



FY 2015 Nigeria Country Operational Plan (COP)

The following elements included in this document, in addition to “Budget and Target Reports” posted separately on www.PEPFAR.gov, reflect the approved FY 2015 COP for Nigeria.

- 1) *FY 2015 COP Strategic Development Summary (SDS)* narrative communicates the epidemiologic and country/regional context; methods used for programmatic design; findings of integrated data analysis; and strategic direction for the investments and programs.

Note that PEPFAR summary targets discussed within the SDS were accurate as of COP approval and may have been adjusted as site-specific targets were finalized. See the “COP 15 Targets by Subnational Unit” sheets that follow for final approved targets.

- 2) *COP 15 Targets by Subnational Unit* includes approved COP 15 targets (targets to be achieved by September 30, 2016). As noted, these may differ from targets embedded within the SDS narrative document and reflect final approved targets.
- 3) *Sustainability Index and Dashboard*

Approved FY 2015 COP budgets by mechanism and program area, and summary targets are posted as a separate document on www.PEPFAR.gov in the “FY 2015 Country Operational Plan Budget and Target Report.”



NIGERIANS AND AMERICANS
IN PARTNERSHIP TO FIGHT HIV/AIDS

Nigeria

Country Operational Plan (COP) 2015

Strategic Direction Summary

July 17, 2015

Table of Contents

Goal Statement

1.0 Epidemic, Response, and Program Context

- 1.1 Summary statistics, disease burden and epidemic profile
- 1.2 Investment profile
- 1.3 Sustainability Profile
- 1.4 Alignment of PEPFAR investments geographically to burden of disease
- 1.5 Stakeholder engagement

2.0 Core, near-core and non-core activities for operating cycle

3.0 Geographic and population prioritization

4.0 Program Activities for Epidemic Control in Priority Locations and Populations

- 4.1 Targets for priority locations and populations
- 4.2 Key population prevention
- 4.3 Voluntary medical male circumcision (VMMC)
- 4.4 Preventing mother-to-child transmission (PMTCT)
- 4.5 HIV testing and counseling (HTC)
- 4.6 Facility and community-based care and support
- 4.7 TB/HIV
- 4.8 Adult treatment
- 4.9 Pediatric Treatment
- 4.10 OVC

5.0 Program Activities to Sustain Support in Other Locations and Populations

- 5.1 Package for sustained- support services and expected volume in other locations and populations
- 5.2 Plans for redirecting PEPFAR support to priority locations and populations

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

- 6.1 Laboratory strengthening
- 6.2 Strategic information (SI)
- 6.3 Health system strengthening (HSS) – clear linkages to program

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

Appendix A- Core, Near-core, Non-core Matrix

Appendix B- Budget Profile and Resource Projections

Appendix C – Sustainability Index Dashboard

Goal Statement

PEPFAR Nigeria will work with the Government of Nigeria (GON) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) to achieve HIV epidemic control in 32 highly burdened Local Government Areas (LGAs). Epidemic control will be achieved in 21 LGAs by the end of fiscal year 2017 and in the remaining 11 by the end of fiscal year 2018. This represents a program pivot, as the Nigeria team refocuses efforts from the state to the LGA level. Our approach seeks to achieve, in a small number of prioritized geographic areas, the ambitious Joint United Nations Program on HIV/AIDS' (UNAIDS) 90-90-90 goal of having 90 percent of people living with HIV in these LGAs diagnosed, 90 percent of those diagnosed on antiretroviral therapy (ART), and 90 percent of those on ART virally suppressed. Doing so, will provide proof of concept to encourage the host-country government to invest more significantly, and in a more focused manner, in the domestic HIV response. Our goals, expressed in terms of PEPFAR's five action agendas, are to:

Impact: Support 32 LGAs to reach 80 percent ART coverage by increasing HIV testing and counseling and improving timely initiation of and retention on treatment. We will work in the highest burden, highest prevalence LGAs where saturation is practicable and maximize epidemiologic impact by saving lives and reducing transmission.

Efficiency: Achieve 281,821 net new patients on treatment over a period of two years, approximately 10 percent of the country's unmet need, with the PEPFAR resource envelope. This is in addition to the 542,541 that are supported by PEPFAR according to our 2014 Annual Progress Report (APR) and the additional 71,593 net new patients that are expected to be placed on ART during 2015.

Sustainability: Graduate LGAs to epidemic control status via a phased approach. Currently 43 LGAs have a coverage rate of 80 percent or greater. At the end of FY 2015, we expect that number to have grown to 65, to 86 by the end of FY 2017, and to 97 by the end of FY 2018.

Partnership: Continue to work in collaboration with the GON, the Global Fund, Civil Society Organizations (CSOs), and private sector partners. We will plan with partners so that their scale-up activities complement those of PEPFAR.

Human Rights: Advocate to improve national laws and policies and to further the goal of non-discrimination of People Living with HIV (PLHIV) in health care settings, in particular, for key populations.

Site yield and efficiency analyses conducted for our prevention of mother-to-child transmission (PMTCT) and HIV testing and counseling (HTC) programs indicate that 2,857 sites have identified four or fewer HIV-positive patients over the past year. These sites will cease to be supported prior to COP 15 implementation. Savings associated with transitioning support to higher-yield sites will be used to support additional patients on treatment and to support increased testing in high burden, high prevalence areas. By increasing HIV testing, incorporating additional community-based models of case identification and management, and improving timely initiation of ART with the right people in the right places, PEPFAR will demonstrate the greatest possible epidemiologic impact with its existing resources.

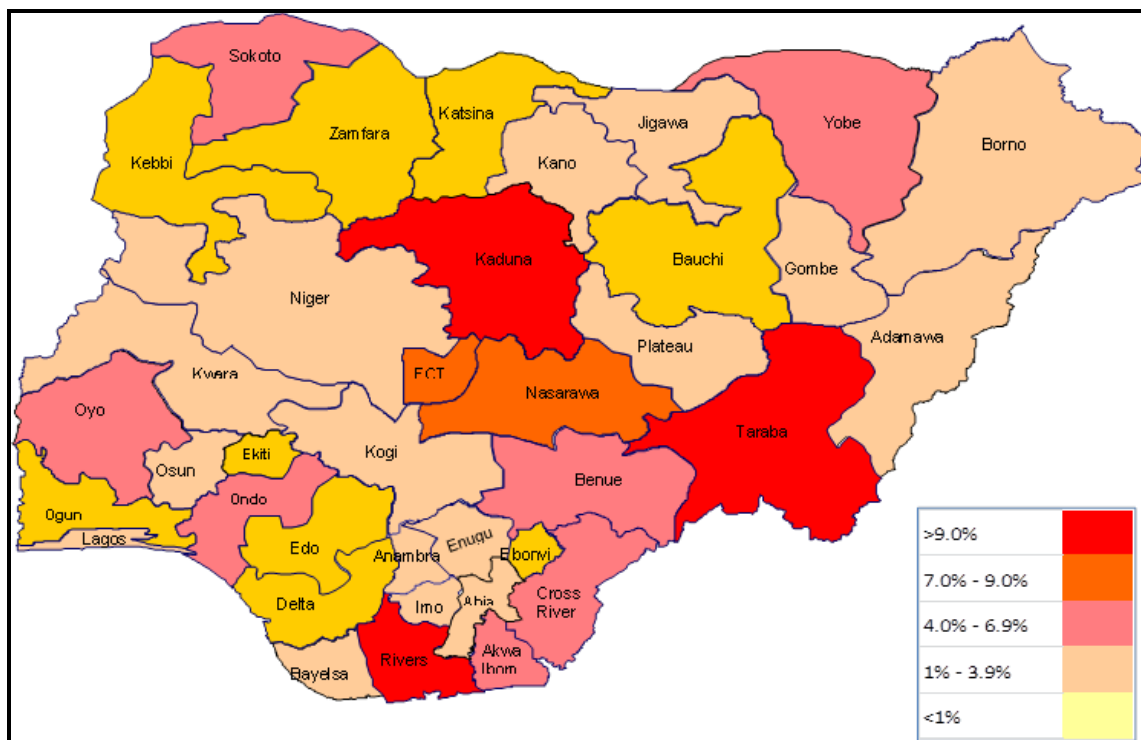
1.0 Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country or regional profile

Nigeria is a lower-middle-income country (GNI: 5,360.0 per capita, PPP adjusted¹) with a current population estimate of 185,206,977 (population demographics: 49% female, 51% male; 54% rural, 46% urban²).

Currently, Nigeria's epidemic is generalized with national HIV prevalence rates for adults aged between 15 and 49 years estimated to be around 3.2 percent³. There is significant variation in prevalence across the states. GON estimates range from 0.6 percent in Ekiti State to 15.2 percent in Rivers state⁴ whereas PEPFAR program data range from 0.6 percent to 7.9 percent. Figure 1.1.1a shows this variation across states (based on the 2012 National AIDS Reproductive Health Survey [NARHS]) while Figure 1.1.1b shows the variation at the level of the 774 LGAs. HIV prevalence among key populations is much higher than the national average (27.4 percent in brothel-based female sex workers (FSW,) 21.7 percent in non-brothel-based FSW and 17.2 percent among men who have sex with men (MSM⁵).

Figure 1.1.1a HIV Prevalence by States (SNU₁)



¹ World Bank, 2013 data

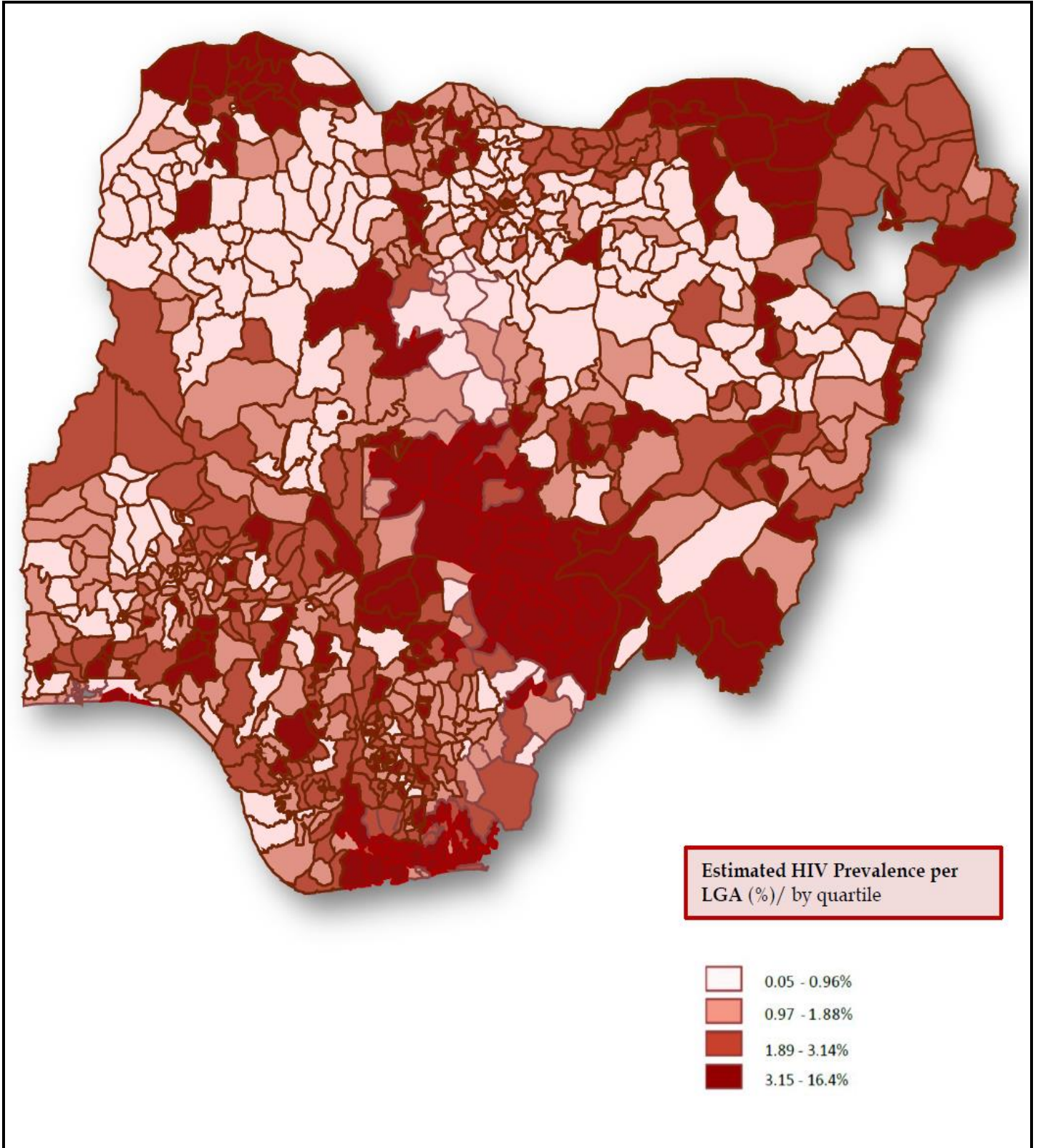
² Projection from 2006 Census data

³ 2013 UNAIDS Estimates

⁴ 2012 NARHS plus

⁵ 2010 IBBSS

Figure 1.1.1b- HIV Prevalence by LGAs (SNU2)



Source: Adjusted PMTCT Program Positivity Data: 2014

In total, about 3,556,962 people are currently estimated to be living with HIV in Nigeria, which has the second highest burden of PLHIV in the world. About 680,924 PLHIV are currently receiving treatment and there has been a slow decline⁶ in the estimated incidence of HIV in Nigeria, with the number of new infections decreasing from 228,869 in 2009 to 220,393 in 2013⁷. Detailed demographic and epidemiological data are presented in Table 1.1.1. Coverage rates for PMTCT, ART, viral load and early infant diagnosis (EID) remain unacceptably low and the country accounts for about one-third of new HIV infections in children (about 60,000 annually) due to high mother-to-child transmission rates. Only 12 percent of eligible children are receiving ARVs.⁸ Due to the high number of AIDS-related deaths, 210,000 per year, the population of orphans and vulnerable children (OVC) is estimated at over 1,736,782.

By September 2017, PEPFAR Nigeria will reach epidemic control in a subset of high burden, high prevalence scale-up LGAs while sustaining its commitment to the PLHIV currently on treatment across the rest of the country. As no one requesting or requiring services based on symptomology will be turned away from PEPFAR-supported sites in LGAs receiving sustained support, passive enrollment in these LGAs potentially adds an additional 29,476 net new patients on treatment over the two year term. Combination prevention interventions will target the cohorts of key populations identified by the National Key Population Size Estimation reports with emphasis on the 32 scale up to saturation LGAs, while also targeting other nearby hot spot locations.

PEPFAR Nigeria will finalize AIDS indicator studies begun in COP14 in two states and set-up new data collection systems to track viral load testing across the network of linked facilities. Smaller-scale surveys and related initiatives will be undertaken in scale-up LGAs. PEPFAR anticipates that similar, complementary LGA-level prioritization of investments will be made by the Global Fund in a subset of LGA's where Global Fund supports all or most of the treatment, PMTCT and HTC services. Community-led demand generation and service delivery initiatives will also be employed to help reach the saturation objectives in all the selected scale-up LGAs.

