia, which respectively contribute 6% of the unmet need with a HIV. In addition, Global Fund will continue to play a critical role in leading the surge efforts in Anambra and Ebonyi.

Table 3.1 Current Status of ART saturation				
Prioritization Area	**Total PLHIV/% of all PLHIV for COP22**	**# Current on ART (FY21)**	**# of SNU COP21 (FY22)**	**# of SNU COP22 (FY23)**
Attained	10,670		0	0
Scale-up Saturation	368,577 / 20%	406,594	2	35
Scale-up Aggressive	305,843 / 16%	313,161	4	0
Sustained	1,082,552 / 58%	1,049,901	29	0
Central Support	0		0	0

For the coming financial year, PEPFAR Nigeria plans to improve the uptake of PMTCT services and provide care and support to infected children and their families using community based and family centered strategies. PEPFAR Nigeria is supporting GoN to bring PMTCT to the forefront through joint target setting for program scale up, as well as capacity building with plans for joint implementation monitoring. As part of this effort, PEPFAR through her implementing partners has flagged-off scalable community PMTCT services around supported health facilities that will allow additional 801,769 pregnant women know their HIV status through community action. Also plans to support the national facility mapping exercise of delivery homes that will precede national program scale-up. Through handholding using PEPFAR ICS template, sub-national units will be empowered to operate a PMTCT incident command structure to accelerate PMTCT by proving HTS to 2,202,446 pregnant women.

The ART coverage for CLHIVs aged <15yrs at end of FY 22 Q1 was 33% and the expected coverage at end of FY 22 Q4 based on current trajectory is 37%. PEPFAR Nigeria aims to improve the ART coverage in this age sub population to 54% in COP 22. Improving HIV case finding among pediatrics and adolescents is critical to bridging the ART coverage gap in this sub population. In COP22, PEPFAR Nigeria will unpack SNUs by unmet ART needs for pediatrics and adolescents and prioritize interventions for states based on the classification of states as red, yellow, and green depending on their closeness to ART saturation among these populations.

The red states include Abia, Akwa Ibom, Rivers, Imo, Bayelsa, Borno, Delta, Ondo, Plateau, Kano, Edo Nasarawa, Taraba, Ogun, Lagos and Oyo. In these red states, at least 170% factor of program growth change was applied to arrive at their ambitious COP22 targets. They will be prioritized for pediatric ART surge where intensified pediatric HIV case finding will be implemented. Family index testing will be scaled up, and all biological children of index cases aged 0-19 years will be targeted for HTS at health facilities and community settings. PEPFAR Nigeria will be scaling up the implementation of community index testing following the successes reported for the implementation of this testing modality for pediatric and adolescent sub populations in the last two reporting quarters. In the red states, all children seen at sick entry points of inpatient medical wards, malnutrition clinics, TB clinics will be provided HTS. Validated HIV risk screening tool will be used to screen children seen at outpatient departments and HTS will be provided to those

identified to be high risk. Children of KPs and Children seen at KP settings will also be target with these testing interventions. PEPFAR Nigeria will deploy resources appropriately to meet the HIV case finding needs of these prioritized SNUs. The increased need for lay HIV counselor testers will be met through the redeployment of some counsellor testers assigned previously to adult HTS and the engagement of more lay counsellor testers to implement the community index-testing and community HTS for this sub-population.

Eighteen States with low unmet pediatric ART need are classified as yellow states namely Zamfara, Osun, Jigawa, Kebbi, Katsina, Kwara, Gombe, Ekiti, Cross River, Kaduna, Kogi, Sokoto, FCT, Adamawa, Enugu, Bauchi, Niger and Yobe States. In setting their modest Targets, 130% factor of program growth change was applied. Pediatric ART program implementation in these states will focus on index testing for biological children of index cases among other interventions.

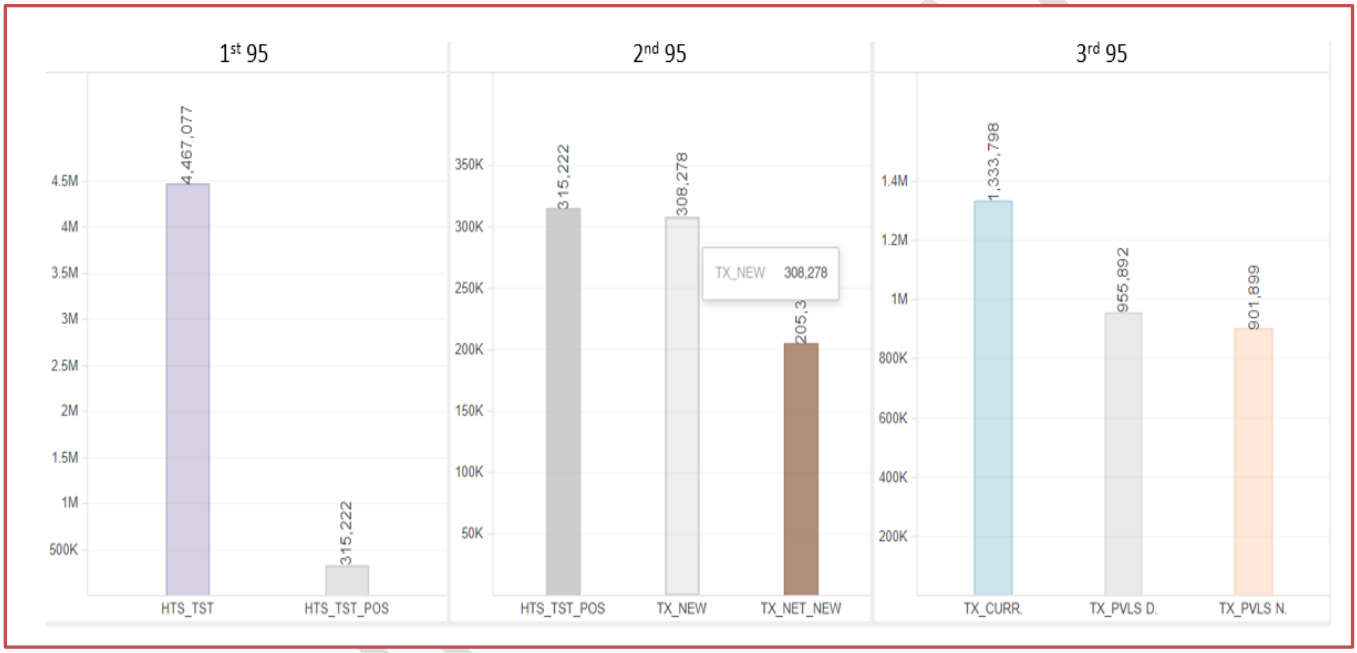
Benue, the only green state, is expected to be at 115% Saturation by end of FY22Q4 and 105% factor of program growth change was applied to arrive at her target. The program will largely consolidate the gains recorded so far while also ensuring HTS for eligible children of index cases.

PEPFAR Nigeria will utilize the OVC and community structures to strengthen the pediatric ART program. The OVC program will increase its footprints to all PEPFAR supported SNUs. The OVC program will implement pediatric and adolescent HIV case finding, treatment support services, viral load monitoring support services using the family centered approach. This integrated OVC-pediatric and adolescent approach will aim to ensure 100% CLHIV enrolment into the OVC program, increase OVC enrolment among children of KPs and provide a platform to achieve community viral load suppression for OVC clients.

4.0 Client Centered Activities for Epidemic Control

The drive towards reaching epidemic control in Nigeria continued to accelerate through COP21, despite the COVID-19 pandemic, with significant increases in case finding seen across the program as a whole. However, there is sub-optimal progress amongst some SNUs, pediatric and adolescent populations, key populations, and within the PMTCT program. The proposed HIV testing strategies in COP22 are designed to intentionally target these specific populations to close the ART coverage gaps and to reach and sustain epidemic control.

Figure 4.0.1 Overview of 95/95/95 Cascade, FY21



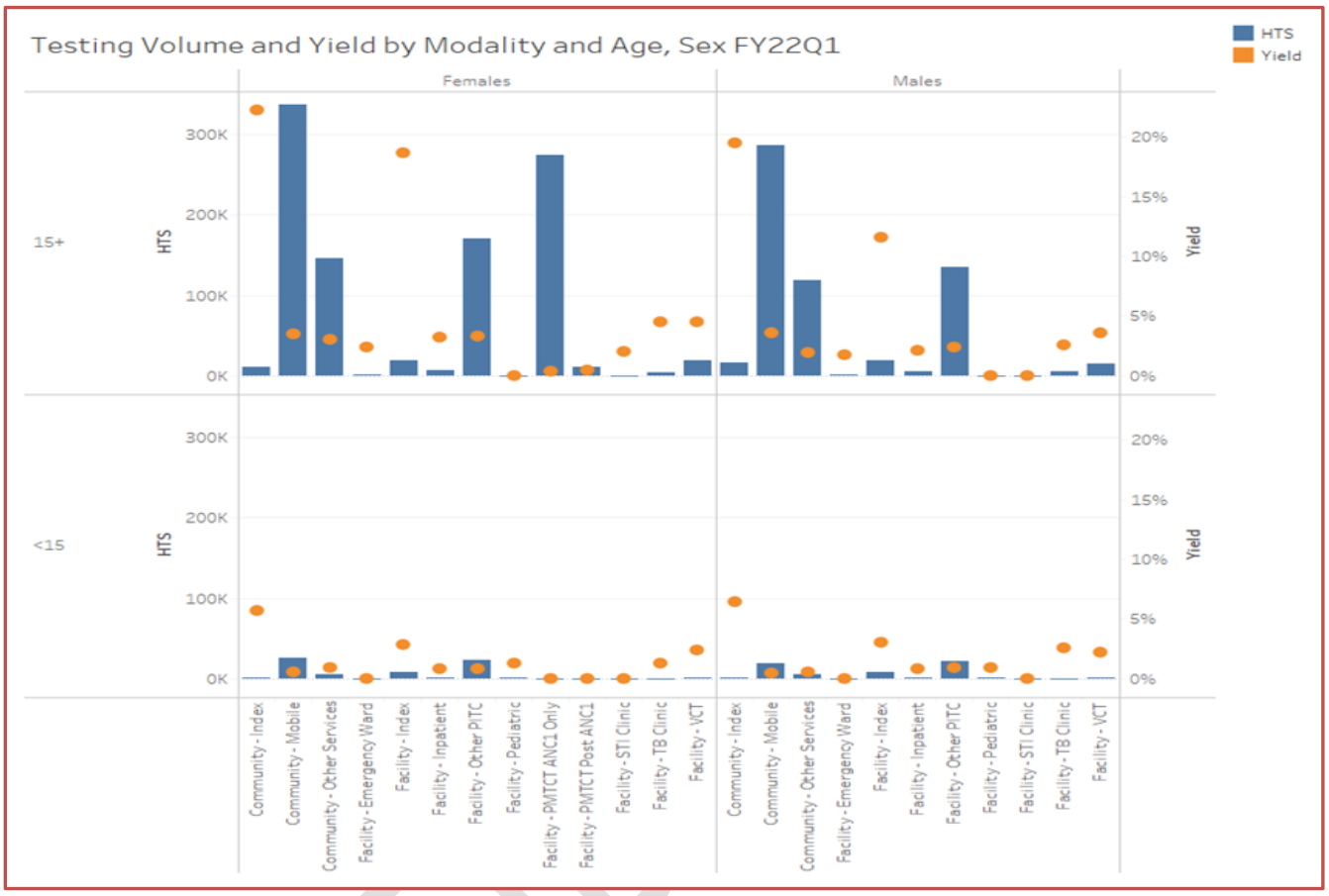
4.1 Finding people with undiagnosed HIV and getting them started on treatment

4.1.1 Key Program Gaps (SNUs and Subpopulations)

The COP22 HIV testing strategies will continue to support the original goal of "Going Green", with all states having an ART coverage of 81% or higher, and with ART coverage among pediatric and adolescent populations increasing from 37% to 54% by FY22 Q4 and from 55% to 86% by FY22 Q4, respectively. Based on the specific HIV treatment coverage gaps for each age band and sub-population across the SNUs, PEPFAR Nigeria will utilize appropriate, targeted, and efficient case finding strategies to close these existing gaps.

The PEPFAR program will continue to work with partners to utilize data for prompt program decision making in assessing and analyzing SNUs that are still lagging in coverage of their HTS gap. PEPFAR will also infuse the use of recency testing results to direct programming to locations where positives will most likely be found, ensuring efficient use of HTS resources by observing and tracking recent infection transmission dynamics to improve targeted case finding efforts across SNUs.

Figure 4.1.1 Testing Volume and Yield by Modality and Age/Sex, FY22 Q1



4.1.2 Key Case Finding Strategies

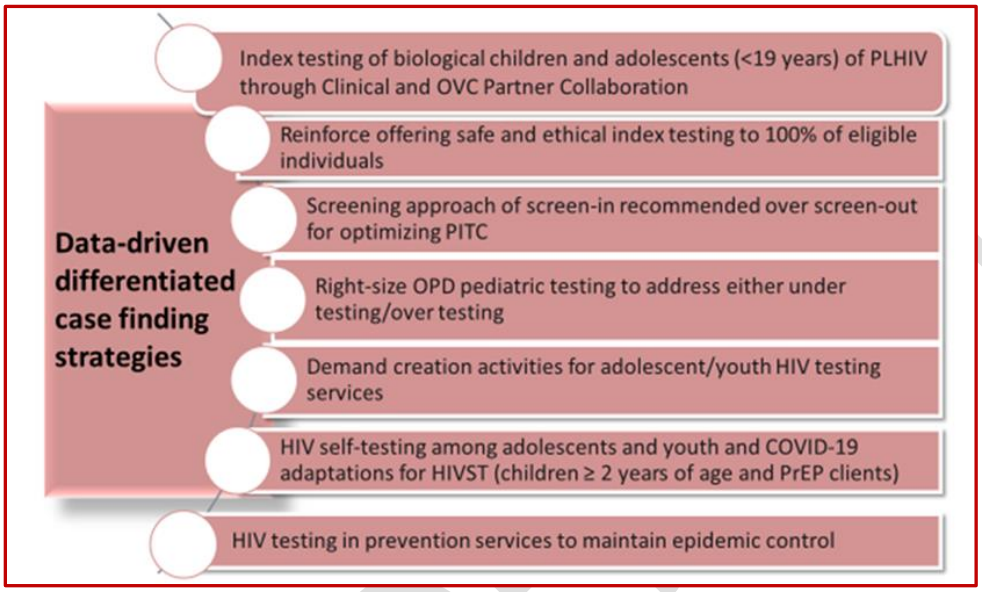
The key case finding strategies in COP22 include the following:

1. HIV testing in prevention services to maintain epidemic control.
2. Index testing of all biological children and adolescents (<19 years) of PLHIV through collaboration with both clinical and OVC partners at facility and communities.
3. Demand creation activities for adolescent/youth HIV testing services at facility and community settings.
4. HIV self-testing amongst adolescents and youth (including children ≥ 2 years of age).

Other contributory strategies include reinforcing safe and ethical index testing to 100% of eligible individuals, using a 'screening-in' approach rather than a 'screening-out for optimizing provider-initiated testing and counseling (PITC), and ensuring right-size outpatient pediatric testing to address both under-testing and over-testing as depicted in fig 4.1.2 below. A key strategy of our case finding efforts ensures that safe and ethical index testing is offered to all eligible people living with HIV (universal offer) in line with PEPFAR guidance on safe and ethical standards in the provision of HIV testing. The scale-up of index testing will include provision of informed consent, ensuring a high level of confidentiality. The team will scale-up index testing of biological children and adolescents (<19 years) of PLHIV through collaboration between clinical and OVC partners to

guarantee that all biological children of HIV infected mothers have a documented HIV test result. Index testing will also be offered to HIV positive sexually active adolescents while using caregiver-assisted HIV rapid self-testing (RST) for screening to increase the uptake of index testing of child contacts and youth.

Fig 4.1.2 Key HIV case-finding strategies



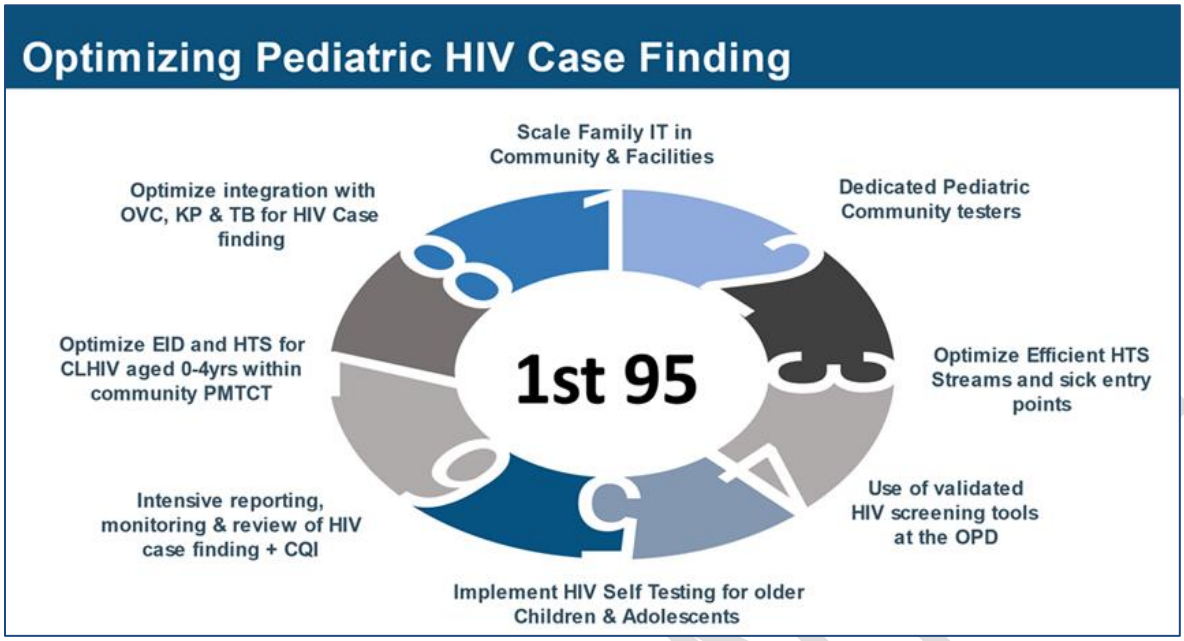
To monitor compliance with safety and ethics, all the scale up sites will have folders for Intimate Partner Violence (IPV) Risk Assessment and Response (that will contain IPV Assessment Questions and LIVES Materials) and Adverse Events (AE) Monitoring and Reporting (containing AE Investigation Form, AE Reporting Form, Customer Complaint Form, Index Testing Sample Register, and Patient Rights Poster). Any form of violation will be promptly reported and escalated to the next level.

4.1.3 Strategies to Address Pediatric Gap

Most of the COP22 testing strategies will focus mainly on addressing gaps amongst peds and adolescents in collaboration with OVC partners to support intensified pediatrics case finding.

To address the huge gaps in pediatric case finding, the program will scale case finding strategies, such as family index testing, in both facilities and communities, ensuring that all pediatric children of index clients are tested. Use of dedicated pediatric community testers will also be scaled to strengthen case finding efforts for this age group.

Fig 4.1.3 Pediatric case finding strategies



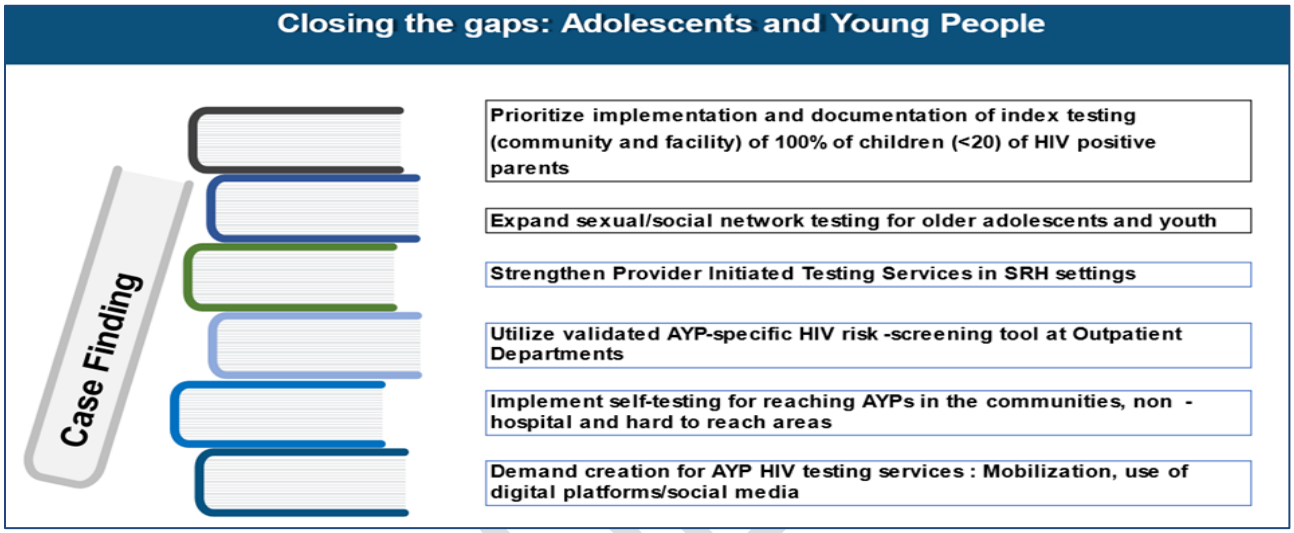
The collaboration between the OVC partners, KP, TB and PMTCT will be strengthened to improve coverage and optimize service integration and delivery. Within the community, PMTCT strategies will be improved to ensure optimal EID testing and HTS for exposed children 0-4 years. Data driven decisions on pediatric intensified case finding (PICF) will be made based on review of data analysis toward achievement of set targets.

4.1.4 Closing the Gap Among Adolescent and Young People (AYP)

With the rising cases of new infection amongst adolescents and young people in addition to gaps in coverage seen from program data across most SNUs, innovative interventions will be scaled to reach this group and effort intensified to ensure that all case finding strategies for this sub-population are optimized. Strong demand creation activities, targeting mostly adolescent and young people, will be intensified, and scaled using known forms of adolescent-friendly strategies to reach the majority of the AYP. Intentional effort will be put to prioritize index testing for all children of PLHIV ≤19 years of age both within the facilities and communities. Sexual and social network testing for older adolescents, youth and key populations will be scaled to ensure wider reach for this sub-population across all SNUs. Facilities with SRH and family planning services will be supported to ensure provision of PITC at those service delivery points. This will include the use of adolescent-specific RSTs for optimal service delivery. The HIV self-test kits will continue to be used to reach adolescents and young people in hard-to-reach areas and other hard to reach areas, linking reactive clients to health facilities for definitive diagnosis and treatment services. Adolescent-friendly services are offered in a manner and environment that is safe and accessible to adolescents and youth, and follows the Nigeria National Standards & Minimum Service Package for Adolescent & Youth Friendly Health Services. These health services are accessible, acceptable, equitable, and appropriate to adolescents and youths and address barriers that prevent adolescents from accessing healthcare in facilities and communities. Barriers include concerns about

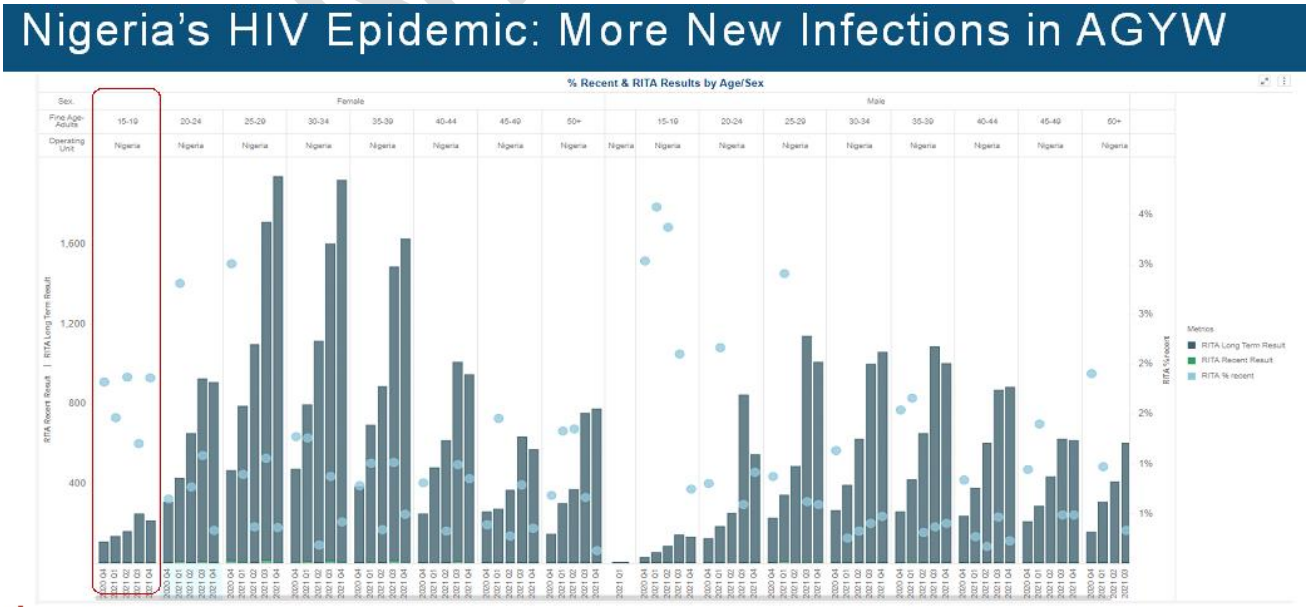
confidentiality, low numbers of youth-friendly clinics, and a larger focus on adult health systems. Adolescent-friendly services offer tailored health care, improved health outcomes, and better meet the unique needs of youth. Some of the adolescent-friendly approaches include a good location, comfortable surroundings, convenient and flexible clinic hours, and weekend clinics to meet the off-hour appointment schedule for adolescents. Clinics also offer adolescent and youth centers with games to use during clinic visits as they wait for consultation.