Concerns have been expressed about the key population estimates from the national size estimation reports because implementing partners have been able to reach considerably more clients than have been estimated in previous years. PEPFAR targets are therefore based on a scientific adjustment of the size estimation data using the previous year's performance.

Tables 1.1.1 and 1.1.2 provide more detailed epidemiological and demographic data.

⁶ UNAIDS Global Progress Report 2013

⁷ Nigeria GARPR 2014

⁸ UNAIDS Global Progress Report 2013

Table 1.1.1 Key National Demographic and Epidemiological Data											
	Total		<15				15+				Source, Year
	N	%	Female		Male		Female		Male		
			N	%	N	%	N	%	N	%	
Total Population	185,206,977	NA	38,844,606	49	40,794,395	51	51,491,686	49	54,076,291	51	NPC 2006, US Census Bureau 2013
Prevalence (%)		3.2%									UNAIDS 2013
AIDS Deaths (per year)	210,000										UNAIDS 2013
PLHIV	3,556,962										UNAIDS 2014
Incidence Rate (Yr)											
New Infections (Yr)	220,394										Nigeria GARPR 2014
Annual births	31,828										Nigeria GARPR 2014
% >= 1 ANC visit		61%									NDHS 2013
Pregnant women needing ARVs	190,000										IATT –Nigeria report 2013
Orphans (maternal, paternal, double)	1,736,782										UNAIDS 2014, UNFPA 2015
TB cases (Yr)	100,401										NTBLCP TB Data, 2013
TB/HIV Co-infection	23,092	23%									NTBLCP TB Data, 2013
Males Circumcised	NA	>90%									UNAIDS 2007
Key Populations	470,488										HIV epidemic appraisals Nigeria, 2013 ⁹
Total MSM*	26,647										HIV epidemic appraisals Nigeria, 2013 ⁹
MSM HIV Prevalence		17.2%									IBBSS 2010
Total FSW	414,805										HIV epidemic appraisals Nigeria, 2013 ⁹
FSW HIV Prevalence		27.4% (brothel) 21.1% (non-brothel)									IBBSS 2010
Total PWID	29,035										HIV epidemic appraisals Nigeria, 2013 ⁹
PWID HIV Prevalence		4.2%									IBBSS 2010

⁹ The HIV epidemic appraisals of 2013 had an incomplete dataset. This missing data points were adjusted using available program data. First, missing figures for number of KPs in respective states were derived by applying the national percentage of respective KP groups to the female population to derive FSW numbers, male population to derive MSM numbers and male/female to derive PWID numbers. Secondly, available data points that were less than program data were adjusted using the average variance by which program data exceeded the epidemic appraisal data.

Table 1.1.2 Cascade of HIV diagnosis, care and treatment (12 months)

				HIV Care and Treatment				HIV Testing and Linkage to ART		
	Total Population Size Estimate(#)	HIV Prevalence (%)	Total PLHIV (#)	In Care (#)	On ART (#)	Retained on ART 12 Months (%)	Viral Suppression 12 Months	Tested for HIV (#)	Diagnosed HIV Positive(#)	Initiated on ART (#)
Total population	185,206,977	3.2%	3,556,962	678,176	542, 541	89	NA	8,671,415	336,558	122,655
Population less than 15 years	79,639,000	NA	348,510	41,554	33,243	89	NA	625,438	23,974	9026
Pregnant Women	7,917,876	4.1%	NA	NA	NA	NA	NA	2,728,511	41,907	8,890
MSM	12,588	17.2								
FSW	232,329	27.4% (brothel) 21.1% (non-brothel)								
PWID	5,368	4.2								

1.2 Investment Profile

Recognizing the scale of the challenge Nigeria faces with keeping its population healthy and productive, the international community has invested billions of dollars in Nigeria toward achieving that objective. However, investments by the international community, alone, are not sufficient to improve in a meaningful way the health status of Nigerians. Moving forward, we would like to transition our relationship to one of partnering with Nigeria, with the GON progressively taking on more responsibility. In the near term, we look to the GON – at the federal and state levels – to increase its commitment to and investments in life-saving drugs, immunization and family planning commodities, and HIV/AIDS treatment.

The HIV response in Nigeria is largely funded by international donors. According to the 2013 National AIDS Spending Assessment (NASA), the GON accounted for 17.7 percent of HIV/AIDS spending in 2011 and 21.3 percent in 2012, devoting the majority of their funds to human resources and administrative expenses. In 2011 and 2012, domestic private sector funding accounted for less than 0.25 percent. International donors contributed the bulk of funds, with PEPFAR accounting for 74.2 percent in 2011 and 70.4 percent in 2012. The Global Fund accounted for less than four percent in both years.

PEPFAR funding has constituted the majority of HIV/AIDS investments in Nigeria and has remained at approximately the same level since 2010. The need to continue to scale-up the number of PLHV reached with treatment, PMTCT, and related services necessitated strategic changes in the package of services supported by PEPFAR to reduce program costs in COP 2014. While the funding level is expected to remain constant in COP15; it is likely to decline by about \$100 million in COP16. As a result, PEPFAR will prioritize future investments to focus on the most critical needs of the national response.

Domestic funding for HIV/AIDS has increased steadily since 2010 even though most of it is tied to human resource investments. More than 90 percent of healthcare workers' salaries in the country are funded by the GON. More recently in 2014, the GON committed about \$40 million of the fuel Subsidy Re-investment Program (SURE-P) fund to the National Agency for Control of AIDS (NACA) for the implementation of President's Comprehensive Response Plan for HIV/AIDS (PCRP). These funds were used to hand over PEPFAR-supported sites in two states; Taraba and Abia, to the government in FY 2015. Additional efforts are ongoing to increase GON engagement and ownership in hope of transitioning other states. While the GON has committed to putting in an additional \$40 million into the national response in 2015, this is in doubt for several reasons. First, the national budget is largely financed by oil, the price of which has plummeted on the international market over the past year. Second, the naira has been devalued by close to 25 percent, making imports more expensive, and third, a new government is being ushered in and commitments made by the previous government may not be upheld.

According to the Country Coordinating Mechanism (CCM), the Global Fund HIV/AIDS program committed \$58.0 million in the 2013-2014 program cycle and increased their investment to \$91.4 million in 2014-2015 program cycle. In addition to HIV investments, the Global Fund spent \$60.4

million in Health Systems Strengthening (HSS) in 2013-2014 and \$92.5 million in 2014-2015. The United Kingdom's Department for International Development (DFID) spent approximately \$14.1 million in 2013-2014 and is expected to spend \$12.4 million in 2014-2015 for HIV/AIDS program activities, of which \$7.4 million and \$6.7 million, respectively, will be committed to HSS activities¹⁰. Nigeria's submission to the Global Fund under the New Funding Model for \$351,780,487 of additional resources was approved in November 2014 and is now in the grant-making process. These resources will be used largely to scale up care and treatment services in six high burden, high prevalence states, four of which overlap with PEPFAR's FY 2015 eight priority states.

PEPFAR contributes the bulk of support for commodities in Nigeria. Data from the 2015 Nigeria National Quantification process indicate that Nigeria's ARVs are funded by three sources—PEPFAR (60 percent), Global Fund (35.5 percent), and the GON (4 percent). In addition to ARVs, the GON procures 25 percent of rapid HIV test kits (RTKs). However, the majority (75 percent) of RTKs, CD4 lab reagents (60 percent), and viral load reagents (100 percent) are procured by PEPFAR. The Global Fund is the primary contributor to EID kits (75 percent) and invests in opportunistic infection drugs (OID) (52 percent) and CD4 laboratory reagents (40 percent).

Tables 1.2.1 and 1.2.2 below contain additional details regarding the HIV investments in the country and Table 1.2.3 specifically documents non-PEPFAR United States government funding for HIV and other health programs.

Table 1.2.1 Investment Profile by Program Area¹¹

Program Area	Total Expenditure	% PEPFAR	% MLO¹²	% GON	% Other
Clinical care, treatment and support	\$135,527,969	76.6	0	0	23.4
Community-based care	\$20,252,061	97.8	0	2.2	0
PMTCT ¹³	\$13,834,320	319.5	2.1	0.3	0
HTC	\$13,578,686	87.7	12.3	0	0
VMMC ¹⁴	\$4,580	100	0	0	0
Priority population prevention	\$34,521,818	64.2	4.2	3.4	28.2
Key population prevention	\$11,510,251	72.4	25.7	0	1.9
OVC	\$14,386,342	92.8	7.1	0.1	0
Laboratory	\$41,456,865	99.7	0.2	0	0.1
SI, Surveys and Surveillance ¹⁵	\$21,781,356	145.5	2.3	0	0
HSS	\$267,455,814	40.3	5.4	45.3	9
Total	\$574,310,062	70.4	3.9	21.4	11.4

¹⁰ Preliminary data from Nigeria National Agency for Control of AIDS (NACA) HIV and AIDS Resource Tracking/Mapping (Commitment and Budget) for NSF-II/NOP Financing Plan and Gap Analyses, 2012/13-15/16

¹¹ Government of Nigeria, National AIDS Spending Assessment, 2012 – Appendix 22 – and PEPFAR EA Submission for NASA 2011/2012, all amounts in USD

¹² GF expenditure is not captured in the program area breakdown of 2012 NASA; instead, this is rolled up into a multilateral organizations category

¹³ NASA 2012 reports a lower amount than PEPFAR EA 2012; likely a transmission error

¹⁴ This figure is erroneous; stems from an inaccuracy in PEPFAR EA 2012

¹⁵ NASA 2012 reports a lower amount than PEPFAR EA 2012; likely a transmission error

Table 1.2.2 Procurement Profile for Key Commodities¹⁶

Commodity Category	Total Expenditure	% PEPFAR	% GF	% GON	% Other
ARVs	\$131,825,649	60.4	35.5	4.0	
Rapid test kits	\$19,602,509	75.2	0	24.8	
Opportunistic infection drugs	\$9,944,277	47.7	52.3	0	
Lab reagents – CD4	\$5,371,685	59.9	40.1	0	
Lab reagents – Viral load	\$21,105,295	100	0	0	
EID kits	\$4,933,923	24.6	75.4	0	
Other commodities					
Total	\$187,849,415				

Table 1.2.3 Non-PEPFAR Funded Investments and Integration and PEPFAR Central Initiatives¹⁷

Funding Source	Total Non-COP Resources	Non-COP Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID HIV (central)	\$2,500,000	\$2,500,000	3		o Accelerate FP-HIV integration in Akwa Ibom, Cross River
USAID TB	\$13,500,000	\$12,700,000	4	\$4,400,000	o Support the NTP to halve prevalence and mortality in 2015
USAID Malaria	\$74,470,000		0		o Halve malaria burden compared to 2010 levels under the PMI
USAID MCH	\$46,000,000		0		o End preventable child and maternal deaths
USAID FPRH	\$32,500,000		0		o Increase contraceptive prevalence
USAID WASH	\$9,227,000		0		o
USAID NUT	\$2,500,000		0		o Reduce under-nutrition among women and children
CDC HIV (central)	\$1,500,000	\$1,500,000	TBD		o Accelerate FP/HIV integration in Benue, Kaduna
CDC TB-HIV (central)	\$291,136	\$291,136	1		o Procurement, technical support and installation of GeneXpert
CDC KADAIDS	\$815,000	\$500,000	1	\$315,000	o Kaduna AIDS indicator survey
CDC Ebola	\$400,000	\$400,000	1		o Post-ebola preparedness
CDC GIV	\$12,000,000	\$12,000,000	1		o National Stop Transmission of Polio (NSTOP)
CDC BEP	\$60,000	\$60,000	1		o Field and Epidemiology Laboratory Training Program
DOD HIV (central)	\$1,000,000	\$1,000,000	1		o FP/HIV integration
DOD Ebola vaccine	\$253,039	\$253,040	1		o Ebola vaccine development
DOD WRP-N AFRICOS	\$85,117	\$85,117	1		o African cohort study: longitudinal follow up of PLHIV
DOD WRP-N Trust study	\$604,982	\$604,982	1		o Reduce HIV/STI incidence and risk behaviors among MSM
DOD WRP-N PMI	\$530,000	\$530,000	1		o Halve malaria-associated mortality
Total	\$198,236,275	\$32,424,275	17	\$4,715,000	

¹⁶Data from the 2015 Nigeria National HIV/AIDS program Commodity Quantification process¹⁷All USAID reported figures represent current year funding; DoD figures represent annual budget

Based on current the investment profile and on efficiencies achieved in PEPFAR and Global Fund-supported activities, Nigeria will continue to improve treatment coverage. Transition of Taraba and Abia states to GON, along with approximately 33,000 persons currently on treatment, is a positive step. There is concern, however, about the ability of the country to meet its commitment to the Global Fund and to sustain investments in the PCR. PEPFAR will continue to work with all stakeholders to streamline investments and prioritize the most critical needs in the event of a major shortfall in funding levels.

1.3. National Sustainability Profile

The GON, civil society, development partners, and PEPFAR convened to determine areas in the national HIV response that are unsustainable. As captured on the Sustainability Index Dashboard in Appendix C, eight elements were deemed to be unsustainable and critical to epidemic control objectives: commodity security and logistics; access and demand; allocative efficiency; domestic resource mobilization and commitments; human resource for health; quality management and quality improvement; and policies, laws, and regulations. Of these, the first three are considered to be high priorities to maintain progress toward sustained epidemic control.

Under the leadership of the GON, there has been considerable progress in commodity security and logistics management through strong collaboration and coordination among key stakeholders. Procurement of HIV/AIDS commodities is pooled in the country and more than 98 percent of HIV service delivery sites have been recruited into the National Commodity Supply Chain network. These sites are serviced out of two national and four regional warehouses which were renovated and are managed through joint funding by the GON, the Global Fund, and PEPFAR. While there has not been a major stock out of HIV/AIDS commodities in the last year, the storage facilities have not maintained acceptable stocks levels for 90 percent of the time. Last year's National HIV Stock Status Report showed that acceptable levels have only been maintained around 50 percent of the time¹⁸. The effort to improve coordination at sub-national levels will help to address this.

To improve access and demand for HIV/AIDS treatment and PMTCT services, the GON and its stakeholders have prioritized 12 states and the FCT(12+1 states), which account for more than 70 percent of the country's HIV burden, as the focus for future scale-up investments¹⁹. The Global Fund has prioritized six of these states while PEPFAR in COP14 focused on eight of them (four of which overlap with the Global Fund). The GON is gradually taking up the responsibility for scale-up in the other states beginning with two, Taraba and Abia.

The GON, Global Fund, and PEPFAR will improve allocative efficiency by utilizing data from the site yield and volume analyses to re-allocate investments to sites which have the best potential to serve the most clients and will focus on the increased and improved use of data to determine priority areas and resources allocation.