Fig 4.1.4 Case finding strategies for adolescents and young people



Targeted demand creation activities for adolescent/youth HIV testing services at both facility and community settings will be intentionally scaled up to bridge gaps in these sub-populations. These populations have sub-optimal coverage, as indicated by program data. Furthermore, recency test results have also shown them to have a high incidence of new infections (RITA).

Fig 4.1.5 Nigeria RITA results by age/sex



The use of GIS and heat maps to indicate the locations of recent infection across SNUs will continue to aid targeting of demand creation and case finding. This will ensure the timely institution of key prevention interventions, including safe and ethical index testing by the recency testing rapid response team. Same day ART initiation for all those newly identified will be strengthened across all SNUs to ensure at least 95% linkage.

4.2. Ensuring viral suppression and ART continuity

The country program has demonstrated impressive steady improvements in viral load suppression from 90% suppression rates in FY20 Q-4 to 96% by the end of FY22 Q-1, as shown in figure 4.2.3. Similar impressive performance has been demonstrated in reducing the viral load testing gap from FY20 Q-4 to FY 21 Q-3, achieving 98% viral load coverage in FY21 Q-3. The improvements in viral load coverage and suppression have been through the deployment of strategic approaches to increase access to viral load and address barriers to adherence However, in the last two quarters gap in testing coverage has maintained a steady increase such that at the end of FY22 Q1, the viral load testing coverage and viral suppression rates were 91% and 96% respectively for PEPFAR Nigeria.

The country program has demonstrated resilience and sustained improvement in viral load coverage and viral suppression rates across all subpopulations, while grappling with the challenges of lab equipment breakdown, commodities supply disruptions and consequent prolonged turnaround time

In COP22, we will enhance strategies which have facilitated sustained increase in viral load service delivery and uptake. Deployment of case managers and client navigators incentivized off-clinic days, community sample collection approaches, use of plasma separation card and dried blood spots for sample collection amongst other services will be scaled up. Suboptimal viral load coverage, especially among pregnant and breastfeeding women will be prioritized, reviewed and remediated. The LIMS-EMR interface will be scaled to all SNUs and supported laboratories to ease viral load processes and reporting.

As we continue to scale up MMD across all SNUs and subpopulations, viral load testing appointments will be aligned with clinic appointments. Community viral load sample collection options will be scaled up to sustain a seamless optimization of MMD and viral load testing coverage.

The major challenges of lab equipment breakdown and commodity supply disruptions will take front-burner. Innovative approaches will be adopted to sustain equipment functionality and supply chain systems. PEPFAR Nigeria will transit to phased implementation of full vendor managed inventory as a panacea to these challenges.

In COP22, the cycle of interruptions and return to ART (CIRA) will be minimized across all SNUs in order to achieve durable suppression. ARV regimen and dose optimization will be tracked and ensured across all groups. Enhanced adherence interventions will be offered in a client-centric approach to unsuppressed and low-level viremia patients. Barriers to adherence will be reviewed

routinely through patient satisfaction surveys and other CQI processes, and change ideas promptly implemented and monitored for impact.

Figure 4.2.1 Number and Percent Contribution of Clients Receiving MMD by Age/Sex, Q1 FY22

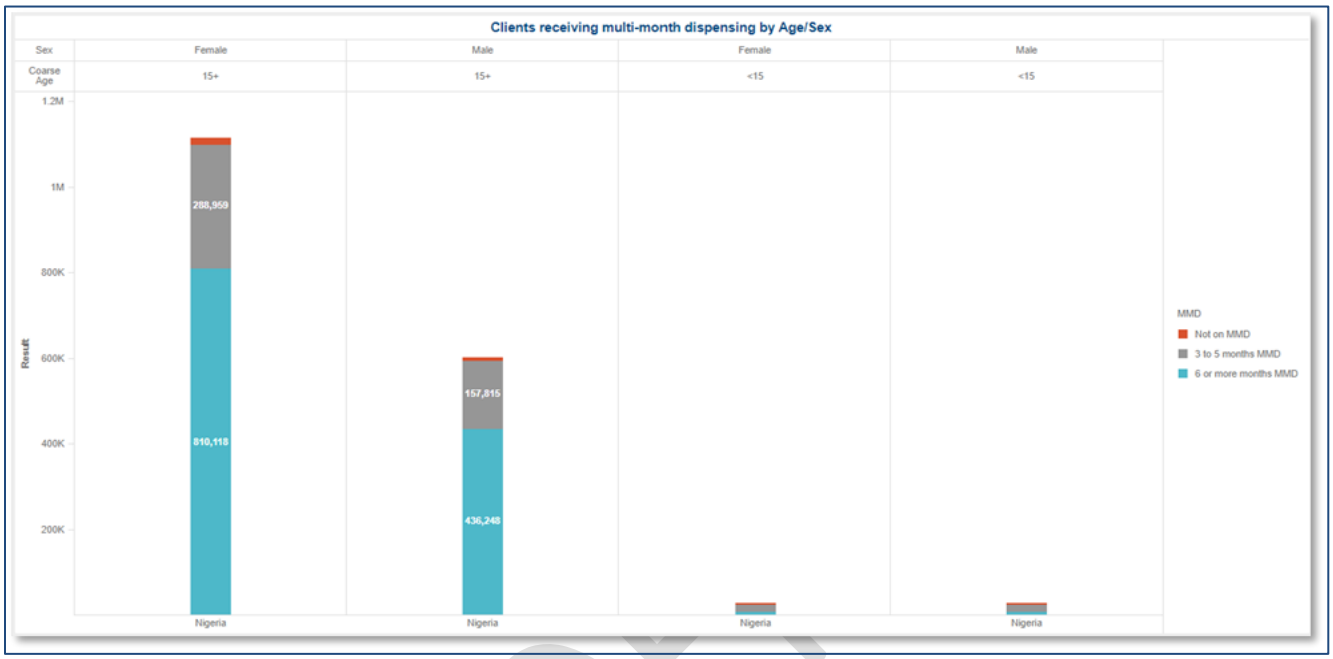


Figure 4.2.2 Viral Load Outcomes, FY21

4.3. Prevention, specifically detailing programs for priority programming:

a. HIV Testing Services (HTS)

The Nigeria HTS program in COP22 will ensure HTS is optimized as a channel for prevention services within PrEP, PMTCT and OVC services. The PrEP program will continue to test clients every three months for HIV, with HTS sessions tailored to address risk reduction and HIV prevention. The PrEP program will also be leveraged to reach both the general population and KP sexual and social networks. In preventing transmission among sero-different couples, annual HTS (or more often if warranted by risk assessment) will be offered as part of a package of services offered to HIV-negative partners in sero-different couples.

For OVCs, the program would continue routine assessments for HIV testing, and those eligible would either be provided a supportive referral or tested within the community. HTS will be provided within the PMTCT and ANC settings as a minimum standard to increase testing coverage among ANC clients within facility and community settings. In line with WHO guidelines, maternal retesting in early pregnancy will be provided at the first ANC visit and/or the third trimester ANC visit/late pregnancy (if ANC care is delayed). Similarly, PEPFAR is including the option of adding an additional retest at either 14 weeks, 6 months, or 9 months postpartum in SNUs with high HIV prevalence and among KPs or high-risk women.

b. Orphans and Vulnerable Children Program

To determine the targets for OVC comprehensive and OVC preventive, the team considered current OVC program data, pediatric treatment coverage, and gaps in the pediatric burden for Nigeria. Other considerations included states with no OVC coverage, poor viral suppression for pediatrics, or poor PMTCT coverage for HIV exposed infants and adolescent mothers. The OVC preventive target was set at 35% of the OU target, based on historical achievements and the need to expand services to meet a demand for sexual violence prevention services for adolescents.

After reviewing implementing partner data for the priority enrollment streams (i.e., children and adolescents living with HIV, who make up about 9% of the OVC achievements,) and FY23 pediatric treatment targets, the program set a target of 12% of OVC_SERV for children and adolescents to reach with services. This target translates to a 95% coverage for pediatric patients on treatment to be enrolled in for OVC services. Other priority enrollment streams followed a similar targeting methodology. In line with the COP 21 pivots, PEPFAR continues to prioritize a greater alignment with the pediatric care and treatment program, which hosts a critical mass of the OVC priority sub population of CLHIV in COP 22. Training on OVC and clinical package of care will also be conducted for clinical and OVC community-based staff respectively to enhance their capacity in the management of those enrolled CLHIV in the HIV continuum. High-risk AGYW enrolled in the OVC comprehensive program in high burden SNUs will receive a mix of evidence-based layered interventions to reduce their risk of HIV infection.

Strategic enrollment to reach >95% of CLHIV & AYP (<19 years) that form a critical mass of the OVC comprehensive population will continue across the PEPFAR support treatment sites. The OVC desk officers, stationed in all high-volume ART comprehensive sites, will facilitate enrollment by working with the pediatrics focal persons to ensure that the caregivers buy into the program by providing their consent for home visits and other differentiated service delivery models. Tracking clinical monitoring indicators, such as CLHIV retention in care and viral load monitoring, will also happen in these activated de-centralized settings by the OVC community-based teams with support from the facility-based clinical teams.

c. Primary Prevention of HIV and Sexual Violence Among 9–14-Year-olds

In COP22, Nigeria will continue to implement evidence-based interventions for primary prevention of sexual violence and HIV for children and adolescents aged 9-14 living in high burden SNUs: the Families Matter Program (FMP), IMsafer (IMPOWER) and PLH (Sinuvoyu). FMP targets the adolescents' parents/ guardians to enhance protective parenting practices and promote parent-child communication for sexual risk reduction. IMsafer, which is an adaptation of the IMPOWER curriculum, focuses on sexual violence prevention (working on integrating HIV prevention content) plus recovery. The IMsafer program, which preferentially targets girls, but also focuses on boys, tailors its activities by gender. For girls, the focus is awareness and verbal/physical skills to prevent sexual assault and other GBV; for boys, the focus is on reshaping harmful beliefs around gender and sexuality and promoting intervention skills. The training is delivered by trained facilitators (women, ideally in their 20s) in school or community settings and includes 12 hours of content for each of the girls' and boys' programs. Parenting for Lifelong Health (Sinuvoyu) focuses on positive parenting, improved parent-child relationships and communication, and decreased use of violence/harsh disciplining in the home as well as in communities. This teen curriculum is delivered to both the 9-14 yo's and their caregivers. It is also a facilitator-led, group-based curriculum and contains 14 modules with a recently developed HIV-enhanced version.

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

Fig 4.3.1 shows the PEPFAR OU 2021 PMTCT clinical cascade. While the maternal cascade shows no significant gaps, the HEI_POS linkage of 86% is sub-optimal. PEPFAR will be scaling up POC EID and introducing HEI birth testing to reduce TAT and ensure early case identification and ART initiation. Mother-to-Mother support groups will be engaged as EID linkage managers. Beyond formal health facilities, PMTCT services, including EID, will be taken into the community and all HIV positive infants shall be linked to pediatric ART.

Figure 4.3.1.a PMTCT Cascade FY21

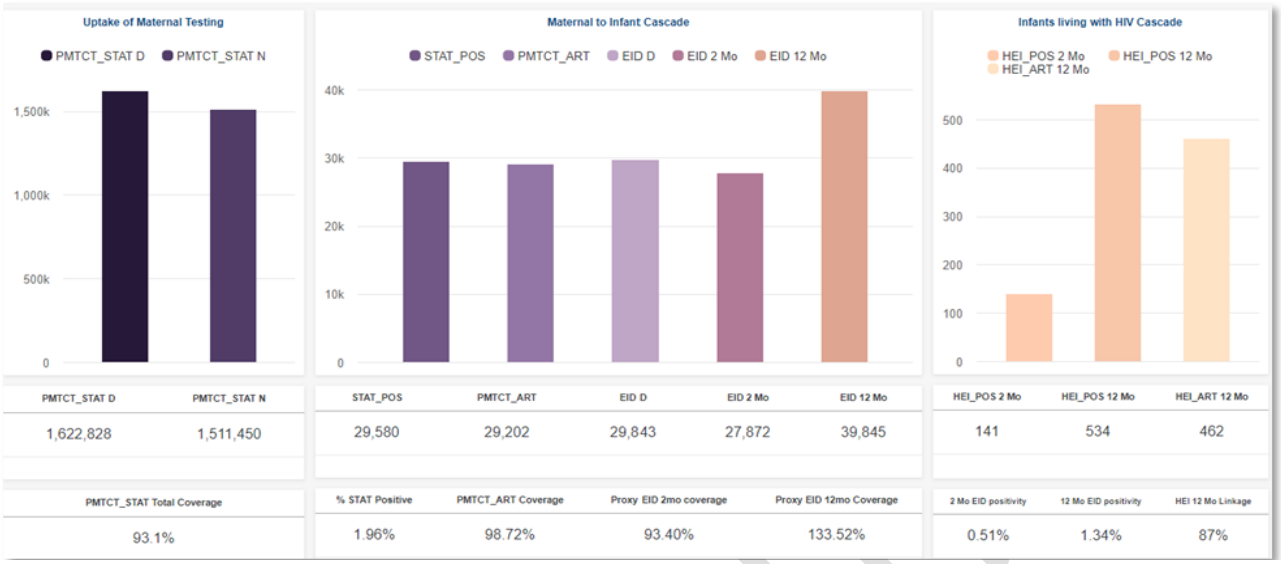


Figure 4.3.1.b PMTCT Cascade FY22 Q1

e. Key Populations

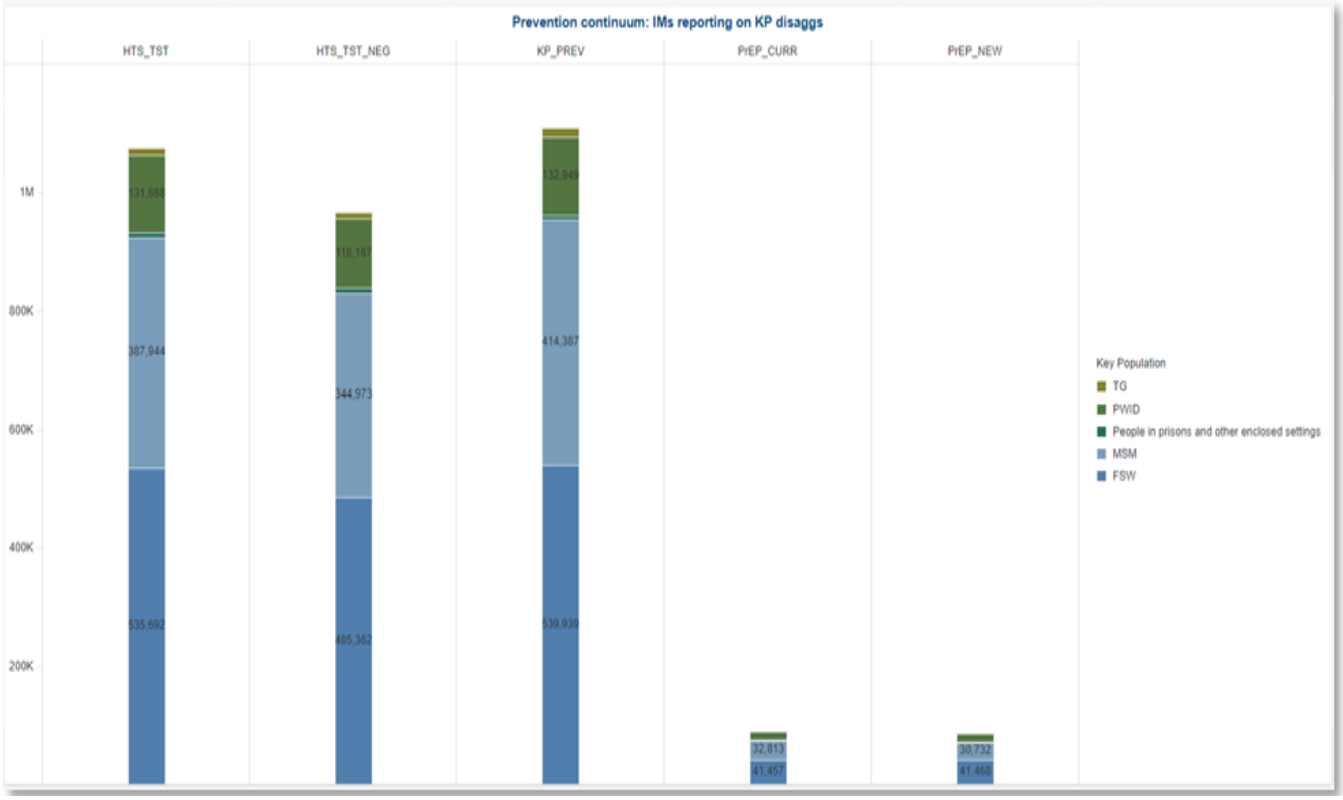
The package of services for KPs and their partners are provided through different models. These include One Stop Shops (OSS), Community ART teams (CARTs) and KP-friendly health facilities. The use of peer navigators, influencers and leaders is critical for demand creation, knowledge sharing, service provision, active referrals and linkages, and monitoring and evaluation (inclusive of community led monitoring activities, social medial virtual platforms, and collaborations with private sector). These services are provided by training healthcare workers, peers, and partnerships with KP led community-based organizations.

A critical component for ensuring quality and responsiveness of our services will be to use the KP competency tool. This is to ensure that KP partners and community collaborators have the capacities, resources, skills, and structures to provide these services as may be required.

Figure 4.3.1.b below indicates the package of services provided for the different KP groups

KP Type	MSM	Sex Workers	TG	PWID	Custodial and other closed settings
Interventions	• HTS (VCT, Targeted community, SNS, Self Testing, Index testing) • HIV Prevention programing (Education, condoms, lubricants, PrEP) • STI management • Adult/Pediatric ART • VL services • Economic strengthening • Legal/Paralegal Support	• HTS (VCT, Targeted community, SNS, Self Testing, Index testing) • HIV Prevention programing (Education, condoms, lubricants, PrEP) • STI management • Adult/Pediatric ART • VL services • Economic strengthening • Legal/Paralegal Support • PMTCT • Cervical Cancer Screening	• HTS (VCT, Targeted community, SNS, Self Testing, Index testing) • HIV Prevention programing (Education, condoms, lubricants, PrEP) • STI management • Adult/Pediatric ART • VL services • Economic strengthening • Legal/Paralegal Support • Cervical Cancer Screening(transmen as may be required)	• HTS (VCT, Targeted community, SNS, Self Testing, Index testing) • HIV Prevention programing (Education, condoms, lubricants, PrEP) • STI management • Adult/Pediatric ART • VL services • Economic strengthening • Legal/Paralegal Support • Gap filling by GF –NSP, OST and Methadone services in four(4)PEPFAR supported states • PMTCT- Female PWIDs, Cervical Cancer Screening	• HTS (VCT, Targeted community, SNS, Self Testing, Index testing) • HIV Prevention programing (Education, PrEP) • STI management • Adult/Pediatric ART • VL services • PMTCT , EID and Pediatric services- Female inmates , • Cervical Cancer Screening

Figure 4.3.1.b Prevention Continuum by Key Population Group FY21



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

A. Nigeria-Specific Directives

A. ***HIV Clinical Services***

- Ensure that safe and ethical index testing is offered to all eligible people living with HIV (universal offer), including those who are newly diagnosed and those with unsuppressed viral load. Report quarterly on this standard. De-emphasize use of risk stratification tool in prioritized PITC settings to increase absolute case finding.
- Treatment coverage for some age bands and PSNUs is over 100%. Re-evaluate estimates for people living with HIV and the distribution by age and sex to ensure best possible population estimates.
- Ensure optimal utilization of NDR and biometric data. Site staff routinely access NDR to investigate new clients to determine their treatment status at time of presentation: Treatment Naive counted under TX_NEW, non-naive counted as returned or transferred, and tracking transfers to ensure completed and trace patients with interruptions in treatment (IIT) across facilities; routine use of biometrics to de-duplicate the count of clients reported on treatment (TX_CURR).
- Investigate sites (> 500 clients) that are reporting zero IIT or less than 0.2% IIT for completeness of reporting. Use findings from investigation of large sites to work with partners to correct TX_ML_IIT reporting errors in all sites to ensure most accurate information on IIT is available for program planning and monitoring.
- To address supply chain constraints on viral load coverage, consider vendor-managed inventory approaches. Fully utilize LIMS for visibility into laboratory related supply chain and optimize EHR-LIMS integration. Ensure all data systems and solutions meet interagency information needs and establish clear expectations around data visibility and use for supply chain management.
- Despite the global gains in VLC/VLS for the 15+, there are gaps in testing across age bands with varying numbers of unsuppressed PLHIV. Along with optimizing lab systems, consider a strategy that will leverage clinical, community and case-based management approaches to expand VL testing equitably across age bands.
- Address PMTCT data challenge and work with NMoH in context of National Alignment to advance PMTCT design and implementation. Strengthen integration of MCH and HIV services and support provision of RTKs for MTCT.

B. ***HIV Prevention Services***

- In COP 2022, PrEP should continue to be scaled up with a focus on ensuring policy and programmatic access to PrEP for higher incidence populations. Populations prioritized for PrEP should be tailored to the OU's epidemic context with a focus on Key Populations (including sex workers, men who have sex with men, transgender people, people in prisons and other closed settings, people who inject drugs), adolescent girls and young women including pregnant and breastfeeding AGYW, and other identified higher-incidence populations. Strengthen the capacity of and fund KP-led organizations to serve as

promoters of PrEP. Ensure demand creation, entry points, accessibility, and barriers to PrEP addressed.

- In order to plan for the sustainability of PrEP programming, PEPFAR Nigeria should develop a plan for differentiated service delivery models, including private sector engagement and solutions, exploring options such as pharmacy delivery models.
- PWIDs continue to be reached, tested, and placed on ART. Implementation of a harm reduction strategy for PWID based on medically assisted therapy (MAT) is needed to ensure they are retained in care in achieve viral suppression. Also, MAT is important as prevention strategy for PWID who are HIV-negative.
- Continue improved wraparound services to enroll children and adolescents living with HIV and improve HIV-Exposed Infant enrollment. Strengthen PSNU-level OVC program alignment with TX_CURR<15 and <20y0 volume (proxy coverage of 75%) as well as with HIV+ pregnant women accessing ANC and other sites. Work closely with PMTCT to align OVC_SERV <1y/o targets with PSNU-level PMTCT_ART results, prioritizing high coverage of PMTCT_ART<20y/o, to accelerate HEI/MBP enrollment in the OVC program. Currently, <1 enrollment for OVC_SERV reached only 24% achievement.
- In the Nigeria PMTCT program, 2-mo and 12-mo HEI linkage remains low (73% and 79% respectively in FY21 Q4). In COP22, Nigeria could optimize client tracking of positive infants and implement case management support. Another effective strategy to consider supporting HEI linkage is point of care testing (POCT) for early infant diagnosis (EID), which has been shown to significantly reduce turnaround times and increase rates of ART initiation.
- Close gaps in PEPFAR-supported countries with highest Pediatric/PMTCT needs. Despite our successes, significant challenges remain to eliminate vertical transmission of HIV and close the treatment gap for children and adolescents. Seven PEPFAR-supported countries have the largest gaps per UNAIDS 2020 estimates triangulated with PEPFAR data/footprint: Nigeria, Mozambique, Zambia, South Africa, Tanzania, Uganda, and DRC. COP 22 submissions for these focus countries must clearly describe existing gaps (including those related to service delivery and socioeconomic needs) and how their respective OU will program to achieve specific goals/targets that will address these gaps. Budgetary specificity for each of these beneficiary groups should be provided in the FAST. Pediatric and PMTCT human resources should be allocated, as needed, to reach goals/targets. Throughout the year these countries will be expected to have dedicated, regular, review meetings to monitor and evaluate progress and take corrective action, if necessary, through the POART process. Reviews should also include detailed expenditure analysis to ensure appropriate resources are directed to closing PMTCT/Pediatric gaps.
- Ensure gender-based violence services include services for sexual violence and post-exposure prophylaxis, as well as linkage to PrEP.