¹⁸ 12th Edition of the National HIV/AIDS stock status report

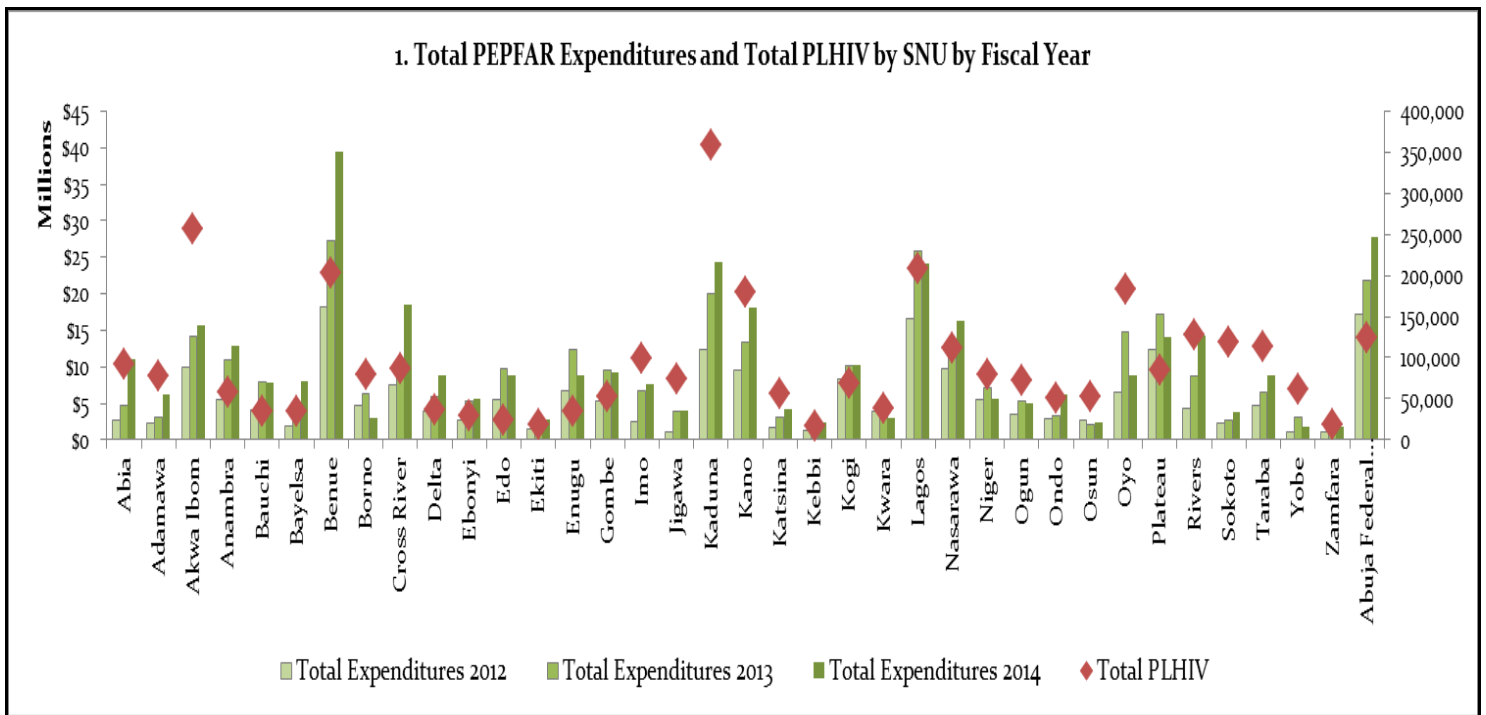
¹⁹ The President's Comprehensive Response Plan for HIV/AIDS I Nigeria

1.4 Alignment of PEPFAR investments geographically to disease burden

In COP14, PEPFAR Nigeria began implementation of a more focused HIV support plan, selecting eight of the GON's 12+1 states for scale-up efforts in HIV treatment, PMTCT, and prevention. Two of those states, Kaduna and Akwa Ibom (PEPFAR priority 1 states), account for 18 percent of the country's 3.5 million PLHIV and were targeted for significant scale-up and mobilization activities. The remaining six states, Benue, Cross River, Lagos, Nassarawa, Rivers, and the FCT (PEPFAR priority 2 states), account for 25 percent and were targeted for moderate scale-up. Combined, these eight priority states comprise 43 percent of all PLHIV in Nigeria. The remaining states in the country were categorized as "maintenance states" - where PEPFAR investments would only focus on sustaining the service needs of PLHIV already enrolled and for passive uptake of new patients identified within health facilities.

Figure 1.4.1a uses 2012, 2013, and 2014 data to compare PEPFAR expenditures and burden of disease by state. Figure 1.4.1a illustrates the degree of alignment of PEPFAR investments with the HIV burden across all 36 states. In this first analysis of historical spending, the eight priority states accounted for 47.3 percent of total investments in FY 2014.

However, the total PEPFAR expenditures in each of the prioritized states varied between \$14.4 million (Rivers) and \$39.5 million (Benue) and represent the highest for the country. Only in Kano State (the most populous state in the country with an estimated 12.6 million people) did PEPFAR investments fall within this range among the maintenance states. Twelve percent of total PEPFAR expenditures were in the eight states with the lowest numbers of PLHIV.



Though the investments appear to align within the eight priority states, further analysis reveals that investments in the two highest priority states, Kaduna and Akwa Ibom (with 358,300 and

257,247 PLHIV respectively), do not reflect this expectation given their comparatively high disease burden. Spending per PLHIV at \$68 in Kaduna and \$60.6 in Akwa Ibom is much lower than the National average spending per PLHIV which is about \$111.8. Comparatively, spending per PLHIV is much higher in several low burden states, varying between \$93.4 and \$374.6 in the six states with the lowest PLHIV burden. These states include Kebbi (16,398), Zamfara (18,654), Ekiti (18,774), Edo (23,714), Ebonyi (29,051) and Bauchi (34,822). This finding reflects the difficulty of finding HIV-positive persons in low burden, low prevalence areas. Furthermore, it underscores the need for future PEPFAR investments to align with HIV burden to achieve the greatest epidemiological impact.

Spending per PLHIV in the other six priority states varies between \$112.3 in Rivers State and \$224 in the FCT. The range across the whole country is between \$28 per PLHIV (in Taraba state) and \$375 per PLHIV (in Edo state), suggesting that variations still exist in the implementation models of different partners. To continue with the COP14 effort to force partner alignment with the streamlined service package, and with the recommendation of our EA advisor, the national unit expenditures (UE) was used in COP 2015 budget calculations and additional lump sum amounts were added to fund community mobilization and other activities in scale-up to saturation LGAs.

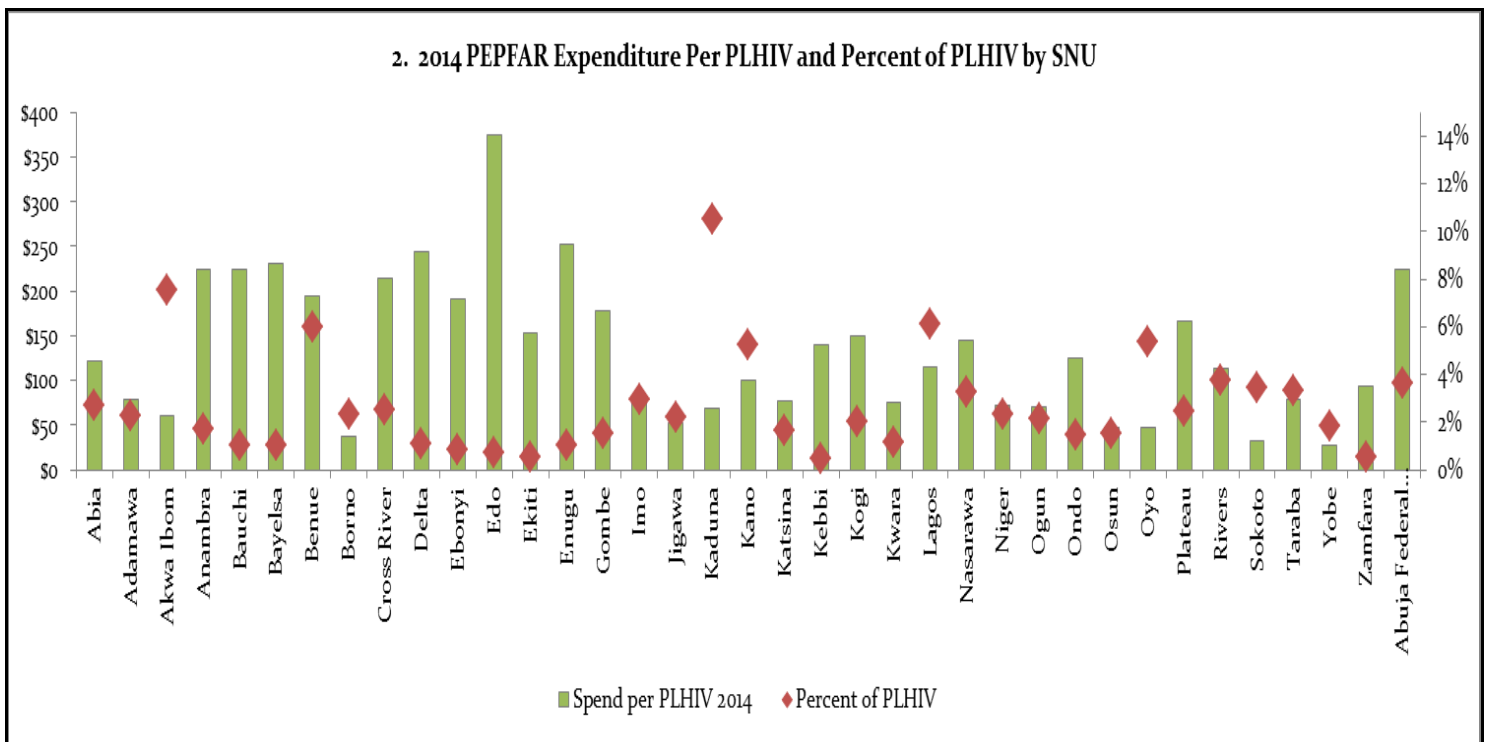
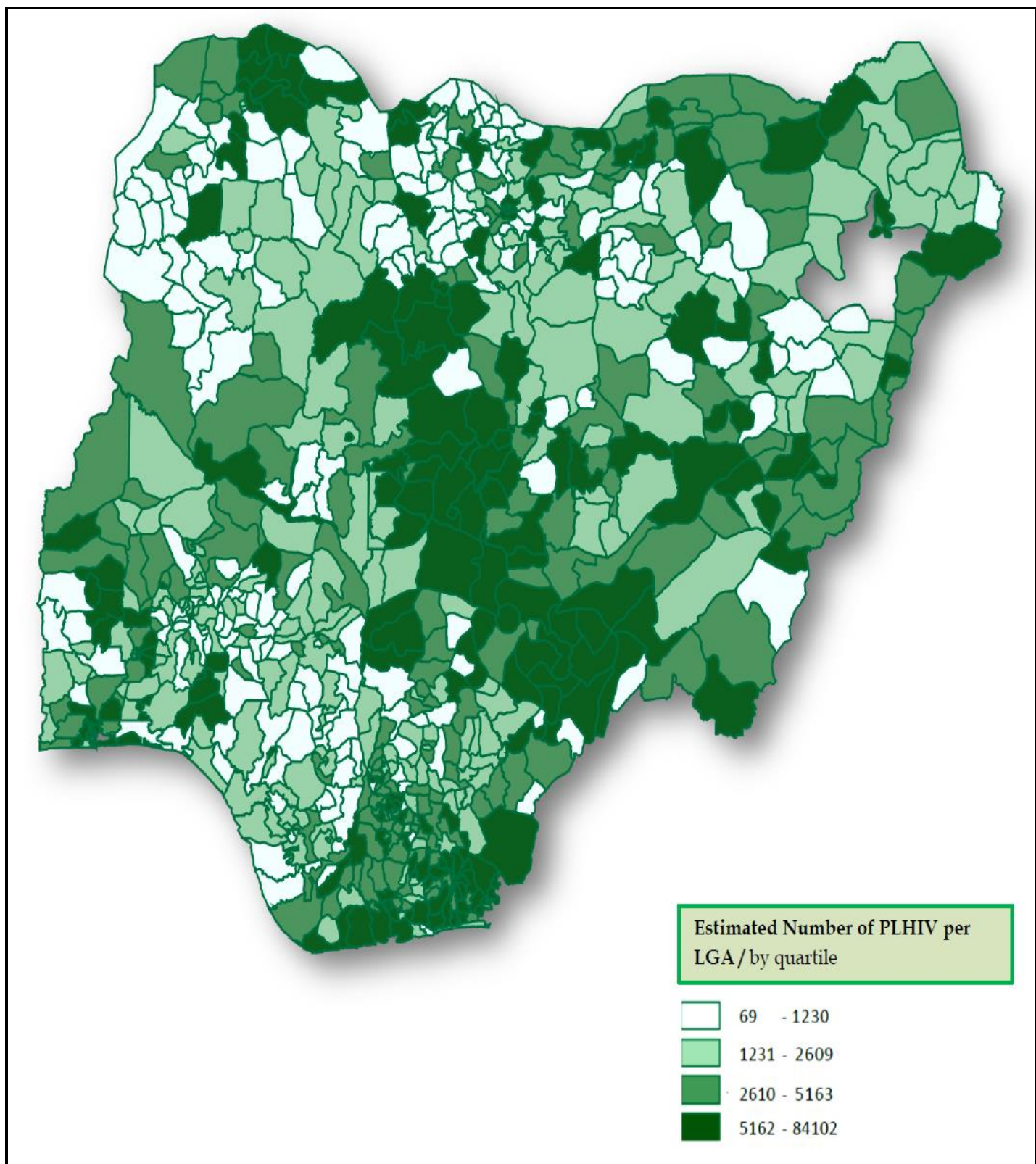
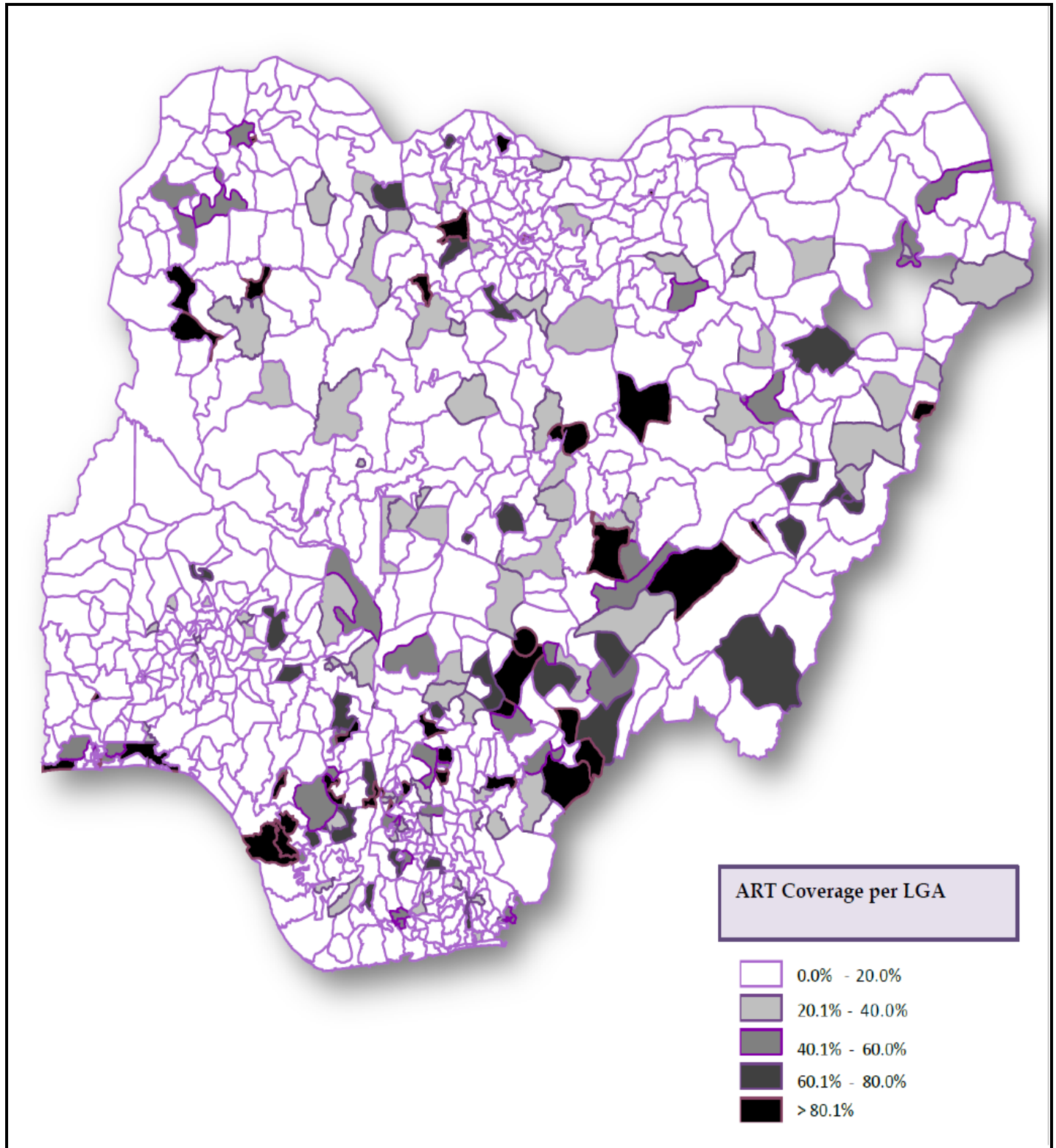


Figure 1.4.2a- Estimated PLHIV in Nigeria's 774 LGAs



Source: 2014 UNAIDS Spectrum Estimates apportioned to LGAs based on PMTCT program positivity in 2014

Figure 1.4.2b -ART Coverage in Nigeria's 774 LGAs



Source: PEPFAR and Global Fund Achievement 2014

1.5 Stakeholder Engagement

In 2014, PEPFAR Nigeria commenced a series of engagements with the National Agency for the Control of AIDS (NACA), the HIV/AIDS Division of the Federal Ministry of Health, the Global Fund, UNAIDS, and other relevant stakeholders about the need to improve resource efficiency in the implementation of PEPFAR-supported services in the national response. The stakeholders were notified of key decisions mandated by the leadership team to streamline PEPFAR support for improved program effectiveness and efficiency in resource utilization.

These plans went into effect on October 1, 2014. Since then, several stakeholders' meetings were held to manage the process and address emerging issues. Similar considerations were adopted by NACA and the Global Fund and included in the New Funding Model Concept Note submitted to the Global Fund in August 2014. The PEPFAR country team participated actively in the development of the concept note.

After an introductory meeting on January 13, 2015, PEPFAR inaugurated the COP15 planning process on February 5, 2015 with a 25-member task team representing key stakeholders from donor groups, CSOs, implementing partners, and government ministries, agencies, and departments.

PEPFAR technical and program management staff collaborated with the task team to develop several documents, spreadsheets, and narratives for COP15 planning, including:

1. The Sustainability Index and Dashboard (SID)
2. Key National Demographic and Epidemiological Data Table
3. Cascade of HIV diagnosis, care and treatment (12 months) Table
4. Investment Profile by Program Area Table
5. Procurement Profile for Key Commodities Table

The task team sought broad participation among stakeholders and completed the initial draft of the SID. The SID was disseminated and reviewed by senior and principal officers of the stakeholder organizations at several meetings in February and March of 2015 and subsequently by the PEPFAR country team. Although time constraints prevented the country team from engaging stakeholders in the final prioritization and planning phases of the SID, it is anticipated that consultation will continue after the submission of the SID. Future discussion will focus on programmatic adjustments to be made in priority areas.

In early June, PEPFAR convened a two-day stakeholder meeting to review the COP15 strategy and program pivots and begin to plan the way forward for implementation. More than 100 stakeholders attended. Ongoing engagement will continue through the existing stakeholder platforms, with the addition of national- and state-level PEPFAR-CSOs engagement. The details of these plans are captured in the Civil Society Engagement Strategy.

Engagement with the Global Fund will continue through the CCM and through meetings with the Senior Fund Portfolio Manager and the Global Fund principal recipients. The PEPFAR

Multilateral Liaison will champion these and similar engagements with other donor groups to improve programmatic and technical alignment among donors and with the GON.

In 2015, Nigeria will prepare a new National Strategic Plan for HIV. The PEPFAR team is fully engaged in its development and will work to establish processes and structures for improved stakeholder engagement and joint decision making. Great strides have been made during the COP planning process in regards to data sharing and joint analysis which is continuing during the detailed Global Fund concept note finalization and NSP planning. PEPFAR will endeavor to ensure that the new plan contains measures of progress through clear milestones and indicators. The United States Mission to Nigeria will continue its efforts in health diplomacy and advocacy for increased domestic financing of the National HIV Response.

2.0 Core, Near-Core and Non-Core Activities

Focusing on what is required to reach epidemic control in a subset of LGAs and to address the complementary elements of the SID; PEPFAR Nigeria prioritized the following program activities:

- Expansion of ART and PMTCT services in 32 scale-up to saturation LGAs targeted for epidemic control within two to three years.
- Efforts to improve site-level data reporting through a single integrated National DHIS platform linked to the PEPFAR DATIM platform.
- Strengthening of PEPFAR-supported labs' effective and efficient delivery of qualitative viral load, EID and HTC testing and the networking of labs to minimize needed investments.
- Improving logistics for the pooled procurement and distribution of ARVs, reagents, and other commodities and the increased involvement of state and LGA structures in logistics management and overall coordination efforts.
- Implementing the Minimum Prevention Package Interventions (MPPI) for key populations and demand creation for these services, including provision of HTC and linkage and integration of identified PLHIV into care and treatment services into Key Population prevention programs.
- Strengthening the capacity of households and communities to support OVC affected or infected by HIV/AIDs.

PEPFAR investments for government reference laboratories, pre-service and in-service training, a government-managed national data repository, the National Blood Transfusion Services, and health-care waste management were considered mature programs ready for transition to the GON and were, thus, classified either as Near-core or Non-core activities. Details of the Core, Near-Core and Non-Core Activities are provided in Tables A.1 and A.2 and transition plans are captured in Table A.3, (located in Appendix A).

3.0 Geographic and Population Prioritization

It is critical to prioritize future PEPFAR investments in high burden, high HIV prevalence LGAs to achieve the greatest epidemiological impact possible with the resources available. An underfunded domestic response, along with exceptional unmet need for HIV treatment at the national level, necessitates a focused approach that will yield localized examples of epidemic control. PEPFAR's demonstration of ART saturation, reduced community viral load, and significantly reduced transmission in the 32 scale-up to saturation LGAs will not only improve health, save lives, and avert new infections, it will demonstrate proof of concept for 90-90-90 and hopefully energize and accelerate the efforts of the GON to sufficiently fund, focus, and capacitate future HIV prevention, care, and treatment activities.

PEPFAR Nigeria scale up to saturation LGAs were selected using the following approach and considerations:

- Classified the 774 LGAs into quartiles for both burden and prevalence
- Rank ordered all 774 LGAs in descending order based on burden
- Excluded from further consideration LGAs that were outside of the current 8 priority states, LGAs that were in states that are insecure or unsafe and to which travel is nearly impossible for USG staff; LGAs in Taraba and Abia, which were transitioned to the government, and LGAs in which the Global Fund is responsible for a significant proportion of achievements and intends to scale-up in the future
- Began at the top of the resulting list and worked down the burden-based ranking, identifying extremely high-burden LGAs that were also in the first quartile for prevalence, where achieving saturation by 2017 was deemed feasible. These LGAs had burdens between four and sixteen times the median LGA burden and served as potential “anchors” for considering scale-up in contiguous and proximal LGAs
- Evaluated the feasibility of achieving saturation in each LGA based on confidence in the PLHIV estimates, observed program positivity results across all PEPFAR testing streams, existing infrastructure to support service delivery, number of and absorptive capacity of existing and potential treatment sites to accommodate new patients, proportion of the population to be tested to identify the number of PLHIV needed on treatment for saturation, population and population density, transportation and patterns of movement across LGAs, and service-seeking behavior among PLHIV
- Adjusted, where necessary (e.g., Lagos), the requirement that LGAs be in the first quartile for prevalence, where LGAs contiguous or proximal to the anchor LGA had moderate or higher burden, high population density, and were hotspots for transmission among key populations
- Reviewed moderate-burden LGAs with extremely high prevalence independent of a super-burdened anchor (e.g., LGAs in Benue)

This approach yields 32 LGAs across seven states and represents 15 percent of the country's total HIV burden. PEPFAR aims to initiate 281,821 net new patients on treatment to reach 80 percent saturation in these 32 LGAs and select military populations over two to three years. PEPFAR will scale-up PMTCT, HTC, care and treatment, community mobilization, and community-based services in the scale-up LGAs to increase demand and expand service uptake. PEPFAR will similarly scale-up investments in OVC care and prevention programs, and linkages in the scale-up to saturation LGAs.

PEPFAR has also prioritized service delivery and coverage for key populations—female sex workers, men who have sex with men (MSM), and persons who inject drugs (PWID). Members of these groups are disproportionately burdened by HIV and contribute to an outsized proportion of new infections and acquisitions.

4.0 Program Activities for Epidemic Control in Priority Locations and Populations

4.1 Targets for priority locations and populations

Given the geographic and population prioritization decisions made for COP15, PEPFAR Nigeria determined the number of additional persons on treatment required to reach 80 percent ART coverage in the 32 scale-up to saturation LGAs and select military populations by the end of FY17/18, taking into account an anticipated 15 percent loss-to-follow-up in setting targets for newly initiating ART patients. In FY 16, PEPFAR aims to enroll 182,977 new patients on treatment in these 32 LGAs and select military populations, with the goal of 265,682 current on ART by APR 16. This represents an increase in coverage in these LGAs from 21 percent to 48 percent, including a threefold increase in number of pediatric patients on ART. Preliminary indications are that Nigeria's PEPFAR budget will be reduced in FY17. Accordingly, we seek to achieve 60 percent of the net new required for saturation in FY16, with the remaining 40 percent to be achieved in FY17.

To reach these targets, PEPFAR Nigeria employed a cascade approach to setting HIV testing targets and considered several program streams to most efficiently identify HIV positives and effectively link them to care and treatment (Table 4.1.2). Given the high burden of TB/HIV co-infection in Nigeria, high rates of TB-related mortality among PLHIV, and the accessibility of these patients through existing PEPFAR supported care programs and TB clinics, the team has committed to improving TB/HIV referral linkages to ensure that 90% of diagnosed co-infected patients are linked into ART. This will be supported primarily through strengthening adherence to testing protocols for both HIV care and TB sites and integration of TB and HIV services (Section 4.7). Given the need to balance the joint goals of eliminating mother-to-child transmission of HIV and attaining sustained epidemic control in priority areas, PEPFAR Nigeria also prioritized diagnosis and ART initiation for HIV-positive pregnant women. The goal in FY 16 is to test 75 percent of pregnant mothers in scale-up to saturation LGAs and enroll 95 percent of those testing HIV positive into ART programs, which is expected to yield an additional 22,559 newly initiated on ART. 24,762 persons who are currently receiving HIV care are expected to

become eligible for treatment during FY16. 13,795 pediatric patients are expected to initiate treatment and the remaining 169,182 required to meet the target for PLHIV newly initiated on ART in scale-up to saturation LGAs will be identified and linked to treatment via provider-initiated, voluntary, and community-based counseling. Based on prior-year program data, 74 percent of those diagnosed HIV-positive through these HTC platforms are linked to care programs.

Current ART coverage in the scale-up to saturation LGAs is low, and scaling at a rate that will achieve saturation by the conclusion of FY17/18 will require utilization of innovative, non-facility-based models of service delivery. Resources have been allocated to these activities and also to activities that will support intensified approaches for case finding, which will be especially helpful with members of key populations that reside or seek services in geographic hotspots. The absorptive capacity of existing ART facilities will not accommodate the number of new patients on treatment required for saturation. Where necessary, existing, moderate-volume PMTCT facilities will be converted to ART sites that serve a broader population.

Service delivery data are currently collected in these 32 LGAs but other data necessary to monitor and evaluate progress toward epidemic control are not. To address that gap, an AIDS Indicator Survey will be conducted across the 32 scale up to saturation LGAs, which will provide improved baseline estimates for numbers of PLHIV, prevalence, incidence, and behavioral risk.

Targets for community prevention interventions were set using an 85 percent coverage goal for key populations. Population size estimates were determined using a recent local epidemic appraisal and APR14 program data. Community-based and key population-focused prevention activities will be the 32 LGAs prioritized for treatment in FY16 with some service delivery permitted in nearby hotspots.

A final priority population is the members and affiliates of the Nigerian armed forces. That population is served by Walter Reed/Department of Defense (DOD), which seeks to newly enroll 8,876 persons on treatment in FY16, for a total of 27,511 current on treatment at APR16.