B. Other Government Policy, Systems, or Programming Changes Needed

Strengthen GoN capacity to oversee the public health supply chain as stewards for commodity availability and security through assistance to NAFDAC and Logistics Management Coordination Units (LMCU), including advocacy for National Traceability Strategy implementation, support for data-driven supply chain decision-making, and accelerated utilization of private sector capabilities. Strengthen the Government of Nigeria's capacity to address structural barriers for KP. Continue to segment supply chains to meet unique patient/population needs by developing and implementing coordinated strategies to increase commodity and laboratory supply chain responsiveness and resilience, including expansion of differentiated service delivery modalities such as MMD.

C. Community-Led Monitoring

In addition to prescribed and routine engagement during PEPFAR's annual business cycle, including around COP/ROP planning and quarterly POART processes, all PEPFAR programs are required to develop, support, and fund community-led monitoring (CLM) in close collaboration with independent, local civil society organizations and host country governments. Community-led monitoring in COP22 should build on prior activities in COP21 and be designed to help PEPFAR programs and health institutions pinpoint persistent problems, challenges, barriers, and enablers to effective client outcomes at the site level. In addition to being data-driven and action-oriented, CLM should continue to ensure indicators are defined by communities and health service users, and data should be additive and not a duplicate collection of routine data already available to PEPFAR through MER or SIMS. New in COP22, PEPFAR-supported community-led monitoring programs must include an explicit focus on key populations. CLM should be utilized to advance equity and to support improvement in programs, especially for populations who have not yet fully experienced the benefits of HIV epidemic control. For example, OUs with pediatric care and treatment programs should consider utilizing CLM to track and ensure accountability for child, adolescent, and family-centered care.

4.5. Additional Program Priorities

The Government of Nigeria has created an enabling policy environment that encourages access to HIV prevention, care, and Treatment. The Nigerian HIV policy and guidelines were updated to reflect current advances in HIV management, and PEPFAR Nigeria is constantly engaging with government and key stakeholders to update the national policy documents and standard operating procedures in line with international best practices.

The Nigerian HIV treatment program has achieved major successes in the implementation of the minimum program requirements. For example, "test and start" with same-day ART initiation is fully implemented across all PEPFAR-supported sites. Additionally, over 95% newly identified PLHIV are

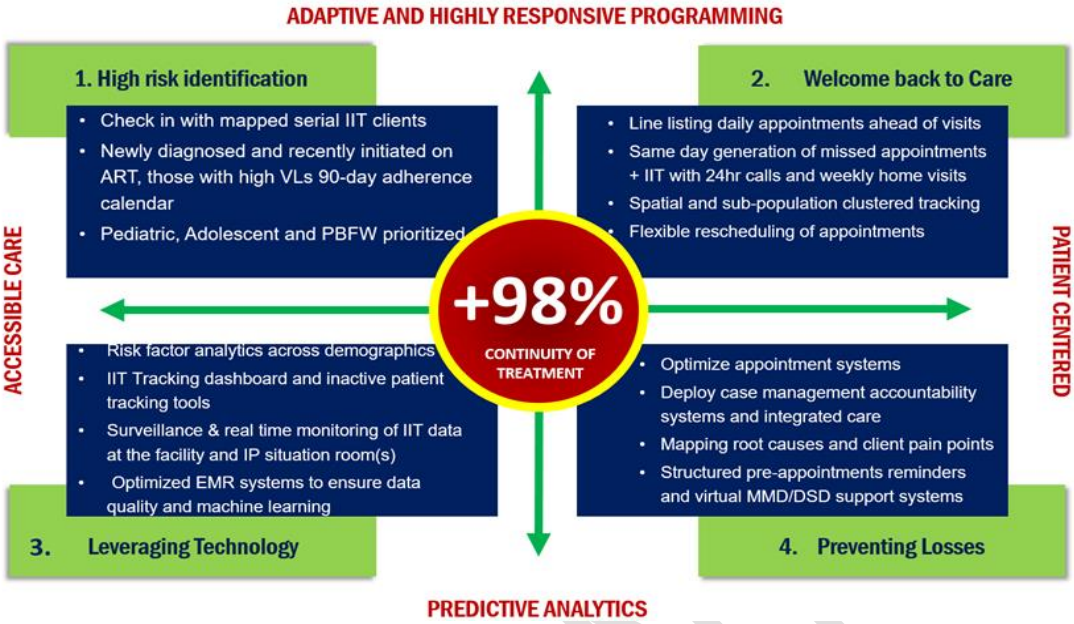
linked to treatment and over 80% of all patients currently on ART are receiving a dolutegravir (DTG)-based regimen. In addition, over 90% of PLHIV weighing >30kg, including adolescents and women of children bearing age, are placed on a TLD regimen. All PEPFAR-supported sites are implementing various forms of differentiated service delivery models, including fast-tracking, peer managed drug delivery (Operation Triple Zero and other support group clubs, etc.), a decentralized hub-and-spoke service delivery model, six month drug dispensing, community-based models that include community pharmacy ART refill, peer-led community pharmacy refills, home drug delivery, and community ART services for the KPs that are all tailored to the clients' needs. The Nigerian HIV treatment program implements a six-month once in lifetime course of tuberculosis preventative treatment (TPT), and a repeat course of TPT is no longer required. All eligible PLHIV, including adults and adolescents, receive TPT and cotrimoxazole as part of the comprehensive treatment package. The TPT completion rate at the end of FY 21 Q4 stood at 95% for adults and 85% for children, respectively.

The country is making significant progress toward eliminating all user fees, which traditionally serve as a barrier to accessing HIV prevention, care, and treatment services. PEPFAR Nigeria has consolidated its engagements with civil society, GoN, 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, and the private sector-led HIV Trust Fund for Nigeria, which was launched in February 2022 by the President of Nigeria.

Appendix D summarizes PEPFAR Nigeria's minimum program requirements (MPRs) status as of FY22 Q1. The figure shows that PEPFAR Nigeria has attained almost all MPRs. In COP22, PEPFAR Nigeria will sustain the achievements in the MPRs already attained and focus on expanding self-testing, scaling up PrEP for the high-risk general/key populations, and completing the use of unique identifiers at all supported sites. In addition, PEPFAR Nigeria will commence the implementation of new MPRs, including advancing equity, reducing stigma and discrimination, and improving treatment outcomes among key populations, AGYW, and other vulnerable populations. Furthermore, the country will institutionalize tracking and reporting of all other MPRs listed in the PLL.

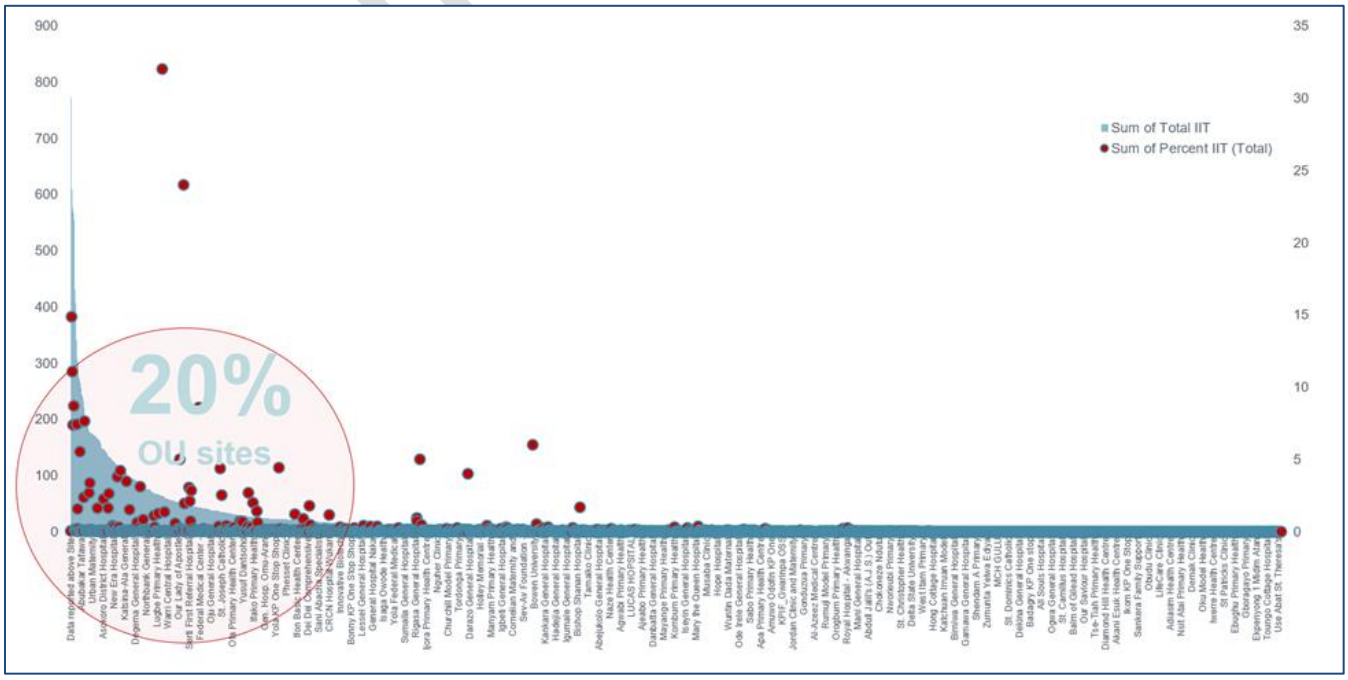
PEPFAR Nigeria will continue to implement adaptive continuity of treatment strategies in all supported sites through high-risk client identification, strengthening back to care programs, optimizing appointment systems to prevent losses, and the use of technology and machine learning to track, predict and prevent client losses. Figure 4.5.1 summarizes the approaches.

Figure 4.5.1: Adaptive Continuity of Treatment Strategies



Using the 80/20 rule, PEPFAR Nigeria is prioritizing and implementing continuous quality improvement (CQI) projects to address IIT in the 20% of sites that contribute to 80% of IIT across the OU. The CQI goal is to maintain IIT rates at site level to less than 2%. Sites are empowered to define and characterize the nature and magnitude of the IIT gap, deploy and analyze patient satisfaction surveys, and use adaptive person-centered interventions to reduce IIT. Figure 4.5.2 shows the granular site level IIT prioritization, and the sites targeted for CQI.

Figure 4.5.2: Granular site level IIT prioritization



4.5.1 Program Performance in COP20 Q1-Q4 Influences Program Direction in COP22

Based on the assessment of program performance at the end of COP20 and COP21 performance to date, the following key programmatic issues/direction will be addressed in COP22:

- Increased focus on closing the treatment gaps in remaining states with ART Coverage <81% with aim of achieving at least 81% ART coverage at all SNUs in COP 22; including prioritizing key populations and sub-populations such as pediatrics & adolescents using strategies that include rollout of pDTG & leveraging OVC to improve VLS & pediatric dashboard for monitoring performance
- Address PMTCT data challenge and ensure pregnant mothers in facilities and communities are linked to treatment and virally suppressed
- Maximize effective interventions to reduce treatment interruptions for clients—particularly people-centered and community-based strategies that have been successful in surge states and strive to re-engage clients who disengaged in previous quarters
- Implement a harm reduction strategy for PWIDs, based on medically assisted therapy needed to ensure they are retained in care to achieve viral suppression. Additionally, children of PWIDs will be linked to OVC programs as part of a comprehensive program strategy.
- Sustain the low IIT rate at the OU level, striving for a maximum of 2%
- Optimize Viral load diagnostic network, including equipment and reagent supply chain management at national and sub-national; as well as client level systems (EMR-LIMS) for improved viral load coverage, turn-around-time, for timely decision-making
- Support implementation of National Domestic Resource Mobilization & Sustainability Strategy, toward the goal of increased GON financial contribution to the HIV response

4.5.2 Implementing Partners Manage with Goal to Ensure Alignment and Efficiency with PEPFAR Program Strategy

PEPFAR Nigeria will continue to consolidate on the gains of its partner management approach. The lessons learned using the Enhanced Site Management (ESM) approach during the ART surge in Akwa-Ibom and Rivers will continue to be optimized in other SNUs in COP22.

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

Program efficiency will continue to be improved by increasing testing yield, improving linkage, and reducing IIT. Testing small changes in the effective strategies that result in these improvements is an important component of CQI process implemented at ESM sites. In COP22, PEPFAR Nigeria will

continue to implement ESM approach across SNUs with less than 81% treatment coverage, with poor pediatric ART coverage, and high-volume sites in SNUs that have achieved treatment saturation.

Furthermore, ESM involves a more intensive routine bi-weekly monitoring of site performance against targets and prompt feedback on key MER indicators, bi-weekly leadership/partner meetings, regular communication with partner staff and weekly video conferencing to share programmatic progress and lessons learned. Due to security concerns and travel restrictions in some SNUs, clinical mentors and a third party-led monitoring will serve as proxies for PEPFAR staff. Clinical mentors and third party led monitoring partners will spread site-level best practices to other sites and support CQI, including identifying the top challenges per site, developing an action plan to solve challenges, and in-depth analysis and reporting of site-level data.

4.6. Commodities

The Nigerian HIV/AIDS program implements a pooled procurement system for drugs and commodities used in the country, with investments from PEPFAR, Global Fund and GoN. PEPFAR does not envisage commodity shortages in FY21, however, there may be stock challenges for cotrimoxazole 960mg required in the first quarter of FY23 to support CPT in adults with an estimated funding gap of $40,913. COP21 funds largely cover commodity requirements through FY22 Q1 for ARVs and laboratory commodities, which gives sufficient time for procurement planning with COP22 funds. The country will continue to manage the risk of manufacturer-related short supplies, particularly for EID and VL commodities, by monitoring trends and ensuring adequate buffer or contingency plans are made on alternative laboratory testing platforms. PEPFAR's commodity investment will ensure commodity availability for the PEPFAR program in Nigeria, hence there will be limited concern for stock-outs during the FY22.

Nigeria has transitioned to an all-inclusive pricing model for two out of three VL and EID equipment platforms and is in the process of completing same for the remaining platform. A Deliver-Duty-Paid (DDP) arrangement has been achieved for Roche and Hologic platforms while the country currently implements Free Carriage (FCA) Incoterm for the Abbott platform. Discussion is ongoing with SGAC to transition the Abbott platform to DDP as well as to explore opportunities to scale up in-country solutions via vendor manage inventory, which will be implemented in a phased approach commencing in FY22. This is targeted at shortening the procurement lead time and minimizing warehousing and in-country logistics costs particularly for laboratory commodities.

Nigeria currently has one national supply plan for condom management. This facilitates coordination of procurement across multiple donors to ensure efficient scheduling of procurement based on available funds. The country condom supply plan incorporates a need for reduced in-country warehousing with a consideration for a semi-annual commodity resupply to service delivery points. The condom supply plan has also provided visibility into condom funding gaps and opportunities for advocacy and resource mobilization.

COVID-19 has continued to have changing and unpredictable effects on the commodity supply chain. These could affect activities at the manufacturing site, availability of API and logistics/freight related delays. The following processes are in place to mitigate the effects of COVID-19-derived disruptions on the timely availability of procured commodities:

- Advance procurement of regularly used commodities and storage at RDC in anticipation of future procurement order, and a focus on commodities with long shelf-life.
- A one-year supply plan, shared with vendor in advance to guide timely planning for requisite raw materials.
- Early procurement order processing to provide sufficient lead time to cushion any COVID-19 related delays.
- Efforts to improve in-country solutions for vendor-managed inventory, including in-country stock holding capacity, especially for EID and VL reagents.

4.7. Collaboration, Integration and Monitoring

A. The National HIV Alignment Program

PEPFAR Nigeria's partnership with GON and The Global Fund under one aligned national HIV program has accelerated the country's progress towards achieving the UNAIDS 95-95-95 goal for epidemic control in a shorter timeframe than envisaged. The national HIV alignment program exhibited resilience through the COVID-19 pandemic using several mitigation strategies to protect PLHIV and health care workers and, ultimately, overachieving its treatment current target by 16%. Alignment 1.0, with an initial 3-year agreement on geographies for service delivery and commodities contribution to the national pool, was based on each party's comparative advantage. Under the agreement, Global Fund increased its commodities footprint while PEPFAR – with boots on ground – increased its service delivery footprint, taking on service provision for an additional 246 healthcare facilities across 32+1 states, including Abia and Taraba. The Global Fund is also providing additional funds for harm reduction services for KP programming in seven states, four of which are PEPFAR-supported states. The alignment agreement resources for FY21, FY22, and FY23 are presented in Table 4.7.1.

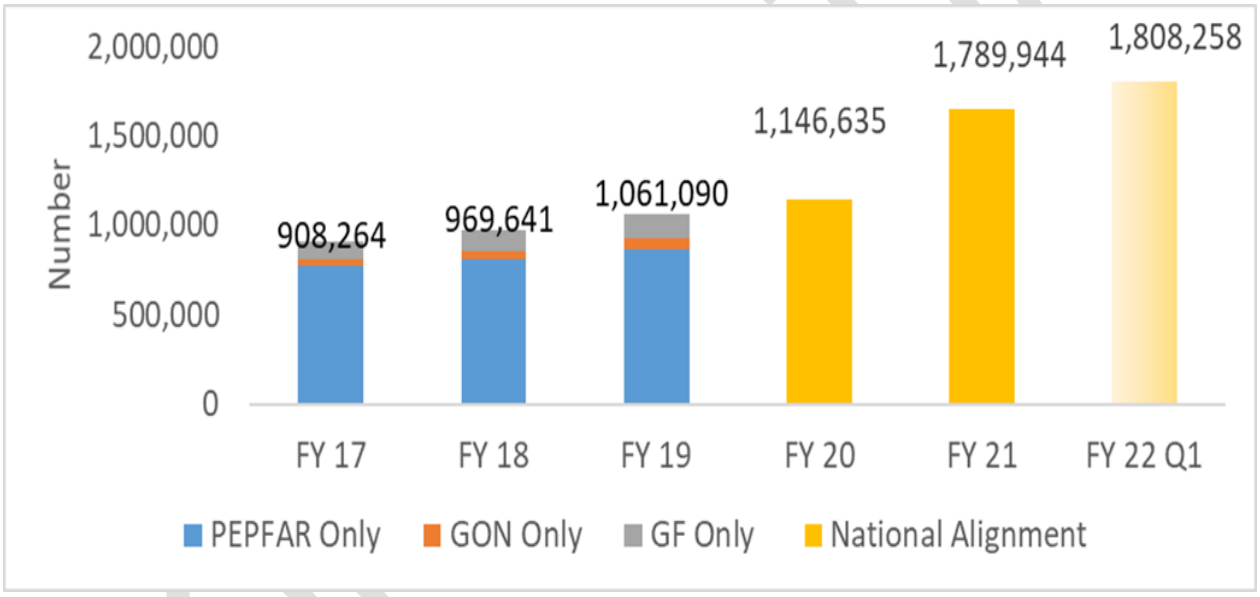
Table 4.7.1: Funding Envelop and Resource Alignment

Global Fund	PEPFAR	Government of Nigeria
FY21 – $73.4m **FY22 - $80.2m** **FY23 - $100.9m**	**FY21 - $371m** **FY22 - $426.5m** **FY23 - $400m**	**FY21 - $16.9m** **FY22 - $6.8m** **FY23 - $8.5m**
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 (3 states); Harm Reduction (7 states)	KP programming (21 states); scale up ongoing	KP Facility services in Abia and Taraba in partnership with PEPFAR

Global Fund	PEPFAR	Government of Nigeria
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

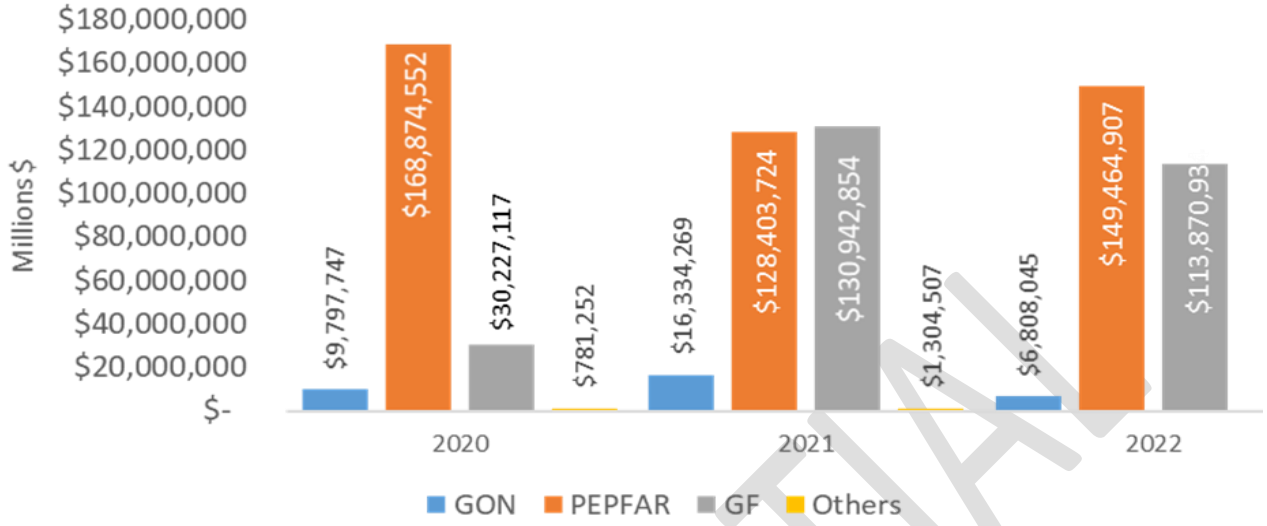
The national alignment program is rapidly progressing towards achieving epidemic control in a shorter timeframe than would have been possible if the partners continued implementation in silos. With joint forces under the national alignment, the country recorded between 2020-2021 a net growth three times higher than had been achieved in the three years prior to the national alignment (2017-2019) when partners implemented individually (Fig 4.7.2).

Fig. 4.7.1 Momentum with Stakeholders in the National HIV Alignment Program



Since initiating the Alignment, respective partners' commodities contributions to the national pools experienced significant shifts (Fig. 4.7.3). While PEPFAR's commodity contribution significantly declined, contributions from the Global Fund dramatically increased, thereby freeing additional resources for rapid scale up of the national treatment programs. The additional commodities supported by the Global Fund and ability to frontload the commodities were critical to maintaining the required commodity stock level in country while ensuring availability of commodities to scale up MMD6 despite COVID-19 challenges.

Fig. 4.7.2. HIV Treatment Commodity Budget 2022-2022



The national alignment program experienced some implementation challenges. The national HIV program recorded low PMTCT and EID coverage, which is partly attributed to low uptake of facility-based antenatal care and hospital deliveries. New approaches to implement evidence based PMTCT activities in community settings through a national PMTCT scale up plan will increase antenatal care (ANC) coverage, testing coverage for pregnant women, and ART coverage in positive pregnant women (PPW). Another concern was in key population programming across 11 states where PEPFAR provides facility-based treatment services for general population and the Global Fund provides community services in OSS. With the high risk of duplication and double counting, working modalities between facility and community needs to clearly outline prevention and minimize duplication and to improve linkage for smooth referrals to prevent loss to follow up (LTFU). The cut in funding level for PEPFAR Nigeria and the overachievement of targets created a gap in available resources for COP22 planning leading to series of engagements between the tripartite partners on ways to close the gap and possible tradeoffs.

National Alignment Plans for COP22 (FY2023)

In FY23 (COP22), the national treatment program plans to reach a current target of 2,167,863 (Table 4.7.2). The goal of the national treatment program is to achieve ART coverage greater than 81% in all 36+1 states by closing the HIV treatment gap among children, adolescents, and youth, with special prominence on girls, young women, and HIV-exposed infants.