Table 4.1.1: ART Targets in Scale-up LGAs for Epidemic Control

S/N	Sub National Unit	Total PLHIV	Expected Current on ART (APR 2015)	Additional Patients Required for 80% Coverage	Target Current on ART (APR 2016)	Newly Initiated in FY16
1	ak IkotEkpene Local Government Area	14,324	4,584	8,403	8,098	4,729
2	ak Okobo Local Government Area	14,825	167	11,749	4,845	5,404
3	ak Uruan Local Government Area	11,897	510	8,215	6,431	2,682
4	ak Oron Local Government Area	10,779	4713	5,481	2,085	1,888
5	ak Uyo Local Government Area	26,480	5,253	11,624	6,989	2,785
6	be Buruku Local Government Area	9,329	2,853	4,973	5,454	3,419
7	be Gwer West Local Government Area	8,684	910	6,156	4,485	4,248
8	be Katsina-Ala Local Government Area	17,608	97	6,792	11,369	5,768

Table 4.1.1: ART Targets in Scale-up LGAs for Epidemic Control

S/N	Sub National Unit	Total PLHIV	Expected Current on ART (APR 2015)	Additional Patients Required for 80% Coverage	Target Current on ART (APR 2016)	Newly Initiated in FY16
9	be Konshisha Local Government Area	10,202	206	6,750	5,462	4,842
10	be Logo Local Government Area	14,990	1,166	10,978	7,601	7,575
11	be Tarka Local Government Area	4,740	2,370	1,731	3,100	1,194
12	be Ushongo Local Government Area	12,995	209	9,609	4,647	4,530
13	cr Calabar South Local Government Area	14,714	1192.55	10,734	5,425	5,045
14	cr Calabar-Municipal Local Government Area	8,920	5040.45	2,753	6,035	1,900
15	fc Abuja Municipal Local Government Area	84,103	22,028	45,072	43,311	27,779
16	fc Bwari Local Government Area	18,082	4,109	10,893	10,109	7,516
17	la Agege Local Government Area	5,711	3	4,566	1,829	2,100
18	la Ajeromi-Ifelodun Local Government Area	20,381	3,077	13,629	8,368	6,546
19	la Alimosho Local Government Area	24,544	442	19,251	8,120	8,896
20	la Apapa Local Government Area	3,761	146	2,882	1,856	1,988
21	la Ifako-Ijaye Local Government Area	13,836	515	10,621	4,736	4,932
22	la Ikeja Local Government Area	5,873	2,582	2,174	3,405	1,333
23	la Mushin Local Government Area	52,824	9,048	34,391	22,333	16,635
24	la Surulere Local Government Area	4,944	100	3,868	2,408	2,669
25	na Doma Local Government Area	7,638	2,169	4,224	4,420	2,915
26	na Karu Local Government Area	13,617	3,129	8,173	7,625	5,639
27	na Lafia Local Government Area	24,115	6,868	13,320	13,964	9,191
28	na Nasarawa Local Government Area	13,133	139	10,383	6,250	7,048
29	na Obi Local Government Area	13,087	236	10,265	6,364	7,083
30	ri Eleme Local Government Area	4,922	0	3,887	1,088	1,251
31	ri Obio/Akpor Local Government Area	9,170	4,235	3,653	5,475	2,062
32	ri Port Harcourt Local Government Area	13,561	2,648	5,195	4,485	2,509
Subtotal		513,790	90,745	312,396	238,171	174,101
zz DOD		39,913	24,014	11,048	27,511	8,876
Total		553,703	114,759	323,444	265,682	182,977

Table 4.1.2: Entry Streams for Newly Initiating ART Patients in Scale-up Sub-national Units in FY16

Category	Tested for HIV	Identified Positive	Enrolled on ART
Clinical care patients not on ART	n/a	n/a	24,762
TB-HIV Patients not on ART	11,276	2,593	2,334
HIV-positive Pregnant Women	430,550	23,746	22,559
Other entry streams:		238,075	133,322
Community-based HTC	1,610,836		
Facility-based HTC	3,856,508		
Total	5,917,290	264,414	182,977

Table 4.1.4: Target Populations for Prevention Interventions to Facilitate Epidemic Control

Category	Population Size Estimate (priority SNU's)	Coverage goal	APR 16 Target
FSW	232,329	85%	197,480
MSM	12,588	85%	10,700
IDU	5,368	85%	4,563
Total	250,285		212,743

Table 4.1.5: Targets for OVC and Linkage to HIV Testing, Care and Treatment

S/N	Sub National Unit	Estimated # of Children PLHIV (<15)	Target # of active OVC (FY16 Target) OVC_SERV	Target # of OVC tested (FY16 Target)	Target # of OVC linked to ART (FY16)
1	Ak IkotEkpene Local Government Area	1,432	11,150	4,460	178
2	Ak Okobo Local Government Area	1,482	11,150	4,460	178
3	Ak Oron Local Government Area	1,078	11,150	4,460	178
4	Ak Uruan Local Government Area	1,190	11,150	4,460	178
5	Ak Uyo Local Government Area	2,648	28,130	11,252	450
6	Be Buruku Local Government Area	933	11,150	4,546	182
7	Be Gwer West Local Government Area	868	11,158	4,549	182
8	Be Katsina-Ala Local Government Area	1,761	24,723	9,976	399
9	Be Konshisha Local Government Area	1,020	11,164	4,551	182
10	Be Logo Local Government Area	1,499	11,150	4,546	182
11	Be Tarka Local Government Area	474	11,150	4,546	182
12	Be Ushongo Local Government Area	1,300	11,164	4,551	182
13	Cr Calabar South Local Government Area	1,471	11,150	4,460	178
14	Cr Calabar-Municipal Local Government Area	892	11,150	4,460	178
15	Fc Abuja Municipal Local Government Area	8,410	26,204	10,482	419
16	Fc Bwari Local Government Area	1,808	21,180	8,472	339
17	La Agege Local Government Area	571	10,035	4,014	161
18	La Ajeromi-Ifelodun Local Government Area	2,038	10,035	4,014	161
19	La Alimosho Local Government Area	2,454	11,150	4,460	178
20	La Apapa Local Government Area	376	10,035	4,014	161
21	La Ifako-Ijaiye Local Government Area	1,384	11,150	4,460	178
22	La Ikeja Local Government Area	587	28,521	11,408	456
23	La Mushin Local Government Area	5,282	11,150	4,460	178
24	La Surulere Local Government Area	494	10,035	4,014	161
25	Na Doma Local Government Area	764	11,150	4,546	182
26	Na Karu Local Government Area	1,362	11,150	4,546	182
27	Na Lafia Local Government Area	2,411	16,423	6,654	266
28	Na Nasarawa Local Government Area	1,313	13,208	5,368	215
29	Na Obi Local Government Area	1,309	27,348	11,024	441
30	Ri Eleme Local Government Area	492	11,150	4,460	178
31	Ri Obio/Akpor Local Government Area	917	13,356	5,342	214
32	Ri Port Harcourt Local Government Area	1,356	22,907	9,163	367
	Subtotal	51,379	460,875	185,551	7,422
	zz DOD	1,996	-	-	550
	Total	53,375	460,875	185,551	7,972

4.2 Key population prevention

Key populations (KP) in Nigeria include commercial sex workers (CSW), men who have sex with men (MSM) and persons who inject drugs (PWID). Prevalence rates among young people are higher than average, estimated at 3.3 percent among 15-19 year olds, 4.6 percent among 20-24 year olds, and 5.6 percent among 25-29 year olds. HIV prevalence is higher among women than men, particularly young women. Thus, the national strategic framework designates these groups as priority populations (NARHS 2012). The service delivery package comprises the national minimum prevention package intervention (MPPI). Common issues noted during SIMS visits include insufficient policies on stigma, discrimination, and confidentiality; the need for gender sensitization; inconsistent lubricant stock; and less than optimal referral to care and treatment. PEPFAR plans to address these issues by supporting partners to directly provide a highly efficacious mix of prevention interventions, develop policies, conduct gender norm training, strengthen referral networks, and procure lubricant. HIV case finding, a core activity, will be an integral component of prevention activities among key populations. Efforts will be directed at linking positive individuals into the HIV clinical cascade and contribute to epidemic control through the reduction of transmission. Prevention programs will align with states prioritized for the scale up of treatment services.

At the national level, the 2014 Same Sex Marriage Prohibition Law impedes prevention efforts among lesbian, gay, bisexual, transgender, and intersex (LGBTI) people. The HIV response also faces a number of commodity concerns including periodic shortages of female condoms and lubricant, and anticipated male condom stock outs as United Nations Population Fund (UNFPA) and DFID discontinue procurement.

In FY16, the program will continue the cohort system in which KPs are enrolled and retained. Implementation will be geared toward saturation in the 32 scale-up LGAs and in other KP hotspots in nearby areas. Structural interventions that promote demand among key populations will continue as part of the MPPI; this includes interventions that assure the security of KPs, in particular MSM. Access for hard-to-reach populations will increase with information technology, peer education and snow-balling techniques within networks, and one-stop "safe space" centers. Community mobilization and dialogue is non-core and has been transitioned to the State Agencies for the Control of HIV/AIDS (SACAs) and local community based organizations (CBOs). Partners in LGA's receiving sustained support are building the coordination capacity of these organizations, which is the primary area of investment for sustainability. To date, services in 12 non-priority states have been transitioned; the Global Fund will support five non-priority states and the SACAs will support the remaining states.

4.3 Voluntary medical male circumcision (VMMC)

This is not applicable in Nigeria, as the rate of male circumcision in Nigeria is >90²⁰ percent.

4.4 Preventing mother-to-child transmission (PMTCT)

The GON developed a National Operational Plan to eliminate Mother-to-Child Transmission of HIV using PMTCT option B. PEPFAR supports comprehensive PMTCT services in 32 scale-up LGAs: provider-initiated testing and counseling (PITC) during antenatal care, CD4 tests, antiretrovirals (ARVs), labor and delivery, cotrimoxazole, early infant diagnosis (EID), PMTCT Option B+ Pilot, and postpartum family planning. Community engagement is important, as traditional beliefs, cultural practices, and stigma and discrimination hinder access and contribute to under-utilization of services. Mother support groups foster continuous home-based care for mother-infant pairs, and mobile outreach services assure access for hard-to-reach populations. Common problems identified through SIMS include prolonged EID turn-around-time and poor client flow. These concerns are being addressed through stakeholder meetings, strengthening demand generation, improved national pooled procurement, and last-mile delivery and reporting. USG staff members contribute to the national PMTCT task team to address these challenges, improve service delivery activities, and lead implementing partners to provide complementary technical assistance at sub-national levels. Other LGAs outside of the 32 scale up to saturation LGAs will receive sustained support with testing targets of 30% of pregnant women attending health facilities.

Program activities have been prioritized as core, near-core and non-core based on their contribution to the various stages of the HIV continuum of care. In FY16, the 95 percent goal for ARV enrollment of HIV-positive pregnant women will effectively contribute to the target. Services in low burden, low prevalence areas are being transitioned through a process of stakeholder engagement and will be complete by October 2016. Technical assistance is planned to build public and private sector capacity with a focus on state-level planning and budgeting. Investments to implement task-shifting are planned to ensure future sustainability of results achieved in PMTCT. Family planning and HIV service integration was identified as near-core. Integrated service delivery has been incorporated into national policy and pre-service curricula for health workers, and thus adopted by the health care system. PEPFAR is sensitizing the Global Fund and other stakeholders for their continued support for implementation of FP/HIV integration activities. PEPFAR will support a streamlined package of care and lab services for pregnant women. Care activities include retention of HIV-positive women, their infants and other family members, including focus on treatment adherence.

²⁰(UNAIDS, 2007) – ‘Male circumcision: global trends and determinants of prevalence, safety and acceptability’ - http://www.malecircumcision.org/media/documents/MC_Global_Trends_Determinants.pdf

4.5 HIV testing and counseling (HTC)

PEPFAR provides site monitoring and mentoring for HTC and supports a service package that includes rapid testing, procurement of HTC commodities, and linkages to treatment and care. The program will strategically support the treatment program to contribute to the achievement of the 90-90-90 epidemic control objective for 32 LGAs in Nigeria by refocusing HTC activities to the 32 scale-up to saturation LGA locations and key populations. The program in COP15 will scale up in the 32 LGAs and will include innovative approaches to case finding, including but not limited to testing partners of index patients, testing within high-risk social networks, and mobile testing. Outside the scale up LGAs, all HTC activities will remain facility-based and no longer include routine provider-initiated testing and counseling (PITC) but will be based on clinical symptomatology or when requested by the client. However, across the existing eight priority states, HTC will still be targeted at key populations.

Thus community engagement in these priority states is important because communities serve as advocates and mobilizers for HTC services and trained volunteers often provide critical HTC services in priority locations, particularly among key populations. In addition, service integration within prevention, treatment, and broader primary health care are critical for hard-to-reach populations. For these activities, resource mobilization is targeted to ensure GON commitment for ongoing service provider training and capacity building. PEPFAR is engaged in discussions with both the GON and the Global Fund to transition these services outside PEFAR scale-up to saturation LGAs.

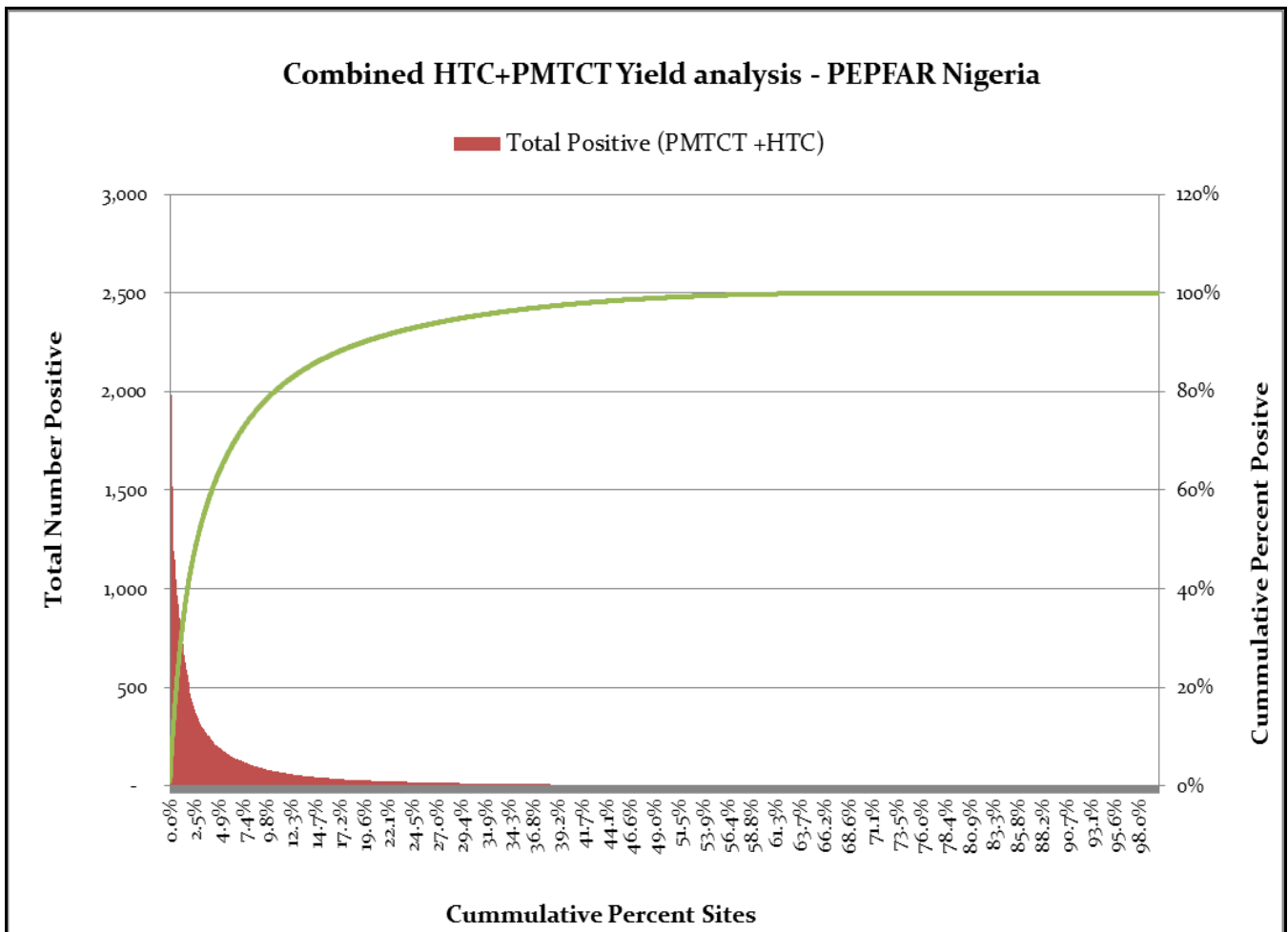
Recent policy and guideline changes pertaining to task-shifting and treatment rationalization affect HTC. The GON approved and signed the National Task Shifting policy in mid-2014, which expands the number of medical and non-medical cadres trained as service providers. Geographic prioritization of treatment, and by implication HIV testing and counseling, disadvantages KPs outside of scale-up to saturation LGAs that do not benefit from the MPPI. In addition, SIMS site visit reveals a lack of funding for supervision and QA/QI activities. These concerns will be addressed during non-core transition discussions with the GON.

Combined PMTCT/HTC Efficiency Analysis

PEPFAR supported PMTCT and HTC services at 6,884 sites in 2014 (6,497 PMTCT sites; 6352 HTC sites, with 90 percent of sites providing both testing for PMTCT and HTC). PEPFAR Nigeria is currently supporting 6,407 PMTCT/HTC facilities after the transition of 477 PMTCT/HTC supported sites in Abia and Taraba states; out of which 2,857 (385 PMTCT only; 263 HTC only; and 2,209 with both services) reported ≤ 4 positives in APR14. All of these sites, except those that are located in the 32 scale-up to saturation LGAs will be transitioned at the end of FY15 and will not be supported in COP15. These sites account for approximately one percent of the positives generated by the program. An additional 1,163 supported PMTCT/HTC sites that reported 5 to 11 positives over the one year reporting period (accounting for approximately three percent of

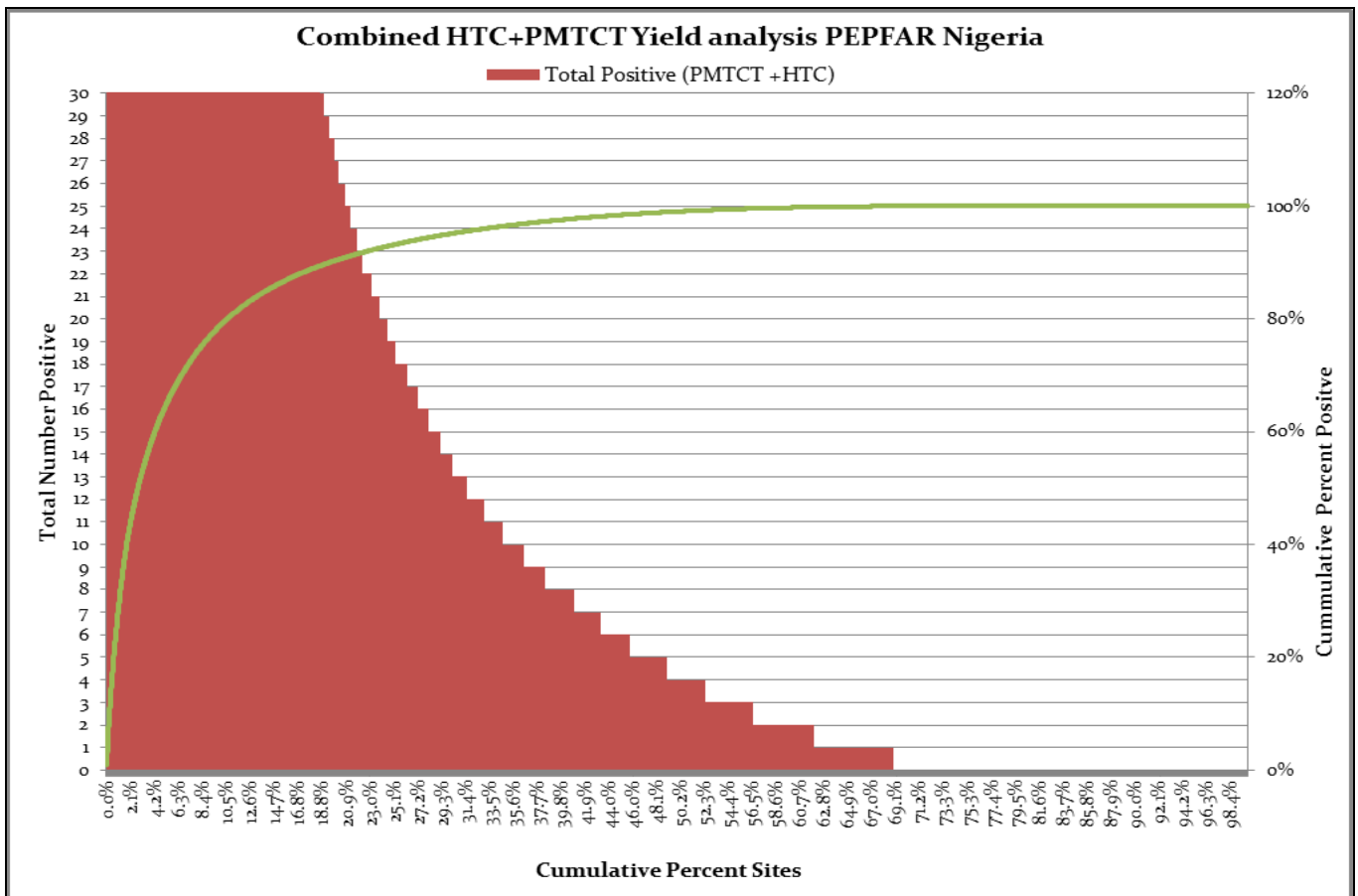
positives in the program) will be transitioned during the COP15 implementation except for those that are in the 32 scale-up to saturation LGAs. Thus, the program will be able to transition 4,020 sites over an 18-month period and retain 96 percent of its positives (in 2,387 PMTCT and HTC sites) while achieving significant cost-savings to be employed for strategic scale-up in the selected scale-up to saturation LGAs. As shown in Figure 4.4.1, 37.3 percent of the sites (2,387) identified 96 percent of positives.

Figure 4.1.1 Combined yield analysis for HTC and PMTCT sites



The following zooms in the on the tail of the chart.

Figure 4.1.1.b Combined yield analysis for HTC and PMTC sites, highlight of tail of graph



4.6 Facility and community-based care and support

Nigeria’s National Care and Support Guidelines (2013) define the minimum package of social, economic and psychosocial services for those infected and affected by HIV: PLHIV, their families and their communities. Services include Positive Health, Dignity, and Prevention (PHDP)/Prevention for PLHIV, tuberculosis screening, cotrimoxazole (CTX) prophylaxis, EID, nutritional assessment and counseling, nutritional support for malnourished children, PLHIV support groups, defaulter tracking, linkages and referrals to complementary services.

It is anticipated that programmatic changes made in the 2014 National Integrated Guidelines for HIV Treatment and Care will affect care services, as eligibility criteria for treatment initiation increased CD4 count from 350 to 500cells/mm³. Based on this and coupled with findings from a 2014 evidence review and prioritization of PEPFAR Care and Support Interventions, non-ART services (TB Screening, Cotrimoxazole prophylaxis, PHDP services) that aim to reduce morbidity and mortality, optimize retention in care, improve quality of life, and prevent ongoing HIV

transmission, all core activities, will be prioritized from FY 2015. HIV exposed infants will be enrolled in care and followed up until no longer at risk of exposure through breastfeeding and final HIV status is confirmed. Exposed infants will benefit from pre-exposure prophylaxis, Cotrimoxazole Preventive Therapy, growth monitoring, nutrition assessment and counseling, EID, and linkage of HIV infected infants to ART services. Referral to OVC services in the community will be strengthened. PEPFAR Nigeria will continue to support geographic areas of low HIV prevalence and burden with clients already enrolled in its care services, whereas adult, adolescent and pediatrics client enrollment will be actively scaled up in the 32 scale up to saturation LGAs.

Access to hard-to-reach populations will be increased by decentralizing care services to primary health centers, which will ultimately reduce stigma associated with accessing specialized care centers. In addition, the program will extend services to non-traditional settings in scale up LGAs, and utilize social networks and media, primarily SMS messages, to disseminate healthy behavior messages and service reminders. PEPFAR Nigeria will embark on an active approach to engaging with communities to expand access, especially in those hard-to-reach areas. Community volunteers, primarily PLHIV will be supported to play active roles in peer adherence counseling, defaulter tracking and coordination of community support groups to improve retention in care for adults, adolescents and pediatric clients. Care providers in the community provide critical services, and support groups are fora for sharing common concerns and sharing in decision-making to address these issues, such as reducing stigma. Additional innovations that provide for or improve non-facility-based service delivery are necessary and will be supported to overcome the infrastructural and absorptive capacity concerns that complicate scaling up in existing and potential facilities.

The program's quality improvement needs are moderate, with approximately 10-20 percent of sites recording >50 percent red and yellow scores during a SIMS visit. Common issues identified in monitoring visits to care sites pertain to gender, in particular post-violence care, gender norms and adolescent support services. PEPFAR Nigeria is currently working with its IPs to strengthen these areas.

4.7 TB/HIV

TB/HIV co-infection has gained recent prominence, given findings from the 2012 National TB Prevalence Survey that indicates Nigeria TB prevalence and incidence has been greatly underestimated. This has resulted in a realignment of activities across stakeholders, including greater use of GeneXpert as a TB diagnostic tool amongst PLHIV, increased integration of TB/HIV services, especially among key populations, and inclusion of ART regimens for co-infected children younger than three years of age.

In FY16 and FY17, PEPFAR will focus on 32 scale-up to saturation LGAs with a high HIV burden to provide HTC for TB suspects and patients, as well as ART at high volume DOTS facilities in order to achieve maximal impact. This "one-stop-shop model" for TB/HIV services will ensure a

coordinated GeneXpert network for improved TB case detection amongst PLHIV to include support for sputum transport mechanisms, maximal ART coverage for co-infected patients, Isoniazid Preventive Treatment (IPT) for all non-TB PLHIV, community-based management of drug-resistant TB (PMDT), and strengthened referral linkages between ART sites and DOTS clinics. Communities play a pivotal role in the identification and referral of TB suspects, mobilization and sensitization for uptake of TB/HIV services, and treatment adherence.

PEPFAR Nigeria recognizes the importance of strong community to facility linkages in order to maximize outreach efforts and ensure access to services. In FY16, the program will engage opinion leaders to mobilize hard-to-reach populations and will strengthen the capacity of community-based organizations to expand service access and linkages to TB and HIV treatment services. To further strengthen referral services between TB and HIV service points, PEPFAR will support position for TBHIV referral coordinators in the 32 scale up to saturation LGAs. This will also ensure that priority attention are given to TBHIV co-infected patients across service delivery points, facilitate timely diagnostic evaluation for TB among PLHIV through sputum referral for GeneXpert diagnosis, prompt treatment initiation for confirmed TB cases as well as follow up and documentation of treatment outcomes.

Priorities for commodity procurement will include RTKs for DOTS sites and provision of 125,000 GeneXpert cartridges through a coordinated logistics system via SCMS to avoid stock outs and wastage amongst implementing partners. Partners in low prevalence areas will be managed via intensified supportive supervisory site visits and strengthened facility-community linkages. These areas are being transitioned to GON and the Global Fund support mechanisms through a process of engagement in technical working groups and the National Tuberculosis and Leprosy Control Program (NTBLCP). PEPFAR engages in joint strategic planning with both the NTBLCP and the Global Fund in order to mobilize resources for TB programming and to promote accountability and transparency. Further, the program's reach is expanded through its leverage of central USAID funds and programs for tuberculosis.

SIMS visits across PEPFAR sites indicate sub-optimal implementation of TB infection control activities as well as IPT and poor documentation of TB/HIV referral. Future efforts will focus on mentoring and supportive supervision to strengthen IPT logistics and capacity building of care providers. PEPFAR Nigeria is strengthening TB infection control through proven strategies such as FAST and TB BASICS.

4.8 Adult treatment

Consistent with the current WHO guidelines, the Nigeria Integrated National Guidelines for HIV Prevention, Treatment and Care revised in 2014 expanded the CD4 eligibility criteria for ART initiation from 350 to 500cells/mm³, thereby increasing the population of PLHIV requiring ART. Treatment activities critical to achieving the PEPFAR strategic objective are retained as core activities for the program. Changes made to the treatment package of services implemented in COP14 remain in effect for COP15. The treatment service delivery package includes: early

identification of PLHIV; early enrollment into care (pre-ART); screening for TB and other opportunistic infections; pre-ART adherence counseling; ART eligibility determination; ARVs; and ongoing facility- and community-based adherence monitoring and retention activities.

Service Package	Scale - Up LGAs	Sustained Support LGAs
Clinical evaluation and assessment	✓	✓
Assessment and management of TB and other OIs	✓	✓
Provision of PHDP services	✓	✓
Provision of ARVS and Co-trimoxazole	✓	✓
Routine HIV testing for TB clients at existing TB/DOHS POS	✓	✓
ART Monitoring (CD4 count testing & Viral Load)	✓	✓
HIV testing among OVCs and linkage to ART services	✓	
Facility & Community Retention & Medication Adherence Support	✓	✓
PITC in multiple POS including ANC	✓	
Provision of EID services	✓	✓
Referrals and linkages – social services, FP/RH	✓	✓
Active Case Finding & Enrolment – Community ART	✓	
Community outreach and demand creation activities	✓	

Pooled procurement of key commodities within the integrated national logistics system has created efficiencies to meet demand. Community activities will be strategically targeted on adherence reinforcement, retention, and viral load suppression. In addition, demand creation activities will be carried out only in the 32 scale-up to saturation LGAs. The program works to sensitize the community on available services and strengthen community support groups to play an active role in community activities targeted to improve medication adherence and retention in treatment. These include defaulter tracking, community adherence support, community drug distribution, and linkages and referrals. The program will use various Community ART service delivery models in different locations to expand treatment access and accommodate the expected increased service uptake in the 32 scale-up to saturation LGAs. Improving access for hard to reach

populations in the scale up to saturation LGAs will be achieved by the decentralization of services to primary health care centers and by mobile clinic services/outreaches.

PEPFAR Nigeria will work in collaboration with Global Fund and other stakeholders to achieve greater impact and disease control in scale up to saturation LGAs. PEPFAR Nigeria has transitioned treatment services in two states, Abia and Taraba, in quarter three of FY2015 to the GON. Additional efforts are ongoing to increase host country engagement and ownership.

Efficiency Analysis

PEPFAR Nigeria supported 908 non-DOD ART sites in FY 2014, of which 15 reported zero patients as current on treatment. These 15 sites are in the COP15 Sustained LGAs and the resources used to support them will be redirected to provide services in the scale-up to saturation LGAs. In 2014, 80 percent of ART patients were seen in 18 percent (159) of PEPFAR supported ART sites. Patient volume in the remaining 82 percent of sites (749) ranged between 0 and 875, with 222 sites (excluding sites with zero patients) reporting less than 20 patients. Of the 222 sites reporting between 1 and 19 patients, 49 are located in scale-up to saturation LGAs. During FY2015, PEPFAR Nigeria supports a baseline of 859 sites after transitioning 49 sites in Taraba and Abia to the GON. 173 of the sites in sustained support LGAs report fewer than 20 patients per site and provide treatment to a total of 1,894 patients. In order to use resources most efficiently, during FY 2016, PEPFAR will seek, whenever practicable, to transfer patients from these sites to nearby higher-volume sites.

In FY2016, PEPFAR will support 141 facilities in the 32 scale-up to saturation LGAs and 543 facilities in the sustained LGAs that will, respectively, provide treatment for 265,682 and 484,245 persons living with HIV. In sustained LGAs, facility-focused support packages will be differentiated by patient volume, which will be discussed further in Section 5.