Table 4.7.2. Testing and treatment indicator targets for October 1, 2022-September 30, 2023

Projected Targets	Tx_Net_New	Tx_New	Tx_Curr	2023 PLHIV Estimates	ART Coverage	HTS_POS	HTS_TST
PEPFAR COP 22	137,158	178,395	2,075,730	1,756,972	118%	187,803	13,623,403
Anambra and Ebonyi	27,080	28,922	92,133	112,287	82%	30,444	2,174,571
National	**164,238**	**207,317**	**2,167,863**	**1,869,259**	**116%**	**218,247**	**15,797,974**

Considering current program performance, a high level of buffer stock is required to mitigate against possible commodity stock challenges and guarantee that PLHIV will continue to receive quality HIV prevention, care, and treatment services. The national commodity requirement, with a full 4-month buffer for ARVs, viral load (VL) reagents, and RTKs is $243.76m (Table 4.7.3), resulting in a gap of **$22.89m (Table 4.7.4)** This gap has been included in the Country Priority Above Allocation Request (PAAR) for funding through the Global Fund.

Table 4.7.3. National Commodity Budget with and without Buffer Stock

Commodity Type	2023 Budget Less Buffer	2023 Budget Plus Buffer
ARVs	$165,880,260	$173,707,402
Opportunistic Infection Treatment	$1,741,214	$1,741,214
Rapid Test Kits	$21,843,409	$23,622,899
Viral Load	$26,045,734	$29,275,244
Early Infant Diagnosis	$433,444	$433,444
CD4	$973,070	$973,070
Tuberculosis	$4,454,097	$4,454,097
AHD & Cervical Cancer Tests	$367,611	$367,611
Condoms	$999,989	$999,989
In-Country Logistics	$6,716,527	$6,716,527
Quality Assurance	$1,469,195	$1,469,195
Total	**$230,924,550**	**$243,760,692**

Table 4.7.4. National Commodity Budget Gap

Commodity Funding Category	2023 Budget Less Buffer	2023 Budget Plus Buffer
Estimated Annual Commodity Financial Need	$230,924,550	$243,760,692
PSM SC Program Management	$3,174,717	$3,174,717
Total SCM Need	$234,099,267	$246,935,409
Global Fund TLD CY 2023 Procurement Orders	$60,000,000	$60,000,000
PEPFAR COP 21/FY 22 TLD Carry Over	$6,827,142	$6,827,142
PEPFAR COP 21/FY 22 VL Carry Over	$3,229,510	$3,229,510
2023 / COP 22 All Inclusive National Balance	$164,042,615	$176,878,757
PEPFAR COP Fund	$127,639,609	$127,639,609
Global Fund Other	$17,841,648	$17,841,648
Government of Nigeria	$8,500,000	$8,500,000
Total Supply Chain / Commodity Budget Gap	**$10,061,358**	**$22,897,500**

The Government of Nigeria, PEPFAR and Global Fund remain committed to finding lasting solutions to implementation challenges and finding new areas for collaboration and integration to increase synergies and reduce duplications. Under Alignment 2.0, the focus will be on addressing health systems challenges in laboratory management, strategic information and in supply chain.

The COP23 planning and Global Fund 2023-2025 funding cycle in FY23 present an opportunity for joint reflections and joint analysis of progress and gaps in the national HIV program for joint planning and priority setting to address bottlenecks, needs and for strategic resource distribution. Considerations for alignment 2.0 also include strong coordination for KP programming; PMTCT service scale-up; and sustainability modelling in Abia and Taraba states. The structure of PEPFAR Nigeria and the GoN's support for Abia and Taraba, where the Global Fund also supports community and KP programming, serves as a sustainability model for state programs. Through four phases of onboarding, surge, sustained epidemic control and full government support, the national alignment partners will mentor and build the capacity of these two states to take over their State HIV programs. Currently surging, increasing treatment coverage, and optimizing services, these States aim to achieve epidemic control by the end of 2023. Lessons from the model will be gradually shared with other states who have the capacity to take ownership of implementing, managing, and coordinating their own HIV programs.

B. Other Collaborations, Integration and Partnerships

Cross-technical collaborations are being reinforced across the nationally aligned HIV program to address systemic challenges. The deep dives initiated during the COP planning process created a shared understanding of the current investments and status of the health systems for synergies in programming. A clear vision for the national aligned program is fundamental to the success of the national HIV response. A task team, under GoN leadership but with representation from the tri-partite partnership and other key stakeholders, is determining the mid- to long- term vision, with a multi-year plan, that will firmly shape the future of the national alignment for a sustainable HIV program.

To improve the integration of quality and efficiency in **HIV Service Delivery,** service packages for General Population and KP programming have been standardized for improved models of care delivery across communities and facilities. The focus remains on ART regimen optimization (100% pediatric optimization to pDTG), consistent IIT recalibration to 28 days across the country, strengthened index testing, and 100% linkage of all facilities to the NDR. Most facilities have biometrics platforms and a pool of HIV clinical frontline healthcare workers with capacity for standard integrated service delivery including advanced HIV disease (AHD), GBV, CQI, PMTCT, HIV drug resistance, and TB. For KP, a package of services has been created based on tailored guidelines that best meet the needs of the different KP typologies in a manner consistent across the entire national alignment. The country envisions a KP program fully aligned and operating within national consolidated guidelines with uniform data collection processes. Under Alignment 2.0, joint planning, supportive supervision, mentoring and data review of all KP programs, as well as strong referrals and linkages between different models of service delivery will be strengthened. The capacity of public and private sector systems will also be supported to provide KP-responsive services, including gender and human rights, as disruptions in these cross-cutting components can impede access and provision of services. A mapping of programmes to reduce gender and human rights barriers to HIV and TB services, funded by Global Fund, revealed barriers to accessing and uptake of both services. Building on the PEPFAR Patient Engagement and Empowerment Project

(PEEP) and other related rights-based programs in country, Global Fund has earmarked resources to strengthen, integrate and support GHR activities into all aspects of HIV and TB programming.

For **PMTCT** service provision, the National Program, along with Global Fund and PEPFAR, is embarking on a national PMTCT surge to improve uptake of PMTCT services across the 36+1 states. The HIV health sector data for 2021 reports low PMTCT and ART coverage. This was also confirmed by a five-year trend analysis of coverage for CLHIV where gaps were identified along the maternal and infant PMTCT cascades. Based on these findings, NASCP, in collaboration with Partners, supported the development of State-specific strategic frameworks and obtained signoffs from the state commissioners for health as indication of their commitment to address the PMTCT gap. The national alignment program has requested additional resources from the Global Fund and assigned community targets to PEPFAR as part of the joint efforts to close this gap. The Global Fund and PEPFAR will work with the Government to provide joint oversight while using quarterly review meetings to assess surge implementation and address gaps in the program

Laboratory systems service packages have been standardized and partners are joining forces to ensure continuous service delivery across the country. The country envisages a fully functional, robust, and resilient national laboratory network for integrated disease diagnosis, treatment monitoring, and surveillance. The alignment partners continue to identify and support critical systems strengthening interventions that improve service delivery efficiency through partnerships. The National Laboratory Network jointly supported by PEPFAR, Global Fund and the GoN, provides HIV viral load, EID, and tuberculosis testing services to all patients across the country in an integrated manner. To further enhance efficiencies, extensions have been made to support multi-disease testing, and the lab network currently provides hepatitis and human papilloma virus testing through partnership with the Clinton Health Access Initiative (CHAI). The lab network also currently serves as the backbone for the COVID-19 testing as part of the overall country response to the pandemic and will continue to do so in COP22 and beyond.

In 2020, Global Fund funded both an evaluation of the sample referral network to determine areas of further improvements to enhance efficiency and effectiveness, and the implementation of the subsequent recommendations. Global Fund is also supporting capacity building of the Nigerian Postal Services on biological sampling handling and transport, to serve as a third-party logistics (3PL) provider in the NISRN system as a sustainability strategy, and in collaboration with PEPFAR, are investing in biosafety and biosecurity management systems. An ongoing enhancement of the existing LIMS for HIV and TB will create modules for multi-disease testing and reporting, which is currently critical to COVID-19 testing and reporting using the PCR and GeneXpert network. The LMIS is currently being enhanced to support remote test ordering through remote sample login and LIMS-EMR integration. Under the RSSH grant, Global Fund will develop an e-LIMS for surveillance reporting across disease programs and for the linkage of 74 reference laboratories onto the national LIMS. The GoN, PEPFAR Nigeria and the Global Fund, through the Medical Laboratory Science Council of Nigeria (MLSCN), are partnering in the implementation of Quality Management System (QMS) and joint laboratory CQI using audits, mentorship, proficiency testing and laboratory accreditation to assure the quality of results from the laboratory network.

In **Supply Chain Management**, PEPFAR Nigeria, Global Fund and GoN are working hard to create a sustainable Supply Chain system with state government ownership and improved coordination. The partners are collaborating with the state HIV/AIDS and TB programs to improve and sustain collaboration, alignment, and integration of key health systems intervention in supply chain to minimize duplication while leveraging efficiencies for a sustainable National Supply Chain Management Program. Key supply chain health systems investments are in warehousing, a National Health Logistics Management Information System (NHLMIS), bi-annual supply planning review meetings, last mile distribution (LMD), national integrated monitoring and supportive supervisory visits and capacity building. Under a public-private partnership, two pharmaceutical-grade warehouses were built collaboratively by the alignment partners to enable ease of LMD for public health commodities (under programs for HIV/AIDS, family planning, TB, maternal and child health, and malaria, etc.) and support management of other donor-funded health commodities. The Global Fund, through its RSSH grant, is funding the upgrade of 13 other state warehouses, with the intention of creating a sustainable in-country supply chain system through state integration and ownership in alignment with the Government of Nigeria's Supply Chain Strategic Framework.

The NHLMIS, domiciled with the National Product Supply Chain Management Program (NPSCMP), is strategic in periodic collection and aggregation of logistics data to inform re-supply and identification of stock and data quality challenges for prompt resolution and prevention of interrupted commodities supply to facilities. As part of the systems to strengthen supply chain logistic data at the sub-national levels, the Logistics Management Coordinating Unit (LMCU) is strategically placed to effectively coordinate supply chain activities across all the States in Nigeria. Biannual national supply planning review and quantification meetings facilitate review of commodity assumptions, forecast and the output of the biennial quantification exercise enhancing estimation of commodity needs and funding requirements. National integrated monitoring and supportive supervision visits to health care facilities ensure systems for capacity building and mentoring are in place and potential commodity challenges identified early so solutions are proffered for sustained commodity security.

Community-Led Monitoring (CLM), piloted in ten (10) states by over 20 civil society organization (CSO) representatives, now has an app version of the CLM service beneficiary data collection tool that was developed and pre-tested as a paper version by all CSO representatives trained before deployment. The PEPFAR Nigeria CLM activity is a community-driven process designed, initiated, led and implemented by representatives from PLHIV groups, adolescent and young persons' associations, key population typologies, and broader CSOs. CLM collects data on indicators (for use with quantitative and qualitative methods), and data collected from over 500 individual client interviews and over 20 focus group discussions (FGDs) at the site level are being analyzed for report writing. After the final reports, implementing partners will provide feedback to supported facilities and OSS for necessary action.

CSO representatives in the different states will continue to monitor implementation of recommendations made from the report and provide feedback on concerns to partners at state level and to PEPFAR through the PEPFAR-CSO quarterly review meetings, as may be required. This loop

will ensure that necessary actions are being implemented to address concerns, issues and recommendations gathered from service beneficiaries during the CLM pilot in these sites, and with other relevant stakeholders to ensure necessary change. PEPFAR will directly engage CSOs in the next phase of CLM implementation, in COP22, through the small grants process. The learning from the CLM pilot will be used to standardize process, build capacity, and support routine CLM data collection by these CSOs from across all PEPFAR-supported sites.

For **Strategic Information Management**, all states are using the same guidelines for reporting as stipulated in the national M&E framework, and quarterly validation meetings and reporting on HIV monthly data have been institutionalized. The country vision is to have a fully functional SI system that addresses the country's data needs. The focus is ensuring all data flows end up in the DHIS2 and the integration of DHIS2-NDR-LMIS-Lab information systems is achieved. E-reporting will also be expanded at the facility level and KP data management strengthened. PEPFAR, in partnership with the GoN, is strengthening the NDR and National OVC Management Information System (NOMIS). It is also supporting LIMS (in collaboration with CHAI) and NHLMIS.

The Global Fund, PEPFAR and AIDS Healthcare Foundation (AHF) are supporting EMR- including mobile versions. Under the national alignment, joint site monitoring visits will continue to assess human resource capacity for M&E, data systems to produce quality data, improve efficacy of the EMR systems for patient monitoring and management and strengthen biometric data capture for unique identification of patients. PEPFAR is also collaborating with the Global Fund. UNAIDS, GoN, AHF and other in country stakeholders to determine country PLHIV estimates. A joint data quality exercise, conducted quarterly, validates data reported from the facilities with recommendations to improve quality of data.

Coordination roles and responsibilities have been delineated at all levels and regular joint supportive supervision to the states with leadership by the government will address challenges in implementation including for KP and PMTCT.

4.8. Targets by Population

The overarching 95-95-95 goal is to achieve saturation levels of >81% ART coverage by SNUs and age groups. Even after achieving 81% treatment saturation, the SNU will continue to scale other core interventions and optimize resource allocation for maximum impact as dictated by epidemiologic need.

The FY23 national targets, including Anambra and Ebonyi, are intended to facilitate attainment of a national TX_NEW target of 207,317, TX_NET_NEW of 164,238 and a TX_CURR target of 2,167,863, as shown in Table 4.8, by ensuring an optimal continuity in treatment of 98%. This will achieve a treatment coverage of >95% across the OU by the end of FY23.

Projected Targets	Tx_Net_ New	Tx_New	Tx_Curr	2023 PLHIV Estimates	ART Coverage	HTS_POS	HST_TST
National Total (PEPFAR)	137,158	178,395	2,075,730	1,756,972	118%	187,803	13,623,403
Anambra & Ebonyi States (GF)	27,080	28,922	92,133	112,287	82%	30,444	2,174,571
National Total	**164,238**	**207,317**	**2,167,259**	**1,869,247**	**116%**	**218,247**	**15,797,974**

The COP22 targets are allocated to the different age groups as shown in table 4.8.1 in line with the COP emphasis on reducing persistent inequalities experienced by children, adolescent girls, and young women. Consequently, a targeted ART surge program will be implemented in states with low ART coverage as well as in states with the highest unmet treatment needs with the aim of improving HIV case finding and ART coverage among the following subpopulations:

I. Achieve >81% ART coverage in 9 SNUs for children less than 15 years, moving the OU coverage from 37% at Q4 FY22 to 54% by the end of Q4 FY23
II. Achieve >81% ART coverage in 16 SNUs for 15-19 years age group, moving the OU coverage from 55% at Q4 FY22 to 86% by the end of Q4 FY23
III. Achieve >81% ART coverage in 26 SNUs for 20-24 years age group, moving OU ART coverage to >95%
IV. Achieve >81% ART coverage in all SNUs for adults aged greater than 24 years, moving OU ART coverage to >95%.

Table 4.8.1: Summary National COP22 Targets by Different Age Groups (Anambra and Ebonyi not included)

Projected Targets	Tx_Net_ New	Tx_New	Tx_Curr	2013 PLHIV Estimates	ART Coverage	HTS_POS	HTS_TST	Country Testing Yield	Linkage Rate
Peadiatrics (<15 years)	13,993	15,266	77,628	144,433	54%	16,072	2,359,673	0.7%	95%
Adolescents (15-19 years)	11,369	12,373	50,196	58,355	86%	13,032	1,621,467	0.8%	95%
Young Adults (20-24 years)	12,161	15,521	162,984	121,826	134%	16,327	2,079,588	0.8%	95%
Adults (>24 years)	99,535	135,235	1,784,922	1,432,358	125%	142,372	7,562,875	1.9%	95%
TOTAL (All Ages)	**137,158**	**178,395**	**2,075,730**	**1,756,972**	**118%**	**187,803**	**13,623,403**	**1.4%**	**95%**

Table 4.8.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate* (SNUs)	Disease Burden*	FY23 Target
FSW	847,664	15.5%[12]	46,731
MSM	300,444	25%[12]	33,017
PWID	301,838	10.9%[12]	16,325
Prisons and other closed settings	68,686[10]	2.8%[11]	2,228
TG	3,004[10]	28.8%[12]	2,184
Total	**1,521,637**		**100,485**

[10] Estimates based on triangulation of program data
[11] National assessments of HIV and AIDS and health services situation in Nigerian prisons 2018
[12] Integrated Biological & Behavioral Surveillance Survey (IBBSS) 2020

Table 4.8.4 Targets for OVC and Linkages to HIV Services

SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY23 Target)	Target # of OVC (FY23 Target)	Target # of active OVC (FY23 Target)	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY23 Target)
		OVC_SERV Comprehensive	OVC_SERV Preventative	OVC_SERV DREAMS	OVC*
Military		32500	17500	-	
Abia		22738	12244	-	26103
Adamawa	*97,817*	42568	22921	-	27522
Akwa Ibom	*200,687*	162677	87596	-	106585
Bauchi	*106,098*	44026	23706	-	28736
Bayelsa		4674	2517	-	3050
Benue	*316,276*	152306	82011	-	98827
Borno		23809	12820	-	35807
Cross River	*136,367*	60651	32658	-	39841
Delta	*124,279*	56567	30459	-	36952
Edo		19441	10468	-	12188
Ekiti		4920	2649	-	3155
Enugu	*94,445*	40238	21667	-	26066
FCT	*117,840*	55309	29782	-	35937
Gombe	*62,562*	28453	15321	-	18450
Imo	*96,393*	28571	15384	-	18496
Jigawa		8273	4454	-	12347
Kaduna	*194,275*	78454	42245	-	51732
Kano	*345541*	136,210	73344	-	89242
Katsina		3,545	1909	-	0
Kebbi		368	198	-	0
Kogi		28,869	15545	-	33637
Kwara		17,516	9432	-	26414
Lagos	*415134*	177,997	95845	-	116420
Nasarawa	*123,408*	59,507	32042	-	38671
Niger		41,253	22213	-	27750
Ogun		30,942	16661	-	37907
Ondo		23,128	12453	-	28796
Osun		20,291	10926	-	27212
Oyo		41,426	22306	-	49877
Plateau		35,870	19315	-	33809
Rivers	*200,188*	138,256	74445	-	90519
Sokoto		9,502	5117	-	14255
Taraba		7,350	3958	-	4593
Yobe		17,300	9,315	-	26414
Zamfara		4365	2,350	-	5,904
TOTAL	***2,631,310***	**1,659,868**	**893,775**	**0**	**123,3215**

4.9. Cervical Cancer Program Plans

PEPFAR Nigeria plans to continue to scale-up women living with HIV (WLHIV)'s access to cervical screening and treatment of pre-invasive lesions by leveraging the support of other stakeholders such as CHAI. Through 607 health facilities that provide screening and treatment of pre-invasive lesions, 87,414 WLHIV were screened for cervical cancer by VIA and PEPFAR Nigeria will be increasing number of WLHIV accessing screening services to 300,000 by optimizing services at current facilities and scaling up to additional 120 health facilities spread across supported states.

Referral directories will be developed and utilized to guide seamless service navigation, and expert clients will act as linkage coordinators.

4.10. Viral Load and Early Infant Diagnosis Optimization

The PEPFAR/Nigeria program has continued to apply innovative approaches and expand the implementation of impactful best practices in order to close the gaps in viral load coverage for priority populations including pregnant and breastfeeding women (PBFW), key populations, infant, children and adolescents, as well as non-suppressed population. As a result of these impactful interventions, the viral load coverage and suppression rates for pregnant and breastfeeding women have increased greatly to more than 90%, while for infants, children and adolescents, viral load coverage and suppression rates are slightly more than 80% across sub-national levels by the end of FY22 Q1.

While these approaches have led to impressive growth in viral load coverage and suppression rates, the viral load coverage rates are still much lower than that of the adult population. To close the remaining gaps in viral load coverage and suppression for these priority populations, the country program has further prioritized focused interventions that would address the lingering problems of disruptions in supply chain and prolonged equipment downtime leading to prolonged turn-around-time (TAT) on return of results for clinical interventions. In COP22, the country has prioritized the expansion of its "all-inclusive pricing" regime to include all reagents and supplies for viral load and early infant diagnosis (EID) testing. This will be achieved through a phased implementation of full Vendor Managed Inventory (VMI). Additionally, the country program is currently rolling out the use of GeneXpert platform (Near Point of Care Testing) for EID testing to address the very long turn-around-time for EID, and to compliment centralized testing of EID in designated PCR labs using the conventional high throughput equipment. The country program has also set a new TAT target for EID of 5-days, from the previous 10-days, to drive increased testing and improve return of results for EID.

As part of the ongoing diagnostic network optimization efforts, the country program is leveraging the American Rescue Plan Act (ARPA) funds, as well as lessons learned from the integrated HIV/COVID-19 testing, to further expand integrated disease testing across the lab network. To this end, the country program will be expanding the test menus on the Roche, Abbott, and Hologic platforms to include integrated HIV/TB/COVID-19 testing in addition to the Human Papilloma Virus (HPV) and Hepatitis testing already ongoing. GeneXpert XIV module platforms are also being deployed to target PCR labs to further expand multiplexed disease testing using common equipment platforms. The program has commenced the implementation of Remote Sample Log In (RSL) process to improve sample reception process and contribute to reducing TAT. The existing Lab information Management system is being updated to include commodities module for full visibility of reagents and commodities utilization in the labs. The ongoing linkage of the LIMS with the Electronic Medical Records (EMR) will be enhanced to include Short Message System (SMS) alerts for Viral load and EID results. We are coordinating with the Global Fund in the implementation of the recommendations of the recent Sample Referral Network Assessment,

funding through Global Fund. This and the planned assessment of the existing Diagnostic Network will enable us to straighten out the kinks in the system for efficient and sustainable laboratory services delivery to all population types and across all geographies within the country.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

Achieving and sustaining epidemic control requires strong key health systems functions to be in place. PEPFAR invests in building local capacity for key health systems components 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	$ 450,000
3	African Cohort Study (AFRICOS)	On-going, continuing	$ 500,000
4	National Data Repository (NDR)	On-going, continuing	$ 3,797,667
5	National Integrated Sample Referral Network (NISRN)	On-going, continuing	$ 3,114,284
6	NOMIS Upgrade	On-going, continuing	$ 320,000
7	Domestic Resource Mobilization	On-going, continuing	$ 625,000
	Total		**$ 9,106,951**

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 PEPFAR and by the U.S. Department of State, Africa Bureau's Ambassador's Special Self-Help (ASSH) Program. In COP22, the ASG will provide small grants funding to local Civil Society Organizations to conduct Community-Led Monitoring activities with the objective of helping the PEPFAR program identify new areas of needed improvement in the services supported by the program. These activities will seek to focus more on the perspectives of key population clients and their recommendations about how to improve the quality of services and access to their communities. Organizations with recognized competence and experience working with key populations will be specifically targeted for the COP22 round of the ASG. The funding level remains same as for COP21 and other prior years.

2. CSO Engagement Plan

Building off on the success of the first phase of the Patient Education and Empowerment Plan (PEEP), the PEPFAR collaboration with NEPWHAN, UNAIDS, the National Human Rights Commission, NACA and NASCP will focus in COP21 and COP22 on -

a. Formalizing and standardizing the training manuals for the patient and health literacy curriculum, based on the feedback from the national training of trainers and the 6 regional trainings.
b. Mobilizing sub-national level stakeholders across the 36 states and the FCT and support the local NEPWHAN constituents and state-level stakeholders to:
    i. Rollout state workshops with the intention to see these workshops deployed annually to reach support group leaders, peer mentors, case managers and other community leaders who serve and engage with PLHIV at facility and community level.
    ii. Develop the grievance reporting and redress system and support NEPWHAN structures at state and national level to collate reports and track the redress process.
c. Working with the National Human Rights Commission to develop informational tools and job aids to support the work of law enforcement officials and the judiciary as regards the rights of PLHIV and other vulnerable populations.
d. Expanding the PEEP to increasingly address the health literacy and rights issues of key populations and
e. Increasing collaboration with other stakeholders supporting structural interventions to address the rights of PLHIV and other vulnerable people and establish a framework for the sustainability of these investments.