Figure 4.8.1., ART site volume analysis

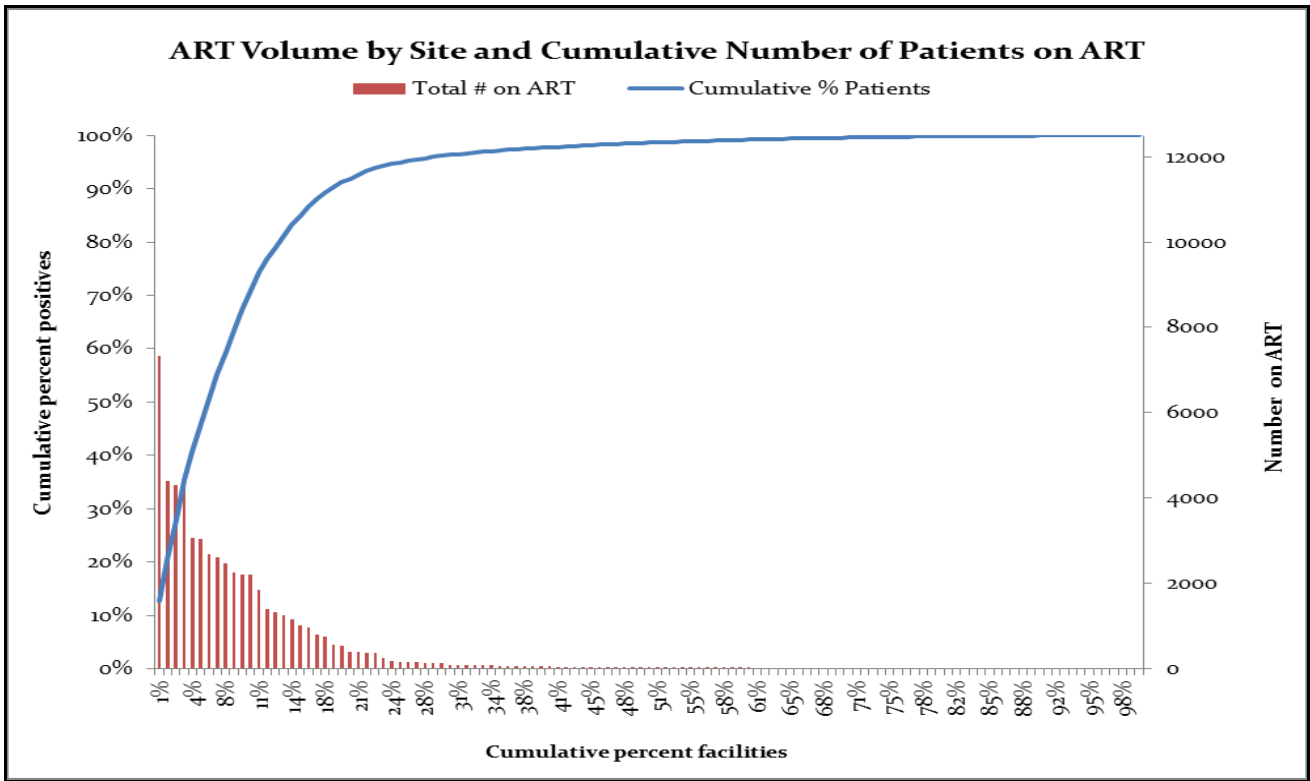
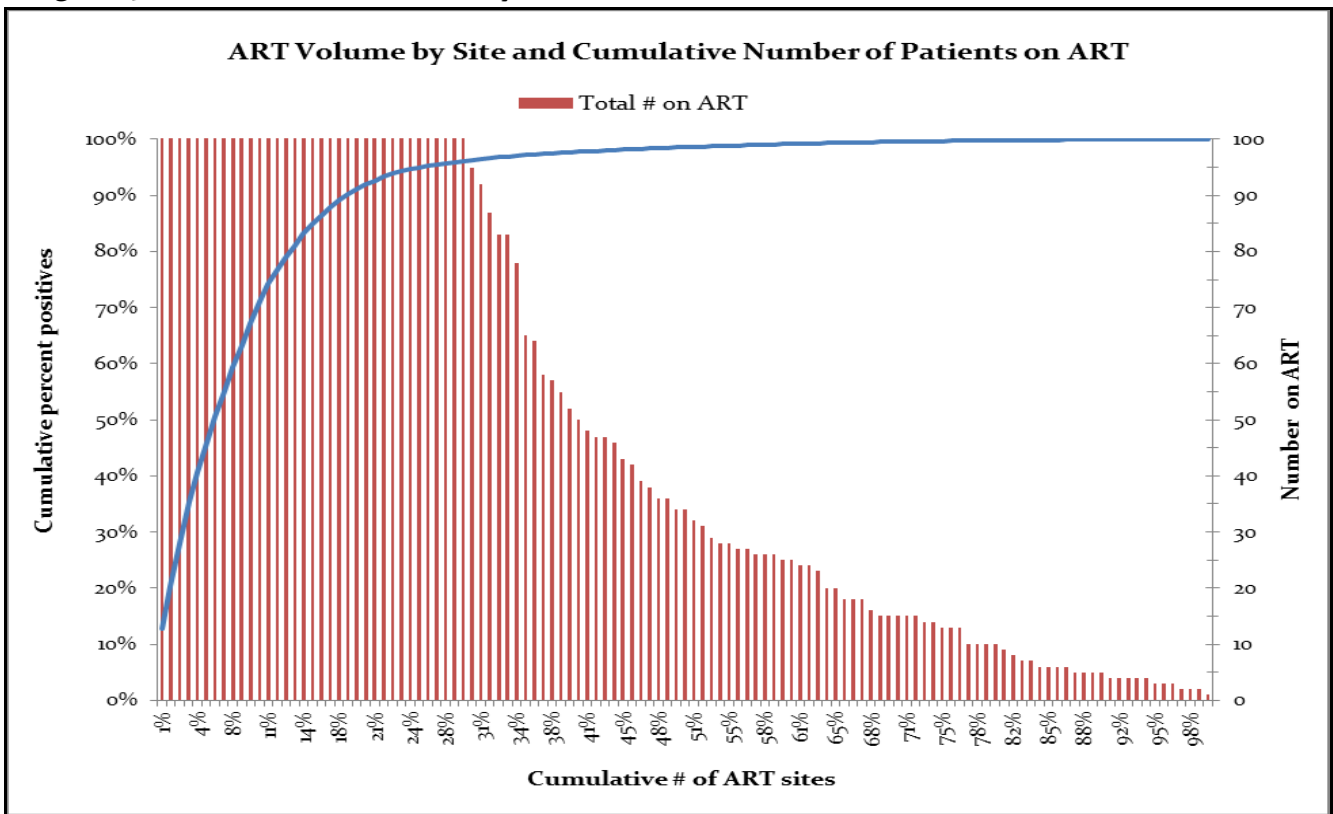
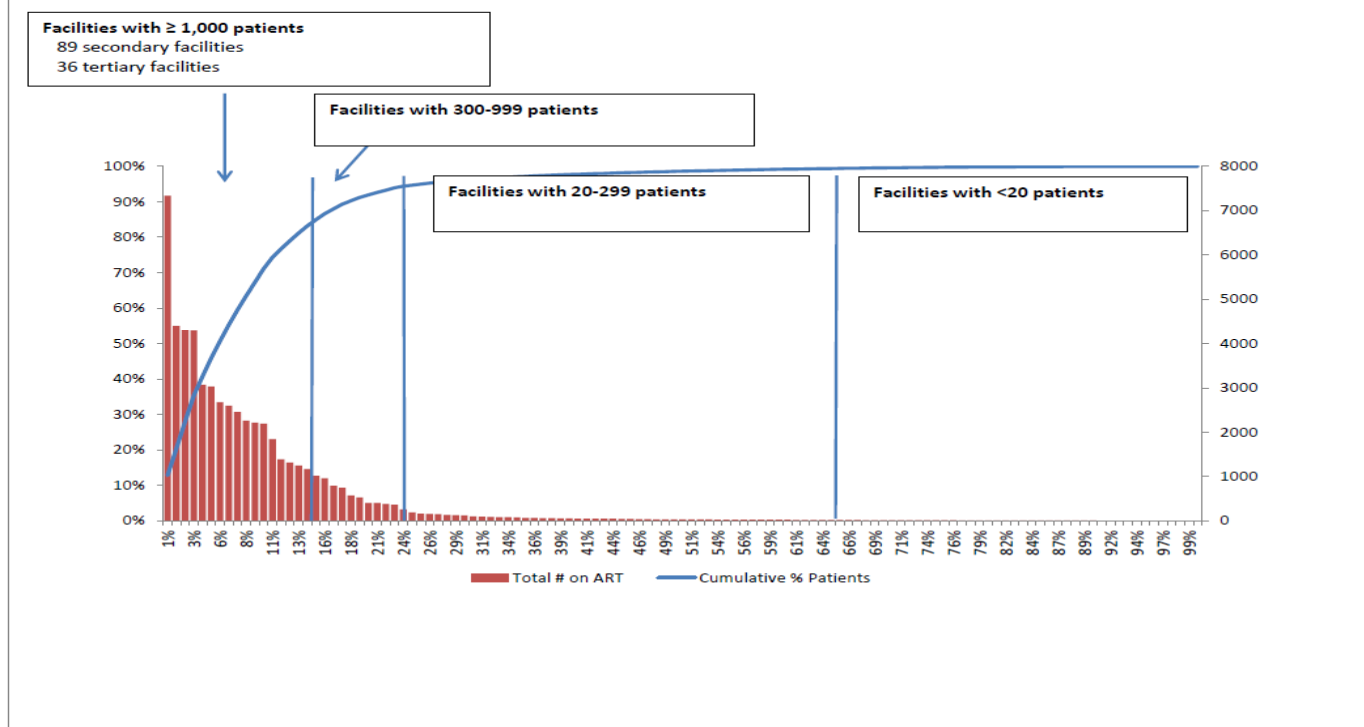


Figure 4.8.1., ART site volume analysis, zoom in on tail



Facility Classification by ART volume in Sustained Support LGAs



4.9 Pediatric Treatment

Pediatric Treatment activities are critical to achieving the PEPFAR strategic objectives of 90-90-90 in scale up to saturation LGAs and are retained as core activities. In the 32 scale up to saturation LGAs the total pediatrics ART gap was calculated and planned to be covered over three years (40% in FY16 and FY17 respectively, remaining 20% in FY18). The service delivery package includes: early identification of HIV infected children under 15 years and enrollment into care; screening for TB and other opportunistic infections; adherence counseling; determination of ART eligibility and timely initiation on ART; optimization of ARVs; activities to improve retention of children in care and treatment such as co-scheduling appointment for parent-child pairs, making facilities children friendly, longitudinal tracking etc. Communities in the scale up to saturation LGAs will be sensitized and engaged to increase demand generation for pediatric HIV services, promote adherence and retention on treatment using existing structures within the community e.g. ward development committees, lay counselors and focal persons to champion HIV services for children. These will also play a vital role in defaulter tracking and promoting adherence.

The program will expand high yield pediatric HIV testing initiatives both in communities especially among OVC and in health facilities by increasing testing among those hospitalized, malnourished, missing school, TB suspects/infected and children of adults enrolled in care. There will be increased effort to improve follow up of mother-infant pairs through strengthened community linkages and longitudinal cohort tracking especially for HIV exposed infants. The revised 2014 Integrated National Guidelines for HIV Prevention, Treatment and Care adopted the

current WHO eligibility criteria for HIV+ children who are under five years old to be placed on ART irrespective of their CD4 count. However, PEPFAR Nigeria will engage the Government of Nigeria in the plan to pilot “Test to offer” ART irrespective of CD4 count for HIV infected children <15years in the scale up to saturation LGAs. This will provide opportunity to initiate HIV infected children under 15years early on ART before immune suppression thereby improving their health outcomes. Improving access of children to ART services and their retention will be achieved by task-shifting from doctor-based to nurse-based and community level care-providers, adherence support through education, counseling, mobile phone messaging services, linkages to OVC and community-based ART programs, promotion of adherence through peers/support group members, and by innovative community outreach in scale up LGAs. In sustained support LGAs, IPs will be directed to retain those currently on treatment, focusing on activities targeted at improved adherence and retention with no demand generation activities.

4.10 OVC

The OVC service delivery package outlined in the National OVC Service Standards will be provided to OVC in scale up to saturation LGAs in FY16. Children will receive need-based and age-appropriate interventions, including support to access healthcare; HIV testing and counselling; linkages to treatment and adherence support for HIV positive children; nutrition assessments and counselling; caregiver and community capacity-building for parenting, early childhood development, and child protection; household economic strengthening, prevention interventions for older OVC, and access to education.

In FY16, the program aims to improve linkages to testing, treatment and care. Community-based OVC programs will recruit referral coordinators to facilitate access and adherence to ART for HIV positive children and caregivers. Table 4.1.5 outlines targets for testing and linkages to care and treatment for OVC. Prevention messaging will target adolescent OVC, especially girls, with linkages to adolescent-friendly reproductive health services. There will be a strong focus across the program on strategies to empower households and communities for better parenting and sustainable care and support to OVC. Services are delivered within the household and community, with strong facility-community referral systems to provide HIV positive OVC with seamless services from the health facility and within the community where they reside.

In LGAs receiving sustained support, partners will focus on intensive household economic strengthening interventions. Households will be graduated out of the program in phases as household income rises. Activities designated as near-core include support to the National OVC Management Information System (NOMIS), professional social welfare training and certification, and advocacy for improved child rights laws, adoption and placement systems. These activities will be transitioned over the next two years to an array of community, private sector, and public sector organizations, under the supervision of relevant government authorities.

During SIMS visits, gender was found to be an area of weakness. In FY16, PEPFAR will build the capacity of local partners to identify and address harmful gender norms and integrate gender considerations into all existing and new activities. Significant CBO capacity has been built to

serve OVC; however, gaps remain in the area of resource mobilization for OVC care and ongoing training for volunteer community para-social workers. The coordination and supervisory capacity of the Ministry of Women's Affairs and Social Development is low, especially at the state level. PEPFAR will continue to build capacity to these groups, including advocacy for workforce development and prevention of and response to violence against children. Implementing partners will also work with community-based organizations to strengthen case management as the gateway to service provision.

5.0 Package for sustained-support services and expected volume in other locations and populations

5.1 Sustained-support services in other locations and populations

Outside the scale-up to saturation LGAs, enrolled patients will be sustained in care and treatment services through FY 16 in both ART and PMTCT sites. In collaboration with GON, PEPFAR Nigeria will discontinue support for low yield HTC and PMTCT sites while patients in ART sites with ≤ 19 patients will be transitioned, where feasible and where service quality will not be reduced to higher volume and higher quality facilities. Low volume facilities with 20-299 ART patients will continue to receive ARVs and other commodities with once a year site visits. Protocols will be implemented to monitor service quality in these facilities and contingency plans will be put in place to, if necessary, provide emergency technical assistance to ensure that quality of services remain optimal. Moderate (300-999 patients) and high volume (≥ 1000) facilities will receive a full complement of support. In the sustained LGAs, passive enrollment of patients into care and treatment services will continue for patients who present requesting services or are in need of testing based on provider-screened symptomatology or the presence of opportunistic infections (OIs.) Patients enrolled in the program will be provided a minimum package of services.