In addition to the PEEP, the program will continue to work with local Civil Society Leaders to implement other prioritized activities in the PEPFAR Civil Society engagement plan (see Table F.2. in Appendix F). These includes the plan to continue to support CSO's activities in the national U=U campaign, Civil Society efforts to track HIV funding allocation and domestic resource advocacy, and specific prioritized capacity building activities for key population and youth led CSOs. The COP22, the budget for the CSO Engagement Plan has been reduced to $450,000 (from $500,000), to reflect the reduction in the Country's PEPFAR budget and the desire to leverage and align these activities with other similar investments funded by the Government of Nigeria, Global Fund, the Joint UN Team, and other stakeholders.

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 3,762 patients (comprising of 3,108 people living with HIV (PLHIV) and 654 HIV-uninfected participants as of

September 1, 2021) globally, while Nigeria enrolled 456 patients (12.1%) and every six 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 are 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.

In COP22, 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. National Data Repository (NDR)

The NDR contains records of over 1.8 million active clients in all 36+1 states in Nigeria, with data coming from all PEPFAR-supported, and some non-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-based, mortality and recency surveillance. The current NDR architecture supports the capture of biometrics and matching and deduplication of clients on treatment. At facility level, the system can authenticate clients to prevent enrollment of clients already enrolled in the same facility. Real time client authentication across facilities is a challenge with the current NDR infrastructure. In this current year, analysis of biometrics has commenced, which assists in identifying and resolving duplicate client records.

In COP22, PEPFAR will focus on the re-architecture and re-design of the current NDR that started as a shared health record that meets the OpenHIE standards and framework. OpenHIE standards align with the principle of digital investment, WHO guidelines on patient-centered care, and the Nigeria ICT Strategic Framework. This will increase and allow for cross-facility unique patient identification, record linkage and deduplication to determine accurate TX_CURR, longitudinal tracking of clients, and access to longitudinal health record of clients from any service delivery point as they move locations. PEPFAR will expand the NDR infrastructure and architecture for timely and efficient authentication services to investigate and determine treatment status of new clients and the point of enrollment and during service delivery. In addition, the OpenHIE will scale up the utility of the NDR by integrating it with other health information systems in near real-time using robust end-end internet capabilities, while also being able to exchange summary data with

the National Health Management Information System through integration with the National Facility Registry.

The critical components of the OpenHIE are the implementation of client registry and other relevant infrastructure to ensure timely and efficient patient matching, authentication, deduplication at the point of service and above facility for patient and program monitoring, case surveillance, and other secondary data use. The client registry will leverage on biometrics from patient biometric solution and other personally identifiable information for cross-facility unique client identification.

In COP22, PEPFAR will build an analytic workspace that is comprehensive, user-friendly, customer-centric that will allow users to design, customize, and organize their visuals based on need. NDR's rich datasets are currently displayed on a dashboard which has vast amounts of data designed to meet the needs of the HIV response and its stakeholders. The dashboard provides a comprehensive overview of program and HIV surveillance data for use by middle level stakeholders in the national HIV response, however, they have been pre-determined and could be restrictive. There is not much flexibility in the visualizations available on the dashboard as users are not able to custom-build the visualizations based on need.

The NDR will continue to support GoN and PEPFAR in COP22 through HIV surveillance activities to track progress in epidemic control, public health action and use of surveillance data to interrupt further transmission of HIV. The NDR recency surveillance visualization analytics dashboards will be optimized to support recency rapid response dashboard and alert notification system. Once the specified threshold is attained, the alert system will provide timely trigger to facilities/GoN and the IPs to mount recency rapid response to the hotspots to identify cases and implement services that will help interrupt transmission, including the use PrEP.

5. 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 VL testing needs.

NISRN became functional in FY18 and serves to pick-up samples from health facilities (using 3PLs), moves these to the PCR labs and other referral labs in the network, and picks-up results from the referral labs to return them back to the clinics. NISRN is operated by a PEPFAR implementing partner but is co-funded by the Global Fund. It is currently the common system for all HIV viral load and EID sample referrals 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 COP22 is to improve turnaround times at the different points of the network and ensure end-to-end visibility across the process points:

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

6. NOMIS Upgrade

In 2020, PEPFAR Nigeria assessed the NOMIS system in Nigeria to identify current system limitations. This assessment was a result of user feedback on the difficulties 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 22 PEPFAR Nigeria will work to address these challenges and make the NOMIS more functional and inter operable.

7. Domestic Resource Mobilization and Tracking

This critical element of the Sustainability Index has recorded improvement from the SID 2019, from **5.56-5.99** in 2021, a long-term financing strategy, The National Domestic Resource Mobilization and Sustainability Strategy (NDRMS), was developed in 2021 and recommends key strategies targeted at mobilizing 662 million USD domestically for HIV control over the next four years. Some of the key strategies include integration of HIV into state health insurance schemes in all 36 +1 states, increasing budget spending on HIV at the national and sub-national levels, improving private sector participation, local production of ARVs and improved governance, efficiency, and accountability of HIV funding. The GoN has made budgetary provisions for the treatment of up to 100,000 PLHIV in the FY22 budget. Presently, there is still a gap in implementing these key policies at the national and sub-national levels, as well as low resource mobilization from the private sector. Therefore, there is need to support the operationalization of these policies at all levels (national and sub-national), especially the expansion of health insurance coverage with HIV integration and inclusion of additional essential HIV services, in order to enhance the financial sustainability of HIV epidemiological control.

On December 1, 2020, the GoN 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. Only Lagos, where PEPFAR is supporting DRM for HIV, has made any solid investment in actualizing this blueprint as of the end of FY21.

At state level, PEPFAR further supported Lagos 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 has empaneled 289 health facilities for provision of HIV services, enrolled over 570,000 into the Lagos SHIS, released funding for health insurance coverage, and commenced HIV service delivery in 50% of empaneled health facilities. In 2021, the Lagos State Government increased its HIV budget allocation by 7% (N605,101,737) and 53% budget expenditure was achieved in 2021 (N360,000,000). In FY21, the Lagos State Government spent ₦100,000,000 for the procurement of 265,000 RTKs. In COP22, 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 and scale up activities in Kano. Emphasis will be placed on demonstrated coverage of HIV services within the state health insurance packages (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.

One of the major pillars and strategies proposed in the draft DRMS is local production of HIV commodities. PEPFAR is supporting the feasibility assessment of local production of HIV commodities, 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 when determining whether to launch local manufacturing of HIV commodities, and, if so, provide key steps for successful implementation.

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 increased federal and state government budget allocations and releases. The HFTN is expected to raise 100 million USD directly from the private sector and additional funds raised through the bond market and philanthropic contributions. Further PEPFAR support for the 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.

6.0 Operations and Staffing Plan to Achieve Stated Goals

United States Agency for International Development (USAID)

USAID is in the process of transitioning its HIV treatment portfolio from international to local prime implementing partners with five new awards made between January and March 2022 with the final anticipated before end of the fiscal year. USAID is already implementing through local partners in the OVC and KP portfolios. USAID will focus on continuous assessment of capacity gaps and targeted technical assistance to address challenges in grants and financial management, operations, data management, and technical oversight. In COP 22, USAID will utilize one-time central funding ($375,000) to recruit and train three new staff to provide hands-on, focused support to ensure compliance with USAID and PEPFAR reporting and implementation requirements. These staff will provide additional support to new partners in key areas identified during pre-award surveys: budget and administration and strategic information. Beyond the one-time management and operations resources, the USAID budget also includes an increase to accommodate local staff salary increases anticipated due to the inflationary environment in Nigeria.

All US Direct Hire and Offshore Personal Service Contractor positions are currently filled. After an unsuccessful recruitment for a local hire American Strategic Information Adviser, the position was repurposed as a financial management certifying officer to support the increased volume of financial transactions managed at the Mission with expanded local partners. This shift will also enable USAID to meet Agency requirements for certification of partner vouchers at country office level. The host country national Operations Specialist position originally planned in COP 21 was in turn repurposed to a Strategic Informatic Specialist, who has been recruited and onboarded. USAID is working to fill vacancies of locally employed staff positions, three of which became vacant in the last year. USAID faced delays in filling vacant host country national positions due to requirements to reclassify positions with outdated position descriptions as well as multiple solicitation rounds to identify qualified applicants for vacant strategic information and treatment positions. Two remaining vacant positions are pending position reclassification while the remaining are under solicitation, pending selection, or in clearance. The additional workload of COVID-19 response assistance and coordination activities through both PEPFAR and USAID American Rescue Plan Act resources including the Initiative for Global Vaccine Access (Global Vax) stretched current staff. USAID's HIV and TB Office shares responsibility for management of USAID Global Vax implementation with the Office of Health, Population, and Nutrition. Mechanisms managed by both offices are being leveraged to support the national COVID-19 response. USAID continues to coordinate these and other cross-cutting health programs with the broader USG health team at post.

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 administrative and financial compliance. The joint efforts of the teams ensure effective partner implementation and grants management of agency funded PEPFAR activities carried out by CDC IPs in Nigeria.

CDC continues to implement the Incident Command Structure (ICS) with Operations Chiefs, and the ART Surge and Enhanced Site Management (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 Extension for Community Healthcare Outcomes (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 an 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.

To maximize current staffing complement and meet current and future strategic goals, CDC management reviewed its program priorities, assessed its current staffing based on these priorities, and identified the need to CDC carry out a realignment exercise that resulted in strategic changes to some positions, Two USDH positions were repurposed to better serve the Mission's goals to develop strategic direction, enhance the capacity of current staff, and design more effective communication channels. Two existing Epidemiologist positions previously with the Surveillance & Epidemiology, and the Prevention branches are now an Associate Director for Science (ADS) position, and a Policy, Partnership and Communications Advisor position. The Senior Advisor, Policy, Partnerships and Communication will support the Office of the Director and the Division of Global HIV and TB and manage a broad portfolio of activities including serving as senior technical expert for health communication, demand creation, and communicating disease prevention strategies, and supporting country office programs through the design and review of relevant communication, social marketing, and demand creation tools. The ADS will serve as the primary scientific advisor to the CDC Country Director, CDC-funded implementing partners, and other CDC technical staff on science issues in public health, epidemiology, biostatistics, behavioral science, and related disciplines. This position will also advise on scientific studies/surveys or projects at local, regional, and national levels. Other staff redirections are the repurposing of an LES Program Specialist – Quality Assurance Management position to a Senior M&E team lead position to provide overall coordination of all M&E activities and be responsible for strengthening the national HIV/AIDS monitoring and evaluation system supported PEPFAR, and the need for deep and applied analytics for prompt course correction, commitment and competitive advantage led to the repurposing of the existing SIMS Coordinator position to a Senior Program Specialist,

Data Science position. SIMs Coordinator functions have been absorbed by the leads of all surge visits.

In COP21, CDC requested the addition of two new Specialists positions. One Senior Prevention Specialist position (Community and Gender-Based Team Lead) to focus on facility-based case-finding and prevention services so as to optimize efforts within the health facilities, and spear-head community case-finding and prevention services; and one Public Health Administrative Management Specialist (CoAg) to support the effective management of the PEPFAR extramural portfolio thereby facilitating the redistribution of direct award management to the three Public Health Administrative Specialists. The Public Health Administrative Management Specialist position has been filled while the Senior Prevention Specialist position (which had to go through classification) is currently being filled and expected to be occupied by end of Q3 of FY22.

CDC currently has eight vacant positions (one USDH position and seven LES positions). The USDH Policy, Partnership and Communications Advisor position is currently being filled, while the LES Data Science Specialist, Health Management Information Systems Specialist, OVC Program Specialist, Health Information System Strengthening Specialist, Gender Specialist, Senior Prevention Specialist, and Senior M & E Specialist are also vacant. Six of the vacant LES positions were recently vacated with only one being vacant for up to 6 months due to required reclassification that has recently been concluded. The 7th vacant LES position is a new position that was approved in COP21 which has recently completed classification and is also being filled. All positions are at different stages of recruitment with recruitment actions expected to all be completed by Q4 of FY22.

To support the effective operations of the PEPFAR Coordination Office (PCO), CDC is requesting one new position – Deputy PEPFAR Coordinator for administrative and financial management to support PCO and the PEPFAR Coordinator. Key responsibilities will be to manage PCO finances; monitor expenditures; lead the COP FAST preparation and expenditure reporting; participate in the Finance TWG; and represent the coordinator as needed.

The Cost of Doing Business (CODB) budget has been strategically planned to adequately support the implementation of the CDC COP22 program activities. For planned management and operations activities to be smoothly carried out, there is a 12.6% increase in the COP22 CODB budget over that of COP21. This increase is largely due to the proposed addition of one US Direct hire position described earlier to support the PCO in finance and administration management planned to be engaged in FY23. Three other contributary factors responsible for this increase are a provision for salary and benefit increase for Locally Employed Staff in FY23, buying into a USAID security contract to support implementing partners and plans to procure three additional armored vehicles in line with the CDC vehicle replacement plan to adequately support field activities monitoring Budget for vehicles was last made in COP19.

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

DoD maintained a flat CODB for COP22, with many of the changes to the CODB initiated in COP21 carried over to COP22.

In COP21, DoD proposed to purchase two Government Armored Vehicles; these were placed into procurement in FY21 but are pending delivery. As such, DoD retained the funds in the COP22 budget in the event the delivery is delayed until FY23.

Also, in COP21, DoD initiated the hire of four new LES positions that will ensure improvement in retention, weekly data analysis and review and ensuring un-interrupted supply of commodities to the sites. The four LES positions were classified in FY22 Q2, and DoD anticipates filling the positions by FY22 Q4. 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 were carried over to COP22 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 FY22Q4. The classification and inclusion of these new positions also necessitated the reclassification of the Deputy Director for Programs position and three Associate Director positions, the increases for which should also be enacted by FY22 Q4.

To maintain a flat CODB for COP22, DoD will eliminate one NSDD-38 position that has only been filled twice in the past ten years. The Deputy Director for Programs, once reclassified, will assume the responsibilities associated with this position.

Department of State/PEPFAR Coordination Office

The CODB budget for the PCO reflect a slight increase as with other agencies, to include the proposed salary and benefit increase for Locally Employed Staff (LES) in FY23. In addition to the five LES staff and USDH PEPFAR Coordinator, the team will add a new Deputy Coordinator position to oversee the interagency finance and administrative responsibilities. This position is proposed to be hired through CDC. Internal operational costs are however, expected to remain flat. Similarly, travels and other related costs remain the same as for COP21.

APPENDIX A - Continuous Nature of SNU Prioritization to Reach Epidemic Control

Table A.1 – Treatment Saturation by State, Age and Sex

State	<01		01-04		05-09		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50-54		55-59		60-64		65+		
Age/Sex	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
Abia	2%	2%	26%	26%	26%	25%	23%	23%	37%	33%	48%	39%	83%	88%	73%	89%	84%	77%	79%	68%	121%	108%	103%	93%	99%	88%	110%	103%	117%	114%	0% - 70%
Adamawa	2%	2%	70%	76%	99%	100%	89%	90%	106%	118%	134%	101%	170%	279%	209%	245%	204%	193%	132%	156%	166%	150%	111%	96%	96%	97%	125%	115%	143%	140%	71% - 80%
Akwa Ibom	1%	1%	76%	73%	73%	63%	69%	58%	78%	84%	147%	196%	148%	144%	113%	176%	135%	195%	127%	234%	132%	219%	163%	132%	150%	123%	180%	162%	203%	192%	>=81%
Bauchi	4%	3%	149%	141%	78%	68%	97%	86%	94%	131%	215%	139%	156%	161%	172%	215%	155%	219%	162%	217%	173%	205%	190%	192%	112%	118%	141%	143%	158%	163%	
Bayelsa	1%	1%	27%	28%	28%	28%	40%	32%	56%	55%	60%	209%	91%	101%	83%	87%	85%	80%	81%	74%	70%	68%	89%	91%	85%	88%	96%	98%	103%	105%	
Benue	4%	4%	128%	133%	127%	127%	126%	118%	83%	103%	119%	102%	175%	152%	203%	118%	161%	105%	100%	118%	149%	113%	116%	136%	131%	128%	113%	152%	141%	171%	
Borno	2%	2%	46%	46%	44%	42%	26%	26%	65%	46%	55%	83%	78%	76%	70%	67%	76%	79%	96%	80%	90%	93%	109%	101%	104%	95%	113%	108%	118%	115%	
Cross River	2%	2%	66%	66%	59%	55%	54%	54%	71%	92%	173%	131%	173%	102%	164%	119%	144%	107%	108%	107%	144%	99%	96%	132%	105%	128%	124%	150%	148%	168%	
Delta	1%	1%	34%	34%	32%	32%	34%	32%	112%	89%	280%	272%	109%	103%	93%	90%	85%	133%	121%	182%	140%	130%	83%	63%	75%	66%	102%	95%	122%	120%	
Edo	1%	1%	57%	57%	61%	55%	52%	54%	41%	29%	80%	75%	103%	105%	98%	100%	104%	95%	95%	100%	94%	85%	105%	104%	144%	135%	92%	86%	103%	111%	
Ekiti	6%	6%	53%	54%	60%	63%	47%	45%	49%	47%	86%	90%	94%	120%	72%	104%	70%	83%	66%	99%	123%	124%	86%	91%	79%	86%	97%	100%	108%	111%	
Enugu	4%	3%	85%	82%	74%	79%	140%	149%	145%	127%	213%	179%	107%	120%	102%	113%	100%	142%	122%	186%	147%	130%	104%	109%	88%	96%	118%	123%	138%	142%	
FCT	2%	2%	83%	80%	79%	76%	107%	121%	128%	128%	407%	305%	263%	182%	321%	255%	246%	262%	247%	353%	174%	160%	123%	105%	124%	102%	156%	138%	178%	172%	
Gombe	8%	7%	39%	41%	52%	60%	53%	53%	76%	82%	140%	147%	209%	154%	241%	160%	152%	172%	147%	284%	148%	120%	124%	106%	100%	105%	130%	126%	153%	154%	
Imo	1%	1%	31%	31%	29%	29%	25%	23%	95%	73%	174%	118%	103%	111%	86%	97%	90%	83%	114%	140%	119%	98%	81%	101%	85%	123%	89%	80%	114%	102%	
Jigawa	9%	9%	69%	57%	33%	30%	26%	23%	37%	25%	67%	87%	98%	103%	90%	102%	86%	94%	97%	93%	93%	93%	110%	105%	108%	103%	112%	108%	113%	112%	
Kaduna	1%	1%	84%	78%	79%	81%	67%	72%	84%	75%	77%	95%	92%	131%	113%	106%	104%	87%	97%	89%	82%	95%	112%	114%	103%	106%	122%	124%	135%	138%	
Kano	7%	7%	46%	47%	43%	41%	38%	37%	52%	67%	92%	114%	89%	98%	93%	90%	94%	124%	96%	109%	88%	93%	125%	99%	119%	93%	135%	118%	146%	137%	
Katsina	4%	4%	45%	44%	50%	48%	47%	47%	66%	62%	99%	118%	83%	106%	70%	80%	70%	75%	73%	122%	126%	73%	108%	77%	105%	72%	113%	91%	117%	104%	
Kebbi	2%	2%	49%	40%	35%	35%	36%	38%	86%	86%	110%	136%	72%	123%	64%	67%	51%	70%	93%	74%	90%	87%	117%	111%	110%	99%	115%	108%	127%	123%	
Kogi	4%	4%	104%	96%	92%	75%	63%	67%	93%	65%	97%	115%	83%	112%	99%	89%	85%	94%	114%	164%	165%	89%	111%	179%	103%	202%	125%	131%	140%	78%	
Kwara	2%	2%	54%	54%	55%	55%	52%	46%	80%	65%	49%	66%	99%	125%	88%	96%	91%	89%	92%	98%	85%	85%	104%	104%	104%	94%	120%	97%	135%	120%	
Lagos	3%	3%	73%	74%	69%	62%	59%	59%	88%	166%	153%	283%	117%	189%	116%	123%	110%	161%	113%	122%	122%	124%	132%	117%	114%	104%	146%	135%	166%	163%	
Nasarawa	3%	3%	57%	62%	58%	56%	61%	59%	82%	124%	140%	194%	147%	110%	165%	120%	135%	121%	141%	152%	132%	121%	122%	120%	112%	113%	134%	134%	148%	149%	
Niger	13%	12%	87%	92%	95%	85%	96%	123%	115%	113%	188%	221%	180%	381%	212%	142%	205%	120%	130%	97%	181%	101%	168%	114%	226%	147%	146%	97%	96%	133%	
Ogun	2%	2%	67%	68%	69%	66%	57%	58%	83%	73%	77%	81%	91%	62%	79%	48%	58%	61%	56%	58%	154%	147%	85%	90%	64%	73%	97%	103%	120%	128%	
Ondo	1%	1%	51%	48%	35%	42%	31%	31%	54%	41%	72%	69%	97%	108%	87%	94%	83%	72%	93%	75%	116%	116%	105%	107%	103%	105%	108%	109%	111%	113%	
Osun	1%	1%	32%	31%	33%	33%	32%	32%	42%	45%	60%	73%	109%	122%	89%	109%	79%	90%	68%	79%	122%	89%	90%	92%	76%	114%	96%	73%	109%	89%	
Oyo	3%	3%	77%	79%	93%	93%	90%	82%	59%	61%	56%	58%	103%	84%	81%	72%	71%	71%	99%	101%	117%	126%	77%	87%	80%	73%	86%	96%	104%	114%	
Plateau	2%	2%	34%	39%	41%	42%	44%	44%	64%	73%	87%	95%	96%	119%	175%	125%	215%	176%	301%	446%	188%	188%	118%	191%	139%	212%	96%	145%	133%	103%	
Rivers	1%	1%	18%	18%	20%	20%	20%	20%	99%	78%	112%	181%	89%	121%	87%	110%	87%	146%	98%	119%	94%	138%	139%	126%	92%	89%	142%	135%	149%	145%	
Sokoto	4%	4%	188%	174%	48%	47%	75%	67%	212%	180%	136%	132%	109%	104%	101%	98%	97%	103%	97%	94%	96%	94%	111%	107%	112%	108%	122%	118%	128%	126%	
Taraba	3%	3%	59%	47%	60%	63%	59%	66%	97%	104%	116%	148%	117%	116%	147%	163%	133%	122%	95%	108%	125%	110%	120%	111%	113%	105%	134%	127%	149%	142%	
Yobe	20%	17%	153%	138%	94%	105%	101%	110%	109%	66%	205%	109%	162%	136%	161%	116%	166%	132%	139%	120%	177%	117%	138%	134%	128%	126%	147%	147%	160%	163%	
Zamfara	2%	2%	30%	29%	31%	31%	30%	31%	53%	44%	107%	88%	84%	90%	79%	98%	73%	93%	76%	87%	88%	79%	105%	94%	101%	88%	107%	98%	110%	106%	

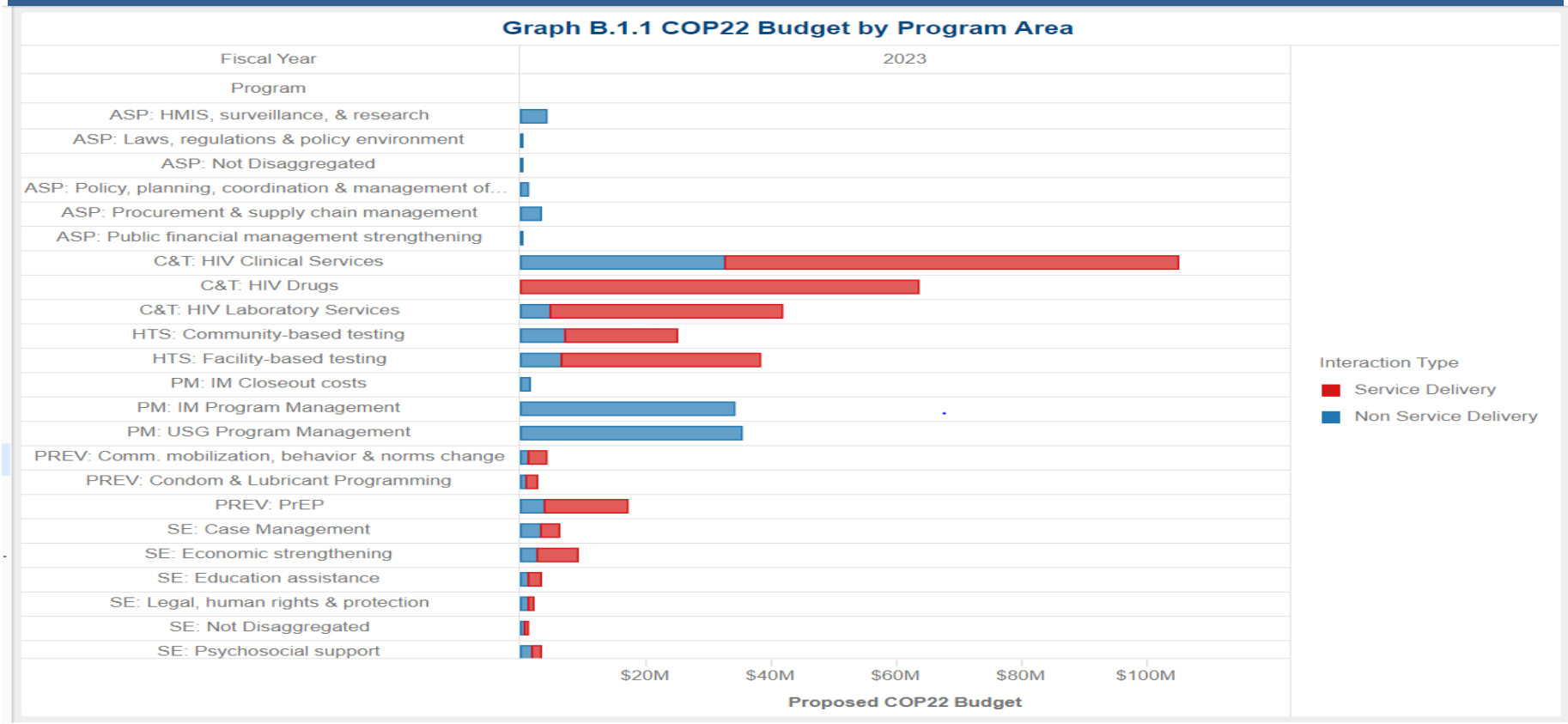
APPENDIX B – Budget Profile and Resource Projections

Operating Unit: Nigeria	COP21 Budget Pivot Table
Fiscal Year	**2023**
Intervention	Proposed COP22 Budget
Total	**$402,075,000**
ASP>HMIS, surveillance, & research>Non-Service Delivery>Non-Targeted Pop>Not disaggregated	$3,728,017
ASP>HMIS, surveillance, & research>Non-service Delivery>OVC>Not disaggregated	$390,000
ASP>Laws, regulations & policy environment>Non-service Delivery>Non-Targeted Pop>Not disaggregated	$78,750
ASP>Not Disaggregated>Non-service Delivery>OVC>Not disaggregated	$42,000
ASP>Policy, planning, coordination & management of disease control programs>Non-service Delivery>Non-Targeted Pop>Not disaggregated	$1,041,500
ASP>Procurement & supply chain management>Non-service Delivery>Non-Targeted Pop>Not disaggregated	$3,114,284
ASP>Public financial management strengthening>Non-service Delivery>Non-Targeted Pop>Not disaggregated	$391,250
C&T>HIV Clinical Services>Non-service Delivery>Key Pops>Not disaggregated	$848,904
C&T>HIV Clinical Services>Non-service Delivery>Non-Targeted Pop>Adults	$17,784,796
C&T>HIV Clinical Services>Non-service Delivery>Non-Targeted Pop>Children	$3,779,735
C&T>HIV Clinical Services>Non-service Delivery>Non-Targeted Pop>Young people & adolescents	$4,306,287
C&T>HIV Clinical Services>Non-service Delivery>Pregnant & Breastfeeding Women>Not disaggregated	$5,845,058
C&T>HIV Clinical Services>Service Delivery>Key Pops>Not disaggregated	$6,548,178
C&T>HIV Clinical Services>Service Delivery>Non-Targeted Pop>Adults	$36,839,073
C&T>HIV Clinical Services>Service Delivery>Non-Targeted Pop>Children	$10,854,469
C&T>HIV Clinical Services>Service Delivery>Non-Targeted Pop>Not disaggregated	$2,277,204
C&T>HIV Clinical Services>Service Delivery>Non-Targeted Pop>Young people & adolescents	$10,100,988
C&T>HIV Clinical Services>Service Delivery>Pregnant & Breastfeeding Women>Not disaggregated	$5,681,614
C&T>HIV Drugs>Service Delivery>Non-Targeted Pop>Adults	$48,202,056
C&T>HIV Drugs>Service Delivery>Non-Targeted Pop>Children	$6,722,369
C&T>HIV Drugs>Service Delivery>Non-Targeted Pop>Not disaggregated	$8,718,248
C&T>HIV Laboratory Services>Non-service Delivery>Key Pops>Not disaggregated	$160,988
C&T>HIV Laboratory Services>Non-service Delivery>Non-Targeted Pop>Children	$167,722
C&T>HIV Laboratory Services>Non-service Delivery>Non-Targeted Pop>Not disaggregated	$4,332,302
C&T>HIV Laboratory Services>Service Delivery>Key Pops>Not disaggregated	$2,092,847
C&T>HIV Laboratory Services>Service Delivery>Non-Targeted Pop>Not disaggregated	$34,977,515
HTS>Community-based testing>Non-service Delivery>Key Pops>Not disaggregated	$2,100,256
HTS>Community-based testing>Non-service Delivery>Non-Targeted Pop>Children	$693,823
HTS>Community-based testing>Non-service Delivery>Non-Targeted Pop>Not disaggregated	$4,298,442
HTS>Community-based testing>Non-service Delivery>OVC>Not disaggregated	$62,082
HTS>Community-based testing>Service Delivery>Key Pops>Not disaggregated	$6,444,959
HTS>Community-based testing>Service Delivery>Non-Targeted Pop>Children	$994,764
HTS>Community-based testing>Service Delivery>Non-Targeted Pop>Not disaggregated	$9,906,933
HTS>Community-based testing>Service Delivery>OVC>Orphans & vulnerable children	$431,753
HTS>Facility-based testing>Non-service Delivery>Key Pops>Not disaggregated	$1,474,205
HTS>Facility-based testing>Non-service Delivery>Non-Targeted Pop>Not disaggregated	$4,945,794
HTS>Facility-based testing>Service Delivery>Key Pops>Not disaggregated	$734,081
HTS>Facility-based testing>Service Delivery>Non-Targeted Pop>Not disaggregated	$31,039,144
PM>IM Closeout costs>Non-service Delivery>Non-Targeted Pop>Not disaggregated	$1,457,289
PM>IM Program Management>Non-service Delivery>Non-Targeted Pop>Not disaggregated	$32,192,638
PM>IM Program Management>Non-service Delivery>OVC>Not disaggregated	$1,970,686
PM>USG Program Management>Non-service Delivery>Non-Targeted Pop>Not disaggregated	$35,365,781
PREV>Comm. mobilization, behavior & norms change>Non-service Delivery>Key Pops>Not disaggregated	$564,527
PREV>Comm. mobilization, behavior & norms change>Non-service Delivery>Non-Targeted Pop>Not disaggregated	$708,036
PREV>Comm. mobilization, behavior & norms change>Service Delivery>Females>Young women & adolescent females	$647,776
PREV>Comm. mobilization, behavior & norms change>Service Delivery>Key Pops>Not disaggregated	$1,512,201
PREV>Comm. mobilization, behavior & norms change>Service Delivery>Non-Targeted Pop>Not disaggregated	$809,989
PREV>Condom & Lubricant Programming>Non-service Delivery>Key Pops>Not disaggregated	$804,942
PREV>Condom & Lubricant Programming>Service Delivery>Key Pops>Not disaggregated	$965,930
PREV>Condom & Lubricant Programming>Service Delivery>Non-Targeted Pop>Not disaggregated	$1,000,000
PREV>PrEP>Non-service Delivery>Key Pops>Not disaggregated	$966,522
PREV>PrEP>Non-service Delivery>Non-Targeted Pop>Not disaggregated	$2,919,177
PREV>PrEP>Service Delivery>Key Pops>Not disaggregated	$1,852,252
PREV>PrEP>Service Delivery>Non-Targeted Pop>Adults	$5,839,932
PREV>PrEP>Service Delivery>Non-Targeted Pop>Not disaggregated	$5,476,552
SE>Case Management>Non-service Delivery>OVC>Not disaggregated	$70,000
SE>Case Management>Non-service Delivery>OVC>Orphans & vulnerable children	$3,116,032
SE>Case Management>Service Delivery>OVC>Orphans & vulnerable children	$2,953,292
SE>Economic strengthening>Non-service Delivery>OVC>Care givers	$560,877
SE>Economic strengthening>Non-service Delivery>OVC>Not disaggregated	$1,304,338
SE>Economic strengthening>Non-service Delivery>OVC>Orphans & vulnerable children	$757,923
SE>Economic strengthening>Service Delivery>OVC>Care givers	$2,020,500
SE>Economic strengthening>Service Delivery>OVC>Not disaggregated	$4,271,496
SE>Economic strengthening>Service Delivery>OVC>Orphans & vulnerable children	$97,292
SE>Education assistance>Non-service Delivery>OVC>Orphans & vulnerable children	$1,117,526
SE>Education assistance>Service Delivery>OVC>Orphans & vulnerable children	$2,219,166
SE>Legal, human rights & protection>Non-Service Delivery>OVC>Not disaggregated	$1,304,338
SE>Legal, human rights & protection>Service Delivery>OVC>Not disaggregated	$804,665
SE>Not Disaggregated>Non-Service Delivery>OVC>Not disaggregated	$669,837
SE>Not Disaggregated>Service Delivery>OVC>Not disaggregated	$437,592
SE>Psychosocial support>Non-Service Delivery>OVC>Not disaggregated	$1,734,249
SE>Psychosocial support>Service Delivery>OVC>Not disaggregated	$1,429,257

B.1 Planned Spending in COP 2022

B.1.1 Total Funding Level				
Applied Pipeline	**New Funding**	**Total Spend**		
$3,925,018	**$398,149,982**	**$402,075,000**		
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	$210,240,353	$0	$210,240,353
PM	Program Management	$34,697,779	$922,834	$35,620,613
PREV	Prevention	$24,067,836	$0	$24,067,836
HTS	Health Testing Services	$63,126,236	$0	$63,126,236
ASP	Above Site Program	$8,785,801	$0	$8,785,801
SE	Social Economy [OVC]	$24,868,380	$0	$24,868,380
M&O	Management and Operations	$32,363,597	$3,002,184	$35,365,781
TOTAL		**$398,149,982**	**$3,925,018**	**$402,075,000**
***Central Funding - $0.00**				

Table B.1.1 COP22 Budget by Program Area



B.2 Resource Projections

The resource projections for COP22 were made using a program-based incremental budgeting approach with consideration for country program needs. This focused on the scope and intensity of activities to be implemented across the different geographic and population prioritizations 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. Partner level COP22 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 COP 22 vision. A new strategy of utilizing interventions was introduced. Also included in this budget is a $1.7million for accelerating progress in pediatrics and PMTCT.

APPENDIX C – Systems Investments Table for Section 6.0

Activity Budget	SID Element	SID Score 2019	SID Score 2021	Expected Outcome	COP22 Activity Description	If ongoing from a previous year, please provide rationale for continued spending	Benchmark from COP21 (if activity existed in COP21)	COP22 Baseline	COP22 Benchmark	Indicator/Measurement Tool
$500,000.00	14. Epidemiological and Health Data	5.99	6.18	Study provides critical evidence to shape clinical practice and policy formulation for the HIV treatment program.	S117 RV 329 Study (AFRICOS)	The African Cohort Study (AFRICOS) is an open-ended prospective cohort study, enrolling 3500 HIV infected adults ≥18 years of age, as well as 700 HIV uninfected adults ≥18 years of age at MHRP PEPFAR-associated clinical sites in: 1. Kenya 2. Tanzania 3. Uganda 4. Nigeria	To enroll 550 clients comprising of 459 PLHIV and 91 HIV-ve participants.	To enroll 550 clients comprising of 459 PLHIV and 91 HIV-ve participants.	To enroll 550 clients comprising of 459 PLHIV and 91 HIV-ve participants.	1. Number of clients enrolled in the study cohort. 2. % of clients on ART that are virally suppressed disaggregated by age and sex.
$450,000.00	3. Civil Society Engagement	7.71	6.54	Civil Society partners collaborate with PEPFAR and other stakeholders to address gaps in Nigeria's HIV response activities.	CSO Engagement Plan/Community Systems Strengthening	The activity supports and funds operational logistics for key Civil Society engagement activities developed in agreement with the CSO leaders and includes funding for the Patient Education and Empowerment Project, PEPFAR Civil Society Quarterly Meetings, the CSO-led U=U national campaigns and other developing activity detailed in the Nigeria CSO Engagement Plan.	Key activities implemented as planned. PEEP curriculum slides developed and disseminated at national (1) and regional (6) training of trainer's workshops. Dissemination will continue in COP21 with 36+1 state-level workshops for PLHIV support group leaders and the work with National Human Rights Commission to develop a Grievance Communication and Management system. Other activities remain on track with planned objectives. Some like the CSO oversight for the National AIDS Spending Assessment will	Similar community-led health and human rights literacy improvement efforts targeted at key population clients will be developed in collaboration with the National Human Rights Commission (NHRC) and the National Agency for the Control of AIDS (NACA).	1. Continue roll-out of health and human literacy knowledge for PLHIV and key populations. 2. Develop the Grievance Reporting and Response system in collaboration with NACA, FMOH and the NHRC. 3. Develop operational manual for legal and law enforcement officers on the rights of PLHIV and KP within the Nigeria legal system.	1. Number of Trainings and people trained with health and human rights literacy curriculum for PLHIV and KPs 2. Grievance management systems operational and tracking reports and interventions to address human rights infringements. 3. Operational manual developed and disseminated. 4. Other CSO engagement activities completed as planned.
$300,000.00	3. Civil Society Engagement	7.71	6.54	Civil society partners are leading the engaging with service beneficiaries and collecting information from them to improve service delivery activities and overall program outcomes.	Ambassador's Small Grants/Community-Led Monitoring	In the current year, the Ambassador's Small Grants will provide a limited number of grants to not-for profit organizations with capabilities to work to implement Community-Led Monitoring of the national HIV programs. These include the monitoring of HIV service delivery at the health facility level as well as the routine and systematic gathering of crucial information and observations about the quality and accessibility of HIV services from the client's perspective.	1. 15-20 grants awarded 2. At least 200 visits conducted by CSO 3. 150 sites covered by CLM activities.	1. Grantee's selection completed. 2. Training of grantees on CLM priorities and data collection processes will be completed soon. 3. Sub-grantee awards commenced.	1. 15-20 grants awarded 2. At least 200 visits conducted by CSO 3. 150 sites covered by CLM activities.	1. Grants awarded and implemented 2. Number of CLM visits conducted by CSOs 3. Number of sites covered in CLM activities
$320,000	14. Epidemiological and Health Data	5.99	6.18	Enhanced linkages of OVC data bidirectionally to NDR and, OVC situation room	NOMIS 3.0 -Upgrading NOMIS to incorporate new GON/PEPFAR Indicators, enhancing usability	This activity will overhaul NOMIS in line with current stakeholder needs so that data can be more easily analyzed to strengthen targeted services/approaches.	1. A survey of current NOMIS users to understand need and gaps has been completed. 2. A bootcamp held to commence review and update of the existing infrastructure. 3. Design of upgraded infrastructure has commenced.	1. A survey of current NOMIS users to understand need and gaps has been completed. 2. A bootcamp held to commence review and update of the existing infrastructure. 3. Design of upgraded infrastructure has commenced	Enhanced use of OVC data for decision making with Fed. Ministry of Women Affairs Situation Room Personnel leading monthly data pulls & reviews All OU OVC Service Delivery Point data onboarded in NDR	Monthly OVC situation room meeting notes
$200,000	11. Domestic Resource Mobilization	5.56	5.99	Increased budget HIV/AIDS allocation and execution	Improved public financial management and domestic resource mobilization (DRM) to: help close RTK gap (short term) and ensure long term sustainability of HIV services	1. The HIV/AIDS response in Nigeria is entirely donor dependent with inadequate domestic funding for the response 2. DRM is critical to achieving and sustaining HIV epidemic control in Nigeria. 3. GON must also be pressed to commit to increased funding of the HIV response, including the provision of RTKs. 4. Additionally, increased host country funding reduces the cost to PEPFAR and helps free up already stretched resources to other priority areas.	1. Increased budget allocations and releases for HIV; 2. Increased state govt purchase of RTKs	1. Increased In budget allocation and release - the Lagos State Agency for the Control of AIDS has increased its budget by 32% to NGN 683.6 million. In addition to efforts to encourage governments to increase HIV budgets, we have advocated for additional expenditures on test kits and other commodities, resulting in a 167% increase in funds released from NGN 136.5 million in 2018 to NGN 364.0 Million in 2021. 2. The activity led to 265,000 RTKs purchased by the LASG.	1.Increase in Public sector budget allocation for HIV/AIDS. 2. % increase in State government purchase of RTKs	1. Increased budget allocations and releases for HIV; 2. Increased state govt purchase of RTKs

Activity Budget	SID Element	SID Score 2019	SID Score 2021	Expected Outcome	COP22 Activity Description	If ongoing from a previous year, please provide rationale for continued spending	Benchmark from COP21 (if activity existed in COP21)	COP22 Baseline	COP22 Benchmark	Indicator/Measurement Tool
$450,000	11. Domestic Resource Mobilization	5.56	5.99	Increased domestic resources for HIV/AIDS including integration and uptake of HIV services within health insurance schemes	Improved domestic resourcing and sustainable financing mechanisms for HIV in Nigeria through leveraging GON sponsored State Health Insurance Schemes, particularly the integration of HIV services in the minimum health insurance service package. Support to GON in the implementation of HIV/AIDS sustainability strategy	• 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. • Additionally, increased host country funding reduces the cost to PEPFAR and helps free up already stretched resources to other priority areas.	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	1. Official inclusion of HIV services into health insurance package 2. Commencement of HIV service provision within Lagos State Health Insurance Scheme 3. Enrollment of over 500,000 persons into the Lagos State Health Insurance Scheme, with 1000 OVCS and 280 KPs fully covered under the scheme 4. National DRM Strategy developed and implementation currently underway	1. Increase in coverage of HIV services within health insurance packages; 2. Provision of TA for implementation of National and State DRM strategies	1. Demonstrated coverage of HIV services within health insurance packages in Lagos; 2. Increased domestic resource mobilization for national and state HIV response from both public and private sectors.
$3,114,284	10. Laboratory	5.94	6.89	Improved access to VL/EID testing, enhanced capacity utilization, reduced cost of sample referral and shorter TAT for test results	National Integrated Sample Referral Network (NISRN) - Will coordinate the integrated transfer of Viral Load, EID and TB samples from hub sites to PCR Labs and GeneXpert laboratories and return of results within defined turn-around-time	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).	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	1. Transported a total of 1,668,941 samples in FY21. 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 NiMS 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	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
$3,797,667	14. Epidemiological and Health Data	5.99	6.18	NDR data warehouse that provides near real-time data for program monitoring, including recency surveillance analytics and dashboard for public health action. Additional enhancements and optimization that prevent double counting of client on treatment, allow clients' access to care in sites other than their primary ART initiation site, as well as a comprehensive, user-friendly and customer centric analytic workspace.	1. A high-level client registry with tier interaction and facility access to the NDR to investigate and determine treatment status of new clients at time of presentation. The system will use biometric data to identify and deduplicate patients using their fingerprints to produce unique longitudinal patient data. Non-naïve patients on transit can access care anywhere via online authentication services without being reported as IIT. 2. A comprehensive, user-friendly and customer centric analytic workspace that will allow users to design, select, and organize data elements for analytics and visualization.	Information platform (NDR) is still rudimentary, requiring investment and high-skilled HR. Utility is currently largely PEPFAR-centric, host government is yet to fully integrate into local HIV plan, and to have an investment line in the federal domestic budget to sustain.	1. 100% of PEPFAR health care facilities patient level data to NDR 2. 100% of facilities supported to upload patient biometric data to NDR 3. 100% of PCR labs with LIMS data directly integrated to the NDR		1. 100% of PEPFAR Facilities reporting TX_CURR through the NDR 2. 40% of health facilities are able authenticate clients at the point of enrollment 3. A comprehensive, user-friendly and customer centric analytic workspace that will allow users to design, select, and organize data elements for analytics and visualization. 4. Recency surveillance alert system to support public health action available on NDR and EMRs	1.Number of health facilities reporting TX_CURR, TX_PVLS. 2. Number of facilities with fully functional client authentication system. 3.Functional analytic workspace. 4.Functional recency surveillance alert system.

APPENDIX D– Minimum Program Requirements

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

	Minimum Program Requirement	***Updates***
Case Finding and Treatment	1. Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to uninterrupted treatment across age, sex, and risk groups.	The Country is on track on this MPR. All sites implement Test and Start with most sites providing Same Day ART initiation. The linkage rate of 98% as at end of FY 22 Q1
	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 who are ≥4 weeks of age and weigh ≥3 kg, and removal of all NVP- and EFV-based ART regimens.	Over 95% of newly identified PLHIV are linked to treatment and over 95% of all patients currently on ART are receiving a Dolutegravir (DTG) based regimen
	3. Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups.	The following Differentiated service delivery (DSD) models are being implemented: Fast-track, peer managed drug delivery (OTZ, support group clubs etc.), decentralization of services to spokes, six months, multi-months scripting, community base models that include community pharmacy ART refill, and community ART service delivery
	4. All eligible PLHIV, including children and adolescents, - should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	All eligible PLHIV including adults and adolescents receive TPT and cotrimoxazole as part of the comprehensive treatment package. The TPT completion rate at the end of FY 21 Q4 stood at 95% for adults and 85% for children, respectively.
	5. 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 country program is on track with the implementation of Diagnostic Network Optimization. The first and second phases, which included the streamlining of supported PCR labs for VL/EID, establishment of Mega Labs, and the roll-out of integrated sample referral systems have all been completed. The continuous process of upgrading aged PCR equipment in the lab network is ongoing and on track. The roll-out of integrated testing for HIV, TB, COVID-19 and other priority pathogens is on-going and on track. A major limitation within the program is ensuring 100% access to EID and annual viral load, with results delivered within 4weeks. The country team has prioritized these for focus in the current fiscal year and moving forward. New approaches and interventions to help address these have also been proposed in COP22 including but not limited to: 1) Roll-out of POCT for EID to complement centralized testing on conventional equipment, 2) implementation of all-inclusive pricing for VL/EID reagents across all vendors, 3) sustained upgrading of aged and low throughput equipment within the network, and 4) roll-out and expansion of plasma separation card for VL to complement DBS and Plasma sample types to increase service uptake.
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 should be offered testing for HIV.	Safe and ethical index testing guidelines and standards have been institutionalized and inform all scale-up efforts. Data collection and reporting are being monitored and reviewed across all SNUs with government supervision. ICT acceptance rate of 90% or greater triggers investigation for any remote possibility of coercion. TOT on HIVST has been conducted in practically all SNUs while demand creation and scale-up of interventions for adolescents are ongoing. IPV monitoring and interventions for both Index testing and HIVST have been incorporated into all approaches including data collection tools. Scale up of PITC and SNS for children of PLHIV have been fully integrated. All children of PLHIV <19yrs are offered HTS through case managers including children of PLHIV within the OVC and KP program.
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)	The program will continue to scale up the offering and provision of PrEP services to HIV positive KPs, their sexual and injecting partners; HIV positive partners of index clients; HIV positive pregnant and breastfeeding mothers with partners of unknown HIV status; HIV positive partners of newly enrolled HIV positive clients who are not virally suppressed amongst other persons identified at substantial risk. In addition, scale of the provision of ED-PrEP with high risk negative MSM who are eligible Priority focus for scale up of PrEP services will include high risk young persons in COP22 prevention activities.
	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 1) actively facilitating testing for all children at risk of HIV infection, 2) 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 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	OVC services are focused on high burden facilities with HIV assessments conducted during home visits to households at risk and referrals provided for testing and enrollment into pediatric treatment and care services. Vulnerable adolescent girls are provided with HIV prevention services using the OGAC approved OVC preventive curricula with integrated HIV testing services to find the positives. Additionally, these curricula are used to prevent sexual violence and provide support to caregivers of high-risk adolescents.

Policy & Public Health Systems Support	1. In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups.	PEPFAR Nigeria has continued to support implementation of structural interventions that ensure access to health services, and non-discriminatory KP competent healthcare delivery for Key Populations. PEPFAR Nigeria is implementing legal/ human rights " know your rights" literacy activities as part of peer trainings, supporting access to paralegal support for violations and abuse cases and collaborating with NHRC and relevant stakeholder in the supported states on channels of reporting grievances and seeking redress for all KP typologies. In addition, advocacy for policies that protect children, adolescents and young persons is a key focus of adolescent responsiveness and OVC programming in Nigeria. PEPFAR continues to work with federal and state institutions to domesticate and implement child protection policies such as the child's right law and legislation to protect women and girls and with GON to mainstream the delivery of adolescent and youth friendly health services using evidence-based models and strategies. Implementing partners invest in community stigma reduction activities and encourage participation in the violence protection, reporting processes and legal processes through institutions that punish violators and abusers of children, adolescents, and young persons.
	2. 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.	PEPFAR Nigeria has made progress through engagements with civil society, GoN and multilateral partners, to negotiate the waiver of user fees, especially for pregnant women, children, and other vulnerable populations. Also, PEPFAR Nigeria has made progress in its engagement with the host country in funding HIV/AIDS service delivery through the expansion of the National Health Insurance Scheme. In addition, the host government has launched a private sector led HIV trust fund to mobilize and deploy domestic private sector resources to address the funding gap in Prevention of Mother to Child Transmission of HIV in Nigeria.
	3. OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy.	The OU is making progress on implementing Quality Assurance (QA) and Continuous Quality Improvement (CQI) programs at site level as part of program management. ESM provides overall strategy for CQI and focuses on using in-depth analysis of site-level data to obtain a deeper understanding of health facility and patient-level factors affecting performance and apply the information through an intensified CQI approach to improve program performance. As of FY 22 Q1, nearly all PEPFAR supported sites are implementing a CQI project to address a gap in program implementation. Since the advent of COVID-19 pandemic, all PEPFAR supported sites are implementing Infection Prevention & Control practices to safeguard safety.
	4. Evidence of treatment literacy 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.	Treatment literacy has become an increasingly relevant component of Nigeria's national HIV response. The Patient Education and Empowerment Plan, a health and human rights literacy program funded by PEPFAR, is a collaboration between the Network of People Living with HIV in Nigeria, the National Agency for the Control of AIDS, the National Human Rights Commission, and the Federal Ministry of Health. Similarly, engagements targeted at vulnerable key population communities, women, and adolescents, have been planned to be funded by the Global Fund through NACA. At the same time, implementing partners and local civil society have been implementing a nation-wide U=U campaign that was launched in 2020. The details of these activities are captured in relevant sections of the Strategic Direction Summary 2022.
	5. Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses	PEPFAR Nigeria has dramatically increased the proportion of its direct funding to local partners (LPs) in the past few years. In COP22, CDC will award 99.6% of its total funding to LPs, while USAID will award 87.5% of its non-commodities funding to LPs, a significant increase from its COP21 level of 53% to LPs. In addition, all of the Ambassador's Small Grants funding has been awarded to LPs. Pepfar currently funds women-led implementing partners and CSO-led organizations to provide comprehensive HIV services as part of our commitment towards equity and equality both in principle and practice.
	6. Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended	The Government of Nigeria made a commitment in 2020 to provide ARVs for 100,000 PLHIVs, and they have demonstrated this over the past two years by providing ARVs for 74,000 patients in 2021 and 97,000 patients in 2022. GON has made an additional commitment for 130,000 patients in 2023 and we will also be tracking its fulfilment. This is in addition to the procurement of four million RTKs in 2021/22 to support the PMTCT program.
	7. 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.
	8. Scale-up of case surveillance and unique identifiers for patients across all sites.	Using NDR as a platform, HIV Case Based surveillance has been expanded beyond the general population, to cover and report sentinel events for other sub-populations - KP, Pregnant Women and Breastfeeding mothers, Pediatric and Adolescent. Recency surveillance coverage has increased to targeted facilities in 34 of the 37 states in the country while mortality surveillance is implemented in some facilities across 8 states. Fingerprints, as a unique identifier, now covers over 80% of PLHIVs active on treatment. The fingerprints data is currently used for deduplication to correctly account for clients that are current on treatment. Plans include optimizing the health information exchange infrastructure to enable real-time authentication of fingerprints at the point of ART initiation.

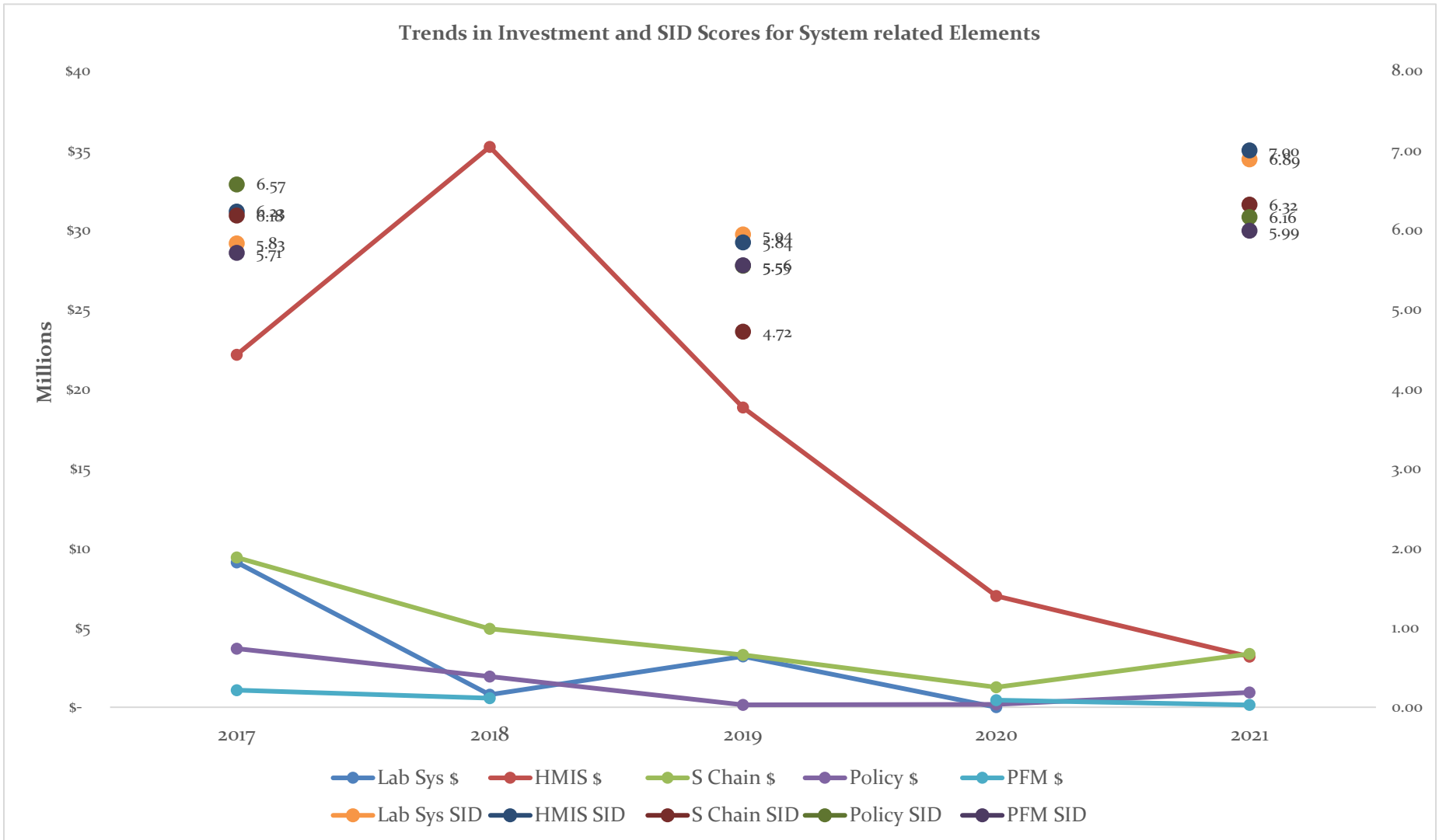
APPENDIX E – Assessing Progress towards Sustainable Control of the HIV/AIDS Epidemic

1. Misalignments between Investments and Outcomes

- ***Program Expenditures vs. SID Score Trends and Responsibility Ratings:***

The first of these analytics compares trends in systems-related (above-site programs) expenditures to changes in relevant SID scores to demonstrate where cumulative investments in these areas may have contributed to improvements in SID scores over time.

Figure E.1.1 - Trends in Investments and SID Scores for System-Related Elements



In the country's context, however, efforts have been made to streamline above-site investments in the past couple of years. This has meant that PEPFAR has allocated significantly less resources during this time period to above-site investments, as is reflected in the expenditure trend lines. This reality, however, hides the fact that a lot of system-focused investments have had to be deployed at the service points level to support the primary function of service delivery across in the HIV program. Despite the falling trends in above-site expenditures, the SID elements have mostly trended in a positive direction, reflecting the ability of health system actors to preserve the gains of prior year investments and improve performance, over time.

Overall, the declining trend in PEPFAR above-site investments reflect the intentional effort to engage other donors, especially the Global Fund, in funding key health system activities. The extent to which the three main funders of Nigeria's HIV response contribute to funding health systems' functions related to the HIV response, is summarized in tablebelow.

Figure E.1.2. Percent Primary Responsibility Ratings from Responsibility Matrix

% Primary Responsibility Ratings from Responsibility Matrix			
Health Systems Area	**Host Country**	**PEPFAR**	**Global Fund**
HMIS	10%	60%	20%
Laboratory Systems	5%	85%	10%
Supply Chain	5%	80%	15%
HRH Systems	60%	35%	5%
Policy	65%	25%	10%
Public Financial Management (financing for national HIV programs) [13]	5%	67%	28%
Other Systems Support	10%	65%	25%
Health Workforce	75%	20%	5%

The three funding institutions play significant roles in different aspects of the Nigeria HIV and AIDS response in Nigeria. The external funders, PEPFAR and the Global Fund, play a greater role in funding the Laboratory, Supply Chain and the HMIS. They both play an

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

essentially supportive role in supporting systems, infrastructure, human resources and health workforce (especially those that are facility-based) and as such, these aspects of the program may be easier to transition to the host country partner.

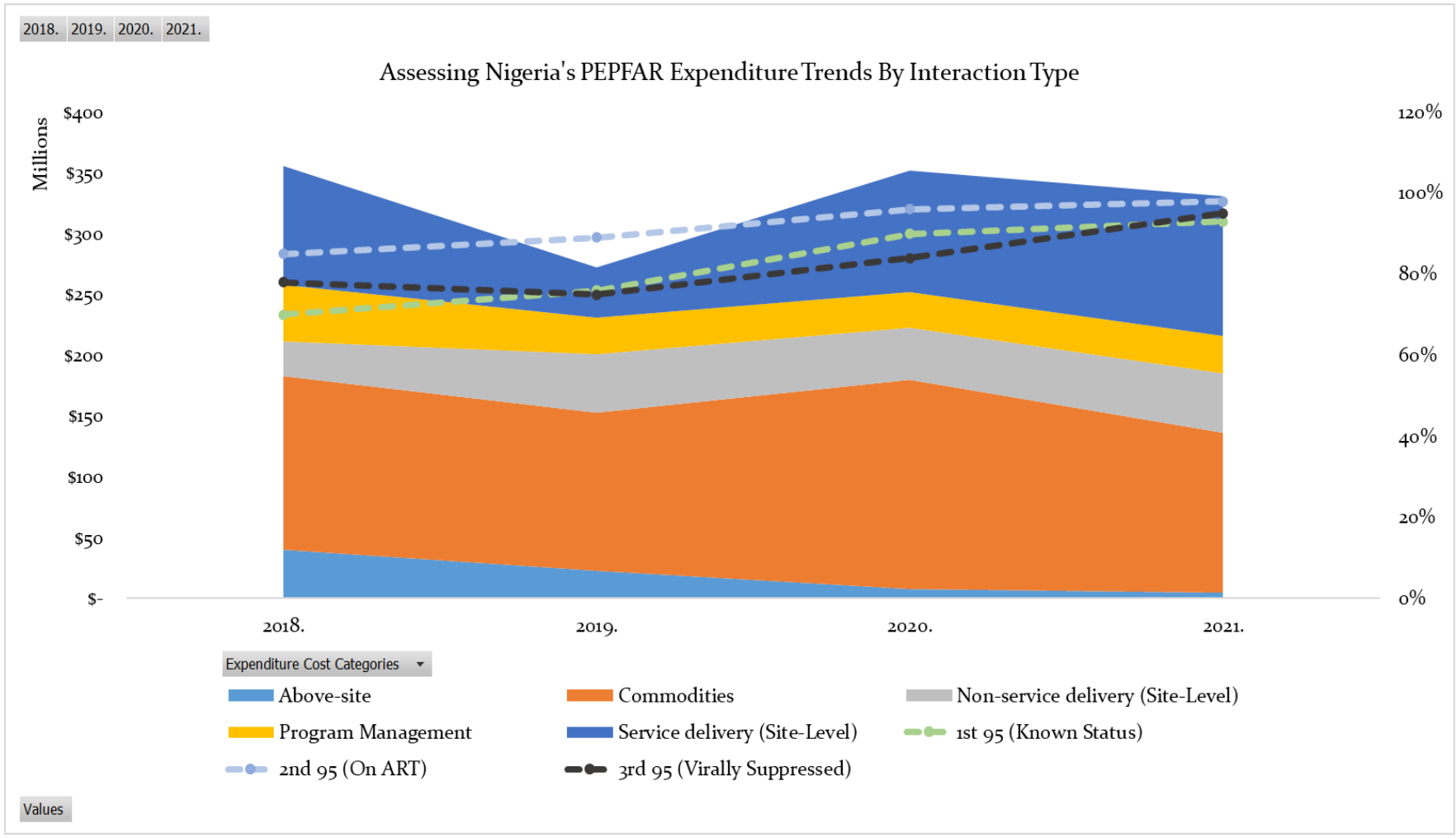
With those system that are still quite dependent on the external donors, sustainability efforts are currently focused on aligning the activities to eliminate duplication and streamlining processes to make them more cost effective and as such, more likely to be transitioned and maintained by the host country. Improvements in domestic financing for HIV and the integration of HIV financing costs into the evolving national health insurance schemes may offer opportunities for increased host country responsibility for financing HIV program needs but these efforts are still a long way off from being significantly capable of meeting the expected needs.

- ***Trajectory of Service Delivery, Commodities, Non-Service Delivery, Above Site Program, and Program Management Expenditures and Country's Status of Achieving HIV/AIDS Epidemic Control:***

The second of these analytics (Figure E.1.3.) looks at trends in service delivery, commodities, non-service delivery, above-site programs, and program management spending by the country's performance towards epidemic control. This analysis aids in understanding how investments are being strategically done and where there is a need for optimization based on program priorities and needs. As countries approach epidemic control and programs mature to a level needed to sustain their achievements, the overall level of non-service delivery spending (on activities such as training, supportive supervision, mentorship, etc.) should stabilize and potentially decrease.

For Nigeria, the increase in expenditure at the site-level drove the improvements in the country's epidemic control from 2018 to 2021. Relative to the positive trends in the country's treatment cascade, commodities costs have changed only to a small degree, reflecting the cost efficiency gains. Although, commodities continue to be the major cost driver of the country's HIV response. As noted previously, above-sites investments have fallen over time while program management and non-service delivery site-levels cost have largely stagnated.

Figure E.1.3. Assessing Country X's PEPFAR Expenditure Trends by Interaction Type and Epidemic Control Status



- ***HRH Remuneration by Site/Above Site & Service Delivery/Non-Service Delivery:***

The last set of charts compares expenditure data for staff by program area and site or above-site level. This show where PEPFAR is investing in staff. This is aimed to assess if PEPFAR's investments are sufficiently targeted and will inform negotiations on increased local ownership of the workforce required to deliver HIV services.

Recent HRH Inventory report from 2021 shows sustained HCW salary transition in the site-level clinical Direct Service Delivery (DSD) cadre (Figure E.1.4b), except in the Other Staff and Ancillary cadres. PEPFAR Nigeria will sustain its continued advocacy with host government for complete HCW salary transition for these site-level DSD cadres, and ensure it is a key component of PEPFAR-host government investment alignment negotiations for increased local ownership and sustainability.

E.1.4.a Remuneration by Site/Above Site & Service Delivery/Non-Service Delivery

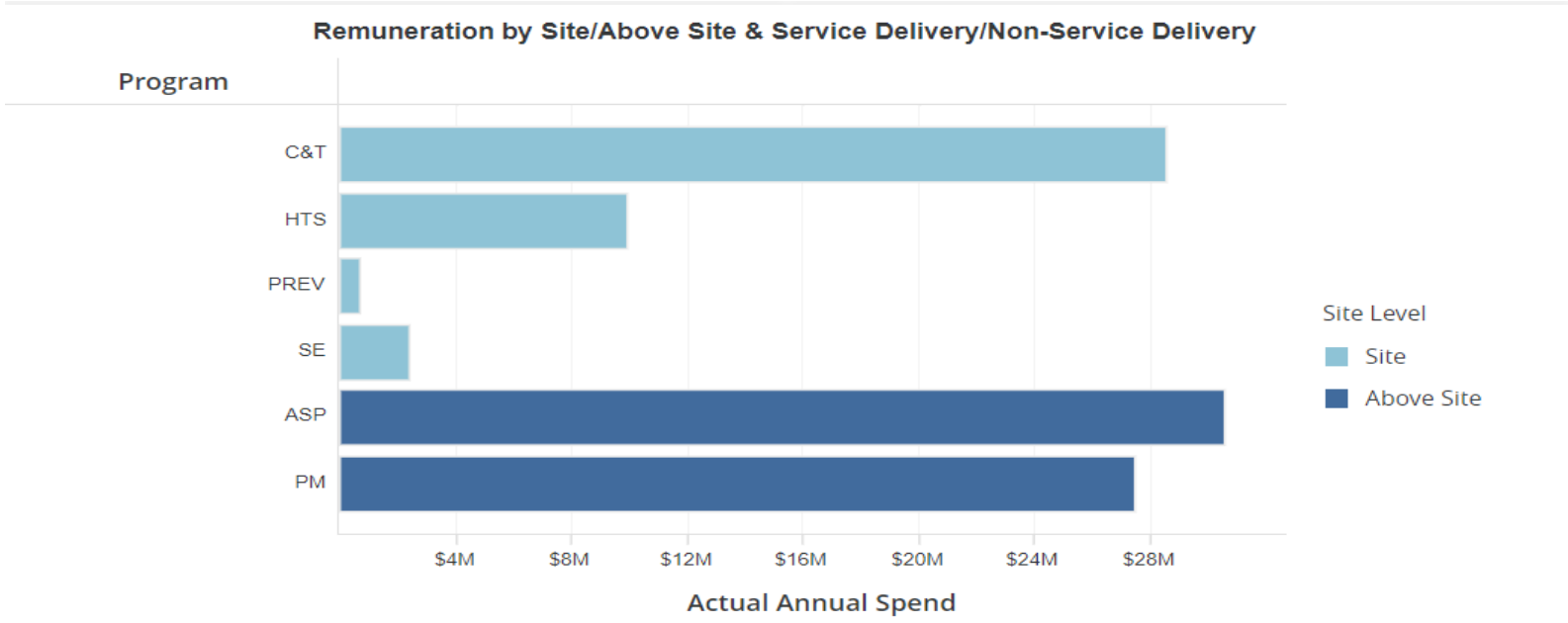


Figure E.1.4b. Remuneration by Employment Category

2. Areas for Transition

The on-going national alignment process has presented several opportunities to advance transition efforts and planning for future sustainability of the national HIV/AIDS programs. Three major areas that the country has set activities in motion to achieve this can be seen in the recently launched HIV Clinical Mentorship program, the national PMTCT scale-up plan, and in the related plans for sub-national Governments to play a more significant role in support of community HIV testing services.

The HIV clinical mentors, though currently funded by PEPFAR, are embedded within the structure of the State Ministries of Health and serve to improve coordination between the states Ministries of Health and NASCP. They primarily support HIV treatment facilities to maintain the required standards in delivery of HIV treatment and PMTCT services. Their roles will likely evolve over time to include primary responsibility for leading and mobilizing States Ministry of Health technical staff in carrying out supportive supervision activities. By doing so, they will eventually replace the PEPFAR IPs in the States and will be more cost-effective to maintain service delivery competencies within the public sector, when the PEPFAR program is fully transitioned to the Government of Nigeria.

The new PMTCT surge plan is purposely designed to ensure the State Ministries of Health play a major leadership and implementing role in mapping and identifying new PMTCT facilities to be established. They will also train, support, and monitor these new service providers and coordinate other stakeholders' efforts to achieve the desired national outcomes. From the beginning of the PMTCT surge plan, the host country institutions at national and sub-national levels will have primary responsibility for mobilizing the needed resources to support these activities while ensuring timely reporting and analysis of data for prompt decision-making.

Part of the PMTCT surge planning is also the activation of community testing activities and community health systems structures supported by the Government. This will be led and implemented by the State Ministries of Health. These will also include extending HIV testing services to traditional birth attendants and other community institutions where pregnant women visit for psychosocial and maternity support.

The National HIV Trust Fund is already positioned to be a major domestic resource mobilization and funding unit for the national PMTCT surge and it is expected, that as more resources become available, the host country will take on additional responsibilities in funding the national HIV response as PEPFAR and Global Fund scaled back and re-directe funding towards other more critical activities in the program.

3. Engagement with Partner Country Governments in COP22 to Ensure Sustainability of Core Elements of the HIV Response

Starting in FY2020, Nigeria's HIV program stakeholders commenced what became the first phase of a national alignment plan. This process, as experienced in the country in the last two years, has implemented a National HIV Treatment and PMTCT Plan (NTTP) which was co-funded by PEPFAR, the Global Fund and the Government of Nigeria. This established clear roles and responsibilities according to each partner's recognized area of comparative advantage. This alignment has been one of the critical success factors for the country's strong achievements in massively scaling-up HIV case-finding, treatment, and viral load services. Subsequently, the national alignment has been recognized as an opportunity to advance the efforts in ensuring sustainability of the HIV response.

During the COP22 planning process, the PEPFAR team facilitated several engagements to help shape the next phase of the national alignment. Several additional components of the national HIV program were identified for future alignment. These included the need to align the investments in health systems components , the national commodities supply chain systems, the national integrated HIV laboratory network, and the national HIV strategic knowledge management systems. Stakeholders in these three health system areas were mobilized and tasked to develop a common framework for looking at how current investments align to fulfill program needs and address system gaps. Preliminary outcomes of these engagements were reviewed at the Virtual Planning Meeting, and it was agreed that the discussions will continue until all potentially duplicated activities have been streamlined. This process will also help to establish the limits of these investments and to ensure that stakeholders understand the priority health systems' processes and activities needed to sustain the delivery of quality HIV treatment and PMTCT services. Other areas of alignment include community systems, structural interventions for human rights and gender. These conversations will need to happen in a broader stakeholder space with additional Government institutions like the National Human Rights Commission, the Ministry of Justice, and the Ministry of Woman Affairs.

The implementation of a fully aligned national HIV program sets the background for future engagement to help the host country institutions fully understand the priority activities, and how to streamline and integrate them over time into host Government systems. Stakeholders have agreed to regroup in the latter part of 2022 to finalize plans for the next alignment phase and to develop a framework for sustainability planning. It is important to note that there is already an on-going engagement led by the Department of Planning, Research and Statistics in the Federal Ministry of Health, to develop a sustainability plan for the whole health sector. However, these engagements have not been as profound as they will need to be to fully address the needs of the national HIV response.

4. Agreements and plans on Data Use and Sharing and Quality control (including Central Support reporting).

Over the years, PEPFAR supported GoN on the development of a robust health information exchange (HIE), including the National Data Repository (NDR) with a shared health record with de-identified patient level information for clients receiving ART. The GoN has since taken leadership and governance of the HIE investments. With technical assistance provided by PEPFAR and its IPs, the GoN is setting up frameworks and developing guidance documents including electronic medical record implementation guidelines, data use and data sharing agreement, and data quality review guideline.

Data from the NDR and the accompanying dashboard is instrumental for monitoring the country's progress towards HIV epidemic control. Data use for routine programmatic reporting to OGAC and GoN, in addition to intensified monitoring, is available to stakeholders via the NDR dashboard (https://ndr.phis3project.org.ng). Access (username and password) to the NDR dashboard is provided to all stakeholders of the national HIV response. The NDR dashboard has built-in data quality review (DQR) module as an additional layer to the data quality assurance processes built into the EMRs, the EMR extraction module and NDR reporting module. The DQR module reports gaps in client-level data completeness at client.

Under the purview of GoN/FMOH, reports of data quality are deliberately and actively shared with implementing &technical partners for prompt actions. Access to data on the NDR for specialized studies, evaluation and research is governed by the National HIV data use agreement (DUA), which was assented for use by the Honorable Minster of Health in February 2020. Concept notes or protocols approved by the National Health Research Ethics Committee or relevant Institutional Review Boards are submitted with dummy tables to FMOH's Office of Coordinator, National AIDS STI Control Program for review and approval through the NDR Analytical Database. Data is released to the recipient in accordance with the confidentiality and security policy in the DUA.

APPENDIX F- COP22 Civil Society Engagement Outcomes

Table F.1 – Feedback on CSO input for COP22

Specific Request	Response
1. We had recommended expanding the scope and coverage of CLM to cover all States and other thematic areas outside health facility and adopt a "Task Team" model. We have since been informed that this year's CLM will deployed through the Ambassador Small Grant where 10-15 organizations will be engaged.	**Unlike this FY21/22 year's exercise where CLM was funded through an IP, CLM activities currently to be deployed through the Ambassador's Small Grant. This will allow us to fund about 12-15 organizations (selected through a competitive grant application) to conduct CLM activities.**
2. Promote Knowledge Management and Learning through support for the Annual Accountability Forum for reviewing previous COP years and Community COP serve as a platform for setting community agenda for the next COP year.	**From investments in the CSO engagement plan, PEPFAR can potentially support the CSOAF as it has done in prior years, but the proposal will need to be reviewed at the appropriate time for consideration. There is a desire to demonstrate that these investments are achieving the desired impact.**
3. Engage communities and human resources for strengthening community-led responses to EMTCT.	**PEPFAR Implementing partners will be engaging community members in the implementation of the Community PMTCT services. PEPFAR will be advocating for similar action by NASCP with respect to their lead role in the new national PMTCT scale-up plan.**
4. Address harmful norms and practices, SGBV, inequalities, stigma and other issues affecting access beyond health facilities through a dedicated fund for interventions outside of health facilities. For example, the root causes and drivers of SGBV are in the communities and should be tackled in the communities.	**Beyond the already set data collection systems, the grievance reporting and redress work of the PEEP will seek to respond to these and related human rights issues. Similar efforts will be made through the GF-fund national $1.3m Gender and Human Rights plan. Additional efforts led by the Joint UNAIDS team will work to ensure improved coordination, streamlining and mobilization of stakeholder activities in this area. Additional details in Section 2.6 and 2.7 of the COP22 SDS (above).**
5. Prevention Intervention Programs targeted at AYP (including in-school and out-of-school youths) with appropriate and comprehensive messaging using organized structures and channels to help prevent new infections. PEPFAR has committed to engage the relevant TWG on this.	**This is a program-related request. The relevant TWG will be tasked to highlight this aspect of their work in future engagements with the Civil Society community.**
6. Primary Prevention of Sexual and gender-based violence targeted at male and female AYP – Same as above	**See response to 4 above**
7. Promoting Youth-led treatment literacy program for AYP towards increasing treatment uptake and retention in care and support services.	**This is the objective of the OTZ program. The relevant TWGs and Implementing Partners will be engaged to elucidate this aspect of their work to the Civil Society community and help more of the organizations find opportunities for collaboration.**
8. Comprehensive access to youth friendly HIV/AIDS, SRH services, eliminating all user fees for sustainability.	**The Youth-friendly clinic model is well recognized within PEPFAR and is support by PEPFAR implementing partners. There has been some success with the user fees component and the Nigeria US mission sustains ongoing advocacy to see this implemented in more states.**
9. Active engagement of young PLHIV as service providers in treatment sites.	**This is already happening to a significant scale and will be expanded as the opportunities present to implementing partners.**
10. Access to PMTCT services for AYP to bridge the gap of age.	**PEPFAR recognizes the need to focus more attention to the first two prongs of the PMTCT program. It requires broader multi-sectoral action led by NACA and the Joint UNAIDS team.**
11. Prioritize PLHIV as service providers for ART and PMTCT - Case Managers, Adherence Counsellors, Mentor Mothers, etcetera should be PLHIV unless where they are not available for engagement. We ask that PEPFAR have this incorporated into the national scale up plan.	**This is an ongoing effort.**
12. Improve remuneration of PLHIV as 'experts' in their own rights and abolish exploitation of PLHIV as casual workers in treatment facilities by IPs.	**PEPFAR agencies have messaged this important HR consideration to all implementing partners especially as regards ensuring the appropriate categorization and remuneration of community members engaged in any service delivery role. Fully recognizing the limitations of the national Labour laws as regards the engagement of lay-workers, PEPFAR is supportive of a broad-based Civil Society-led effort to engage appropriate structures to see these gaps addressed.**
13. Promoting interventions for increased awareness and rights-based approach for responses to stigma and discrimination.	**See response to 4 above**
14. Strengthening the capacities of PLHIV and Community Organizations for Community-led community engagement for HIV prevention and treatment, PMTCT, SGBV and SRH interventions. This can be incorporated in the CLM agenda.	**PEPFAR-funded CLM interventions has always been led and implemented directly by Civil Society. CLM is currently supported through the Ambassador's Small Grants program through which CSOs receive funding directly for CLM activities.**
15. Scale up and cascade PEEP to the grassroots to promote community ownership and ensure sustainability. We are aware that this is in the PEEP planning and look forward to seeing it rolled out.	**This is already part of the on-going phased scale-up. The PEEP objectives will also be support through the GF-funded national Human Gender and Human Rights plan.**
16. Reintroduce other tests beyond Viral Load and CD_4 Count tests as part of Test and Treat and routine tests in view of reports of increased morbidity and mortality among HIV treatment clients due to late detection of liver and kidney problems – regardless of ability to pay.	**Given the country's successful ART optimization effort, most PLHIV now have access to much safer ART drug options and national data does suggest a declining trend in mortality of PLHIVs.**
17. Expand the geographic reach of interventions for people who inject drugs to cover 36 states of Nigeria.	**PEPFAR is supportive of a national alignment agenda to achieve this as priority HIV services are expected to be universally accessible.**

18. Capacity building and Support for drug user community organizations and collectives on Community Led Monitoring.	**Several of these organizations have been participating the PEPFAR-funded CLM activities.**
19. Support continued engagement of PWID organizations with law enforcement agencies especially the "enforcement unit" for protecting the rights of people who use drugs.	**This is very much part of the broader agenda on human rights. See response to 4 above**
20. Scale up of SRH for women who inject drugs, especially in areas of PMCT and OVC care	**The recommendation is well received as part of a need broader response to improve service access generally to key populations in line with the new standard package of services.**
21. Engage the enforcement unit against arbitrary arrest and rights violation.	**This is very much part of the broader agenda on human rights. See response to 4 above**
22. We are aware that PEPFAR supports FBO programmes including through implementing partners in Nigeria, however this needs to translate to the level of the congregation.	**The national community PMTCT scale-up plan has a significant focus on the role of congregations and will be exploited where the opportunities present.**
23. Support capacity building for faith-based responses to stigma, discrimination, and human right issues against PLHIV and KP and OVC response. We are aware this is currently happening but needs to be scaled up.	**Already happening. PEPFAR notes the request to have further scale-up based on the availability of resources.**
24. Relevant Government agencies to collaborate with FBOs in addressing stigmatizing practices like pre-marital HIV testing by religious institutions.	**Also, an agenda on the PEEP as there are several rights-related issues emerging from these practices.**
25. Just like PEPFAR has priority grants for KP, OVC etcetera in the PEPFAR Small Grants, they can give priority grants also for small FBOs in rural communities to help expand reach in underserved communities.	**Prioritization of any thematic areas or population is very often, determined by epidemiological considerations.**
26. Law enforcement agencies, hotel managers and gatekeepers should be included in human rights training as they affect FSW	**Law enforcement agents are a special target audience in the national Gender and Human Rights plan.**
27. Prioritize SRHR interventions without leaving out the last "R"	**PEPFAR already places significant priority on the human rights aspects of Sexual and Reproductive Health services.**
28. Access to PMTCT for FSW as many FSW deliver at home due to stigma experienced in ANC clinics	**The PMTCT needs of key population is fully recognized by the national guidelines and is part of the new standard package of KP services.**
29. Ensure access to cervical cancer screening and family planning services for FSW.	**PEPFAR already provides access to Cervical Cancer screening services. See section 4.9 of the SDS.**
30. Skill acquisition, interest-free loans, and educational aid for FSW	**These opportunities used to be covered through the Ambassador's Small Grants but have now been deprioritized for CLM. PEPFAR will notify the civil society of other opportunities within the US Mission to address these needs.**
31. Advocacy campaigns to end stigma and discrimination around sex work.	**Part of a broader national rights agenda.**
32. PEPFAR and other programmes to adopt a much more human centered approach which allows stakeholders to look at the structural hindrances that affect effective programming and access to services. Constitutional frameworks and policies that hinder the process need to be lifted.	**Implementing partners have increasingly developed a human-centered design approach in their work with PLHIV and key populations.**
33. A high-level advocacy team to hold discussions with government towards a solution on rights violation. We are aware that this is ongoing and NHRC, NACA, GF, PEPFAR and the UNJT are working to address this.	**As acknowledged, this is on-going. Future efforts will seek to ensure greater community participation in these engagements.**
34. A more deliberate and elevated involvement of communities at the state level in projects for community capacitation and sustainability.	**The PEEP state-level rollouts will impact significantly on this.**
35. Continuous capacity building for staff of Community Centers and One Stop Shops based on community feedback.	**This remains an on-going effort.**
36. The offerings of services that are more specific to the needs of key populations	**Also, an on-going effort as reflected in the new KP standard package of services.**
37. The HIV programme to draw on the multisectoral platforms and approaches to address issues such as mental health, economic empowerment, sexual and gender-based violence.	**This is very much part of the broader agenda on human rights. See response to 4 above.**
38. The standardization of job descriptions and remuneration packages.	**See response to 12 above**
39. Standardization of packages of service across states, donors, and government to ensure that persons who seek these services always get the best service regardless of the location.	**This is one of the key objectives of the national alignment and remains a priority for PPEFAR. See section 2.5 above.**
40. Implementation of sustainable mechanisms to preserve the longevity and effectiveness of such initiatives.	**Sustainability planning is a major area of focus for the next phase of the national alignment discussions. See sections 2.5, 2.6 and 2.7 in the SDS.**
41. The broadening of PrEP messaging, including a national PrEP campaign/approach.	**On-going**
42. Leveraging on support groups to expand the training programme on health and legal literacy for key populations.	**This is one of the key objectives of the PEEP.**
43. Addressing the problem of users' fees for PLHIV with a national stakeholders' conference to find a final solution to the SEEMINGLY INTRACTABLE problem	**User fees advocacy remains a key activity for PEPFAR and the wider US Nigeria country mission.**
44. Addressing out of pocket expenditure for PLHIV	**Same as above**
45. Enrollment of PLHIV on a Community Health Insurance Scheme in all states in a way and manner that it addresses user fees and out-of-pocket expenditure.	**Efforts to achieve this are part of the Domestic Resource Mobilization (DRM) activity in Table. Please see section 5 for additional details.**

46. PEPFAR is currently supporting HIV services in prisons and is achieving results, however, mapping/linkage of prisons health facilities to public health facilities in a hub & spoke approach is needed to enable linkage of all prisons health facilities to public health facilities. The public health facility to which a prison health facility is linked will be responsible for providing support including capacity building, supply of test kits and medicines, provision of documentation and reporting tools	**On-going**
47. PEPFAR is encouraged to adopt this model in all KP supported states.	**On-going**
48. Gaps in Knowledge. There currently exist huge knowledge gap on the TG community, their issues, including Transgender health, sexual orientation, Gender Diversity particularly among health care workers.	**PEPFAR is actively advocating for the inclusion of Gender and Sexual Diversity training in the national training curriculum for all HIV program areas and is already implementing this as part of the PEEP and through some implementing partners.**
49. Capacity building and TG Community empowerment: This should be priority and key component that should be taken seriously in trans programming. When the community have a full knowledge of who they are, it will be easy to defend and speak for the community. This will reduce the impact of abuse on mental health and facilitate sensitization of trans identity. This should be inclusive of the economic empowerment of transgender community	**Potentially part of the next phase of the PEEP with objectives including health literacy of key population.**
50. Transgender Health: The peculiar health needs of the transgender people should be given significant attention including counseling, hormone therapy, medical procedures, and the support necessary to freely express their gender identity and maintain productive and healthy living.	**Programs will seek to do this within their resource availability and to partner with other stakeholders to address needs beyond their resources.**
51. Support group of Trans People there should be a professional to assist the support groups address the significant problems such as counseling, hormone therapy, sexual diverse human and mental issues and the social support necessary to freely express their gender identity. This because when a trans person walk into a support group meetings and other audiences seems to see the person as a taboo. Thus, they do not go back to access care which result to Lost to follow up	**See response to 48 above.**
52. Rights Protection and Zero Discrimination: The rights, and dignity of TG people should be respected and promoted. The client bill of rights, and relevant laws that protect the rights of the people should be applied to all TG.	**Part of the on-going broader human rights agenda. See response to 4 above and in the stated sections of the SDS. The Patient Bill of Rights guarantees health rights for all Nigeria irrespective of their gender and sexual orientation.**
53. Security and Safety: The provision of safe spaces meant to support and protect Trans people, against abuse and unlawful arrest	**An expected deliverable of the GF-funded national Gender and Human Rights plan.**
54. Use data /evidence about TG e.g., the IBBSS 2020 to drive strategic engagement with stakeholders.to address the human right gaps and for sustainable intervention for harm reduction amongst TGs in Nigeria	**On-going.**

Table F.2. - CSO Engagement Plan

Activity	Sub-activities	Budget
Patient Education and Empowerment Plan (PEEP)	Capacity Building for NEPWHAN to develop and 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, grievance communication and feedback)	**$150,000**
Capacity building amongst AYP-led CSOs	Mapping of AYP-led organizations and needs assessment	**$50,000**
CSO Domestic Resource Tracking and Advocacy	Support CSO work with NACA to improve accountability for HIV program investment through the NASA.	**$50,000**
U=U Campaign rollout	Support On-going CSO campaigns on UequalsU	**$50,000**
PEPFAR/CSO/stakeholder quarterly meeting/CSO reps	> Quarterly monitoring meetings > Production of briefs for dissemination and action	**$20,000**
Structural interventions responding to KP rights issues	> KP CSOs capacity strengthening > KP advocacy actions for community needs	**$60,000**
Support for CSO Accountability Forum	> Annual conference for stakeholder engagement to enable CSO identify gaps in response for action in subsequent year.	**$20,000**
TBD	Other efforts prioritized by CSO leaders' group	**$50,000**
TOTAL BUDGET		**$450,000**

APPENDIX G – Summary of COP22 Program Targets –

Treatment			
Indicator	**Pediatric**	**Adult**	**Total**
TX_CURR	77,628	1,998,102	2,075,730
TX_NEW	15,267	163,126	178,393
TX_NET NEW	-6,518	381,782	375,264
PVLS (Denom.)	133,031	1,613,105	1,746,136

OVC	
OVC_SERV (Active)	1,538,933
OVC_HIVSTAT	894,809

PMTCT	
PMTCT_STAT (Denom.)	1,603,522
PMTCT_STAT (Num.)	1,587,513
PMTCT_STAT (newly tested)	1,588,244
PMTCT_STAT POS	34,346
PMTCT_ART	34,119
PMTCT_EID	33,452
< 2 months	33,452
2-12 months	0

HTS	
PMTCT_STAT (newly tested)	1,588,244
TB_STAT (newly tested)	54,543
Pediatric HTS_TST	1,069,052
Adult HTS (excludes, EID, PMTCT, TB)	11,977,503
Key Population HTS	1,137,008
HTS_SELF (KP)	114,703

KP	
KP_PREV	1,518,045
KP_PREV MSM	722,818
KP_PREV FSW	598,762
KP_PREV PWID	168,583

TB	
TB_STAT (Denom.)	54,543
TB_STAT (Num.)	54,543
TB_STAT (newly tested)	52,165
TB_STAT POS	3,759
TB_ART	3,747
TX_TB (Denom.)	1,878,859
TB_PREV (Denom.)	366,355
TB_PREV (Num.)	348,049

APPENDIX H: COP20 – COP21 Commodities Budget Table

Commodity Type	COP21 (%)	COP21 Budget	COP22 (%)	COP22 Budget
ARVs	47.40%	$100,059,245	34.78%	$ 61,305,626
OI & STI	1.20%	$2,490,202	0.99%	$ 1,741,240
TPT	1.20%	$2,550,761	0.30%	$ 535,964
RTKs	6.50%	$13,740,653	10.56%	$ 18,608,162
Recency & Self-Test Kits	1.10%	$2,424,623	1.32%	$ 2,322,861
VL Reagents	11.40%	$24,125,061	14.78%	$ 26,045,711
EID Reagents	0.10%	$279,228	0.25%	$ 433,456
GeneXpert Cartridges	1.00%	$2,175,557	1.69%	$ 2,979,353
CD4 Reagents	0.50%	$975,346	0.55%	$ 973,067
Other Reagents	0.30%	$644,212	0.19%	$ 333,727
Condoms/Lubes	0.70%	$1,500,004	0.57%	$ 999,989
GF Contribution (ARVs)	28.40%	$60,000,000	34.04%	$ 60,000,000
TOTAL		**$210,964,892**		**$ 176,279,156**

APPENDIX I: PEPFAR Nigeria Implementing Partner Directory

Implementing Partner/Project	Physical Address	Principal Investigator's Contact			Other Contacts		
		Name	Phone Number	Official Business E-mail	Name	Phone Number	Official Business E-mail
APIN Public Health Initiatives, Ltg.	Plot 1551 Apo Resettlement Zone E, Apo Gudu District FCT Abuja Nigeria	Prosper Okonkwo	234 9 780 9377; 234 803 322 6902	pokonkwo@apin.org.ng	Kamarudeen Ismaila	234 803 786 5239	kismaila@apin.org.ng
APIN Public Health Initiatives, Ltg.	No. 10 Ndagi Mamudu Close Jabi District Abuja	Jay Osi Samuels	234 805 840 6423	nolaofin@apin.org.ng	Kamarudeen Ismaila	234 803 786 5239	kismaila@apin.org.ng
Institute of Human Virology	Plot 62, Emeritus Umaru Shehu Avenue Cadastral Zone COO, After Baze University	Patrick Dakum	234 803 304 7250;	pdakum@ihvnigeria.org	Charles Olalekan Mensah	234 803 650 0427	cmensah@ihvnigeria.org
Center for Integrated Health Program	Plot 1129 Kikuyu Close, off Nairobi Street, Wuse II, Abuja-FCT, Nigeria	Bolanle Oyeledun	234 807 749 2515	bolanle3@gmail.com; boyeledun@cihpng.org	Tolulope Ariyo	234 809 042 2547	tariyo@cihpng.org
Catholic Caritas Foundation of Nigeria	Plot 459, Cadastral Zone B2 Durumi, Garki Abuja	John Oko	234 803 979 5181	johnokpanachi.oko@ccfng.org	Gabriel Tyona	234 803 709 9291	ggbenyi@ccfng.org
University of Maryland, Baltimore	University of Maryland 620 W Lexington St School of Medicine Baltimore, MD 21201-1508	Kristen Stafford	410 706 6230	kstafford@ihv.umaryland.edu	Gregory Sorenson	410 706 1186	Gsore001@umaryland.edu
University of Maryland, Baltimore	University of Maryland 620 W Lexington St School of Medicine Baltimore, MD 21201-1508	Charurat, Manhattan	410 706 1101; 410 706 1948	MCharurat@ihv.umaryland.edu	Dennis Paffrath	410 706 1101	dpaffrat@umaryland.edu
Implementing Partner/Project	**Physical Address**	**Chief of Party/Chief Executive Officer's Contact**			**Other Contacts**		
		Name	Phone Number	Official Business E-mail	Name	Phone Number	Official Business E-mail
Reaching Impact, Saturation and Epidemic Control (RISE)	Plot 971, Reuben Okaya Crescent, off Okonjo Iweala Street,Wuye District, Abuja	Atuma Emmanuel	234 803 377 7211 234 807 520 0164	Emmanuel.Atuma@jhpiego.org	Yemisi Ogundare	234 803 595 7337	yemisi.Ogundare@jhpiego.org;
RCAY-ACHIEVE	16, P.O.W. Mafemi Crescent, Utako,Abuja Nigeria	Manji Rengshwat	234 803 835 1235	mrengshwat@pactworld.org	Dansebe Sule		dsule@pactworld.org;
Breakthrough Action Nigeria	The Plaza, Floor 03, 23 Ibrahim Tahir Lane Cadastral Zone B05 Utako, Abuja	Ian Tweedie	234 818 714 0099	itweedie@jhu.edu	Bolatito Aiyenigba		tito@ba-nigeria.org
Accelerating Control of the HIV Epidemic in Nigeria (ACE: Lagos, Edo Bayelsa)	Heartland Alliance Nigeria LTD/GTE 33A, 4th Avenue Gwarimpa Estate F.C.T Abuja	Dr Clifford Umeh	234 809 590 6497	cumeh@heartlandalliancenigeria.org	Dr. Majekodunmi Omololuoye	234 802 814 5875	omajekodunmi@heartlandalliancenigeria.org
Accelerating Control of the HIV Epidemic in Nigeria (ACE: Borno, Adamawa and Yobe)	TBC	Dr. Umar Usman Adamu	234 802 401 3326	Uadamu@ahnigeria.org			TBC
Accelerating Control of the HIV Epidemic in Nigeria - Bauchi, Jigawa, Kano	No 2 Babatope Ajakaiye Crescent, By Gilmore Engineering Container Yard, Jahi Abuja	Ibrahim Bola Gobir	234 802 326 5259	ibg7@georgetown.edu			TBC
Accelerating Control of the HIV Epidemic in Nigeria - Kwara and Niger	TBC	Dr Andrew Etsetowaghan	234 706 663 99546	aetsetowaghan@cccr-nigeria.org	Abutu Inedu	234 817 421 0220	ainedu@cccr-nigeria.org
Meeting Targets and Maintaining Epidemic Control (EpiC) Nigeria	#8. Yedseram Street, Off IBB Way, Maitama Abuja-Nigeria	Satish Raj Pandey	234 814 586 9906	spandey@fhi360.org	Hadiza Khamofu	234 803 737 6804	hkhamofu@fhi360.org
KP-CARE1	#33A, 4th Avenue Gwarimpa Estate F.C.T Abuja	Godwin Emmanuel	234 908 702 7495; 234 803 566 9662	gemmanuel@heartlandalliancenigeria.org	Bartholomew Boniface	234 818 480 5117	
KP CARE 2	8 Porthacourt crescent, Off Gimbiya street, Area 11, Garki, Abuja	Salihu Abdulsamad	234 808 773 3756; 234 803 064 4746	asalihu@sfhnigeria.org	David Olusegun Oyedeji,	234 803 404 1144	
GHSC-PSM Project (Global Health Supply Chain Systems Procurement and Supply Management)	The Plaza, Floor 01, 23 Ibrahim Tahir Lane Cadastral Zone B05; Utako, Abuja	Mike Egboh	234 908 720 2268	megboh@ghsc-psm.org	Jiru Bako	234 908 720 2276	
Health Policy Plus (HP+)	20 Port Harcourt Crescent, Off Gimbiya street, Area 11, Garki, Abuja	Frances Ilika	234 8037911805	frances.ilika@thepalladiumgroup.com			
Integrated Child Health and Social Services Award (ICHSSA 1)	Plot 58, Unit G – Ewet Housing Estate, Uyo – Akwa Ibom State, Nigeria	Peter Adekoya	234 805 022 5350 234 701 683 4313	padekoya@cccr-nigeria.org	David Akpan	234 903 584 9843	
Integrated Child Health and Social Services Award (ICHSSA 2)	16, Collins Onabule Crescent, Diamond Estate, CMD Road, Magodo, Lagos	Dr. Felix Iwuala	234 803 507 7504	unimerit@yahoo.com	Faith Lannap	234 703 655 8463	
Integrated Child Health and Social Services Award (ICHSSA 3)	8 Port hacourt Cresecent Off Gimbiya Street Area 11 Garki Abuja	Halima Nuhu Dikko	234 803 317 5893	hdikko@sfhnigeria.org	Dr. Omokhudu Idogho	234 802 300 6631	
Integrated Child Health and Social Services Award (ICHSSA 4)	#49 Kado District, Cadastral Zone B09, Kado, Abuja	Dr. Tosin Idaboh	234 817 216 1697; 234 806 321 8850;	tosinidaboh@yahoo.com, tidaboh@phint.org	Iko Ibanga	234 809 925 0000	
Data for Implementation (Data.Fi)	#20 Port Harcourt Crescent, Garki, Area 11, Abuja, Nigeria.	Dr. Dauda Sulaiman Dauda	234 803 705 2337	Dauda.Sulaiman@thepalladiumgroup.com			

APPENDIX J: 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			