This package includes cotrimoxazole provision, periodic clinical assessments/monitoring, screening for OIs including TB, routine HIV testing at TB/DOTS centers and routine laboratory monitoring, including viral load monitoring and CD4 tests. Selected community activities targeted at improving medication adherence and retention in care and treatment will be conducted. No patient will be denied treatment; therefore, persons requesting HIV testing or presenting with an OI will be provided testing and treatment as needed. There will be no demand generation for testing and no active scale-up of care, treatment, and HTC or PMTCT services in these areas. OVC currently served with core interventions in these sustained LGAs, primarily household economic strengthening, capacity building of caregivers, and linkages to care and treatment, will continue to be supported through the end of FY 16. Following improvement in household income levels, households in the program in the sustained LGAs will be graduated out of the program in phases. Outside of passive testing and linkage to care in PMTCT and ART sites as well as routine testing at TB DOTS centers, PEPFAR support for HTC will be discontinued in these LGAs and populations.

The expected volume of patients needing the minimum package of services in these LGAs has been calculated by LGA and summarized in Table 5.1.1. In FY 16, the expected number tested at PMTCT sites was derived based on the assumption that these sites would continue to provide counseling and testing in ANC settings only at the client’s request as well as when clinical symptomatology warrants. It is estimated that 28.5% of pregnant women in these LGAs will seek care in PEPFAR-supported facilities and be tested under these conditions. There will be no routine testing of women attending ANC clinics in sustained LGAs. Recent, updated PEPFAR guidance may allow limited exceptions to this if epidemiology warrants and budgets allow. Those exceptions will be considered on a case-by-case basis. Stand-alone PMTCT sites with a yield of four or fewer positive clients will no longer be supported by the end of FY 15. By the end of FY16, low yield PMTCT sites with fewer than 12 positives identified during the last year will also no longer be supported. It is anticipated that there will be a significant reduction in the number of women in the PMTCT PEPFAR Nigeria Program due to the discontinuation of PMTCT services at low yield antenatal clinics, discontinuation of active demand generation in these areas, and limited testing (on request and for symptomatic clients only.)

Expected volumes for current on care and current on ART in the sustained LGAs were derived using current program data and account for: (1) the recently revised National guideline for early initiation of ART ($CD4 \leq 500$ cells/mm³); (2) estimated loss to follow up; and (3) the anticipated decline in HTC services in these LGAs. It is anticipated that the pool of patients in care will increase slightly over time, as the passive enrolment rate will be marginally higher than anticipated losses to follow up. PEPFAR is planning on a 2% increase in net new on treatment associated with PEPFAR inflow streams and is also budgeting for another 2% increase associated with inflow from GON-supported testing streams. The GON is aware of our intent to only sustain existing services in those LGAs receiving sustained support but often conducts demand generation activities independent of PEPFAR, and those patients are likely to seek care at PEPFAR-supported facilities.

Finally, the number of OVCs receiving the minimum package of services outlined above will decline gradually as the OVC households are graduated out of the program. The resources from these sustained LGAs will be redirected to the scale-up to saturation LGAs.

Resources required to support sustain services in these LGAs are calculated using the unit expenditure from the last expenditure analysis (EA). This is projected at \$86.95 million.

Sustained Services Volume by Group	Expected result APR 15	Expected result APR 16	Percent increase (decrease)
HIV testing in PMTCT sites	1,922,744	1,075,654	-44%
HTC (only Sustained services ART sites in FY 16)	3,289,178	2,620,712	-20%
Current on care (not yet initiated on ART)	186,388	113,768	-39%
Current on ART	484,801	455,073	-6%
OVC	947,136	485,299	-49%

5.2 Transition plans for redirecting PEPFAR support to priority locations and populations
PEPFAR Nigeria will no longer support 2,857 low yield HTC and PMTCT sites at the beginning of FY16. PEPFAR Nigeria has commenced discussion with NACA and the MOH's HIV/AIDS Division during COP 15 planning and has shared strategic directions, key programmatic decisions, as well as data and analyses used for decision making. In COP14, PEPFAR support for human resources for health (HRH) was discontinued with the GON stepping in to absorb those staff whose salaries had previously been paid by PEPFAR. Some of the sites were negatively impacted, especially the high volume sites in tertiary health facilities and some secondary health facilities as they had been completed paid for by PEPFAR and were not considered part of routine facility services. Salary top-ups were also discontinued during the second half of FY14. Ongoing efforts continue to engage various levels of government to address critical HRH gaps in health facilities especially in treatment sites which include support for implementation of the task shifting and sharing policy.

Most ART sites will be sustained in areas outside of the scale-up to saturation LGAs during FY16 and phased transition of patients to other sites will commence in FY16. PEPFAR Nigeria will continue to engage the GON to take on additional states following the successful transition of two states, Abia and Taraba, in FY 2015. Furthermore, other key stakeholders including the Global Fund, State Governments and CSOs will be involved in developing transition plans for sites in sustained-service areas. Laboratories categorized as primary labs, except those in scale-up to saturation LGAs and five of the PCR laboratories located outside the priority states, will be transitioned to the GON by the end of FY 2016. Similarly, OVC services in non-priority states will be scaled down and efforts to strengthen the program to identify beneficiaries that can be graduated will be intensified. Civil society is being engaged to assist with developing innovative ways to continue these services beyond FY 2017 without direct PEPFAR support.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Laboratory Strengthening

In order to strengthen Nigeria's laboratory infrastructure for improved access, quality, and coverage of HIV related diagnostics and testing, PEPFAR Nigeria will focus its core activities on:

- 1) Maintaining existing laboratory infrastructure for service delivery;
- 2) Provision of laboratory commodities;
- 3) Quality assurance programs for HIV rapid testing, CD4 testing, EID and HIV viral load testing;
- 4) Support for national equipment harmonization and maintenance program;
- 5) Technical assistance activities; and
- 6) Support for sample transport network.

PEPFAR Nigeria currently supports basic laboratory infrastructure for a total of 566 labs. In FY 2016 PEPFAR will support a maximum of 428 labs. The supported labs in FY16 will include 76 tertiary facility-based labs, 352 secondary facility-based labs while all primary facility-based labs will have been transitioned to the GON. Transition of PCR supported laboratories will occur in phases in order not to disrupt EID and viral load services. In FY 2016, five PCR labs will be transitioned to the GON while the second phase will focus on PCR labs located outside the non-priority states. As PEPFAR scales up its usage of viral load for patient monitoring, CD4 testing will be used for staging. Scaling for viral load will be concentrated in the 32 scale-up to saturation LGAs with limited use in other sustained LGAs in order to establish an operational linked network of labs.

6.1 Laboratory Strengthening											
1. Brief Activity Description	Deliverables		Budget Codes and allocation (s)		6. Imp. Mech. ID	7. Relevant Sustainability Element and Score	Impact on Epidemic Control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkages to Care (LTC)	10. ART Uptake	11. Other Combination Prevention	12. Viral Suppression
1. Support Laboratory infrastructure and equipment maintenance in order for laboratories to remain functional/ operational for service delivery. The funding support will also be for commodities not included in pooled procurement in priority states and SNU's	All 425 (25% reduction) laboratories to provide EID, VL and CD4 services to over 500,000 patients in care and treatment. The number of labs will further be reduced after low yield analysis	Further 20% reduction in the number of clinical laboratories from COP15 to 342 will be supported to provide EID, VL and CD4 services	[REDACTED]	[REDACTED]	[REDACTED]		This activity is important for diagnosis of HIV infections (e.g. EID) can be used as a tool for prevention of new infections.	Supports CD4 monitoring of patients	Critical for staging and putting patients on ART as well as monitoring those on treatment	The activity also critical in the preparation of QC materials in support of HIV RT in HTC; which is a strategy for prevention of new infections	Enables VL suppression to be monitored
2. To build sustainable and highly trained human resources and Lab Systems Strengthening through the pre and in-service trainings. The activities includes: In-service trainings targeting existing lab workforce supporting PEPFAR program, to improve the quality and reliability of HIV and TB test results used for diagnosis and monitoring. The pre-service is focused on curriculum improvement for the training of lab science in the universities and schools of health	Pre-service - improvement of curriculum in 10 universities. For the in-service 800 lab staff will be trained in difference areas to support quality service delivery	Support Pre-service - improvement of curriculum in 20 universities and in-service trainings for facility staff in scale up districts, priority states and sustained sites. For the in-service 1000 lab staff will be trained in difference areas to support quality service delivery	[REDACTED]	[REDACTED]	[REDACTED]	HRH – 8.0	Support quality assured laboratory testing in the most efficient and effective ways			Support quality controlled and quality assured testing in PMTCT, blood transfusion, DoTs centers and ARTs for CD4 monitoring	Support quality assured viral load monitoring tests in the most efficient and effective ways
3. Provide in-service training of trainers (TOTs) done for laboratory professionals to achieve standard quality management system in GON and PEPFAR supported facilities (e.g. SLMTA, DBS, logistics and inventory management, etc.). Activity will include training across all partners, coordinate the implementation of PMV, provision of QC materials to all testing sites in the states The in-service training is pooled together and use across the agencies	Provide update information on the in-service training of trainers (TOTs) done for laboratory professionals to achieve standard quality management system in GON and PEPFAR supported facilities (e.g. SLMTA, DBS, logistics and inventory management, etc.)	TOT training for 72 laboratory professionals (3sets)	[REDACTED]	[REDACTED]	[REDACTED]	HRH – 8.0	Improve quality of HIV testing		Improved		Implementation of QMS will improve VL testing

6.1 Laboratory Strengthening											
1. Brief Activity Description	Deliverables		Budget Codes and allocation (s)		6. Imp. Mech. ID	7. Relevant Sustainab ility Element and Score	Impact on Epidemic Control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkages to Care (LTC)	10. ART Uptake	11. Other Combination Prevention	12. Viral Suppression
	Provide updates on other in-service capacity building trainings (e.g. auditors training, FLLM training, etc.) done within the budget year to enhance quality management system in GON and PEPFAR supported facilities.	<ul style="list-style-type: none"> o In -country capacity building trainings o State QA team training for post market validation of HIV RTKs o PEPFAR supported sites which received HIV testing controls - 100% o The GON/PEPFAR supported sites which received NMLStP Implementation - 100% of supported labs o 				HRH - 8.0	Improve quality of HIV testing		Improve quality of testing		
Capacity building for Continuous quality improvement (CQI) and implementation of QMS (this include PMV, EQA, SLMTA/SLIPTA, FOG) in all PEPFAR supported priority Labs											
4. Implementing step-wise laboratory quality improvement (SLIPTA) through Mentorship, training of auditors, audits/assessment and M&E of selected high volume sites in priority states.	8 laboratories mentored	Using the step-wise process 16 laboratories will be mentored. Enroll new labs in priority districts into stepwise QMS implementation	[REDACTED]	[REDACTED]	[REDACTED]		Improve quality of HIV testing				Improve quality of Viral Load testing
	24 laboratories audited	20 laboratories after going through the process will be audited by ASLM certified auditors and awarded stars	[REDACTED]	[REDACTED]	[REDACTED]		Improve quality of HIV testing				Improve quality of Viral Load testing
	50 lab professionals trained and certified as auditors	50 laboratory professionals trained and certified by ASLM for sustainability	[REDACTED]	[REDACTED]	[REDACTED]		Improve quality of HIV testing				Improve quality of Viral Load testing
5.To Conduct post market validation (PMV) of all HIV Rapid test kits (RTKs) procured by PEPFAR or GON for use in all supported sites, as part of quality assurance. Grantee will be working with the national QA team coordinated by FMOH/HAD. Support HIV and related disease test kit evaluations to be conducted by GON/PEPFAR as part of quality assurance associated with testing algorithms. Procure and distribute proficiency testing panels to all PEPFAR supported laboratories and	Conduct 6 rounds of PMV/year of all procured under MLSCN mechanism	Conduct 5 rounds of PMV/year of all procured HIV RTKs for national use.	[REDACTED]	[REDACTED]	[REDACTED]		Assure the quality of HIV testing on the field		Only clients requiring ART will be given. No wastage.	Clients who truly test negative are counselled to stay safe.	
	Provide 4 rounds of PT/Year in all supported laboratories (panels to cover HIV serology, CD4, EID, VL and TB under MLSCN mechanism	Provide 4 rounds of PT/Year in all supported laboratories (panels to cover HIV serology, CD4, EID, VL and TB)	[REDACTED]	[REDACTED]			Help in assessing the quality of testing		Support appropriate monitoring of patients on ART		Ensures VL testing is done correctly

6.1 Laboratory Strengthening											
1. Brief Activity Description	Deliverables		Budget Codes and allocation (s)		6. Imp. Mech. ID	7. Relevant Sustainability Element and Score	Impact on Epidemic Control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkages to Care (LTC)	10. ART Uptake	11. Other Combination Prevention	12. Viral Suppression
address PT failure through the implementation of corrective actions. Provide plan for working with MLSCN, the NQA team and HAD to implement these activities. Support the training and retraining of the federal and state quality assurance officers to ensure adequate evaluation of test kits. Support the maintenance of the NLEQAC, Saye – Zaria where the kit testing takes place.	Maintain the NLEQA Center infrastructure and equipment under MLSCN mechanism	Maintain the NLEQA Center infrastructure and equipment	[REDACTED]	[REDACTED]			The maintenance of the labs where the various testing takes place is key to obtaining quality results.				
6. Provide TOT trainings across PEPFAR partners on laboratory systems strengthening (SLMTA). These trainings are targeted at laboratories in high volume treatment sites. The training will enable partners to monitor and evaluate the lab systems for quality. The Implementing Partner will also support state QA teams to conduct HIV RTK post market validation at the state levels. To coordinate the preparation and distribution of controls to all testing points. To provide support for implementation of National Medical Laboratory Strategic Plan (NMLStP)	Conduct in-service training of trainers (TOTs) for laboratory professionals to implement QMS in PEPFAR supported laboratories. 24 lab professionals trained.	72 laboratory professionals (3sets) will be trained to implement QMS in supported laboratories	[REDACTED]	[REDACTED]	[REDACTED]	HRH – 8.0					
	Indicate the number of professionals trained in various laboratory skills and the number of such trainings done.	Step-down SLMTA trainings for 120 lab personnel from FMOH, SMOH and health facilities (5 sets) -Other in-country capacity building trainings - 48				HRH – 8.0				Assurance that the standard of care is comparable to world accepted standards.	
	Capacity building trainings (e.g. auditors training, FLLM training, etc.) done within the budget year to enhance quality management system in GON and PEPFAR supported facilities.	State QA team trained conduct post market validation of HIV RTKs at the state levels				HRH – 8.0	The quality of testing at sites impact on HTC - entry point for care				

6.1 Laboratory Strengthening											
1. Brief Activity Description	Deliverables		Budget Codes and allocation (s)		6. Imp. Mech. ID	7. Relevant Sustainability Element and Score	Impact on Epidemic Control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkages to Care (LTC)	10. ART Uptake	11. Other Combination Prevention	12. Viral Suppression
7.Provision of Basic Lab Information System (BLIS)in selected high volume treatment sites in priority states	BLIS Implemented in selected high volume sites and data generated integrated into national reporting system	BLIS Implemented in selected high volume sites and data generated integrated into national reporting system	[REDACTED]	[REDACTED]	[REDACTED]						Increase the quality of test results generated in the lab
Technical Assistance for National Laboratory Strategic Plan Implementation											
8.Support government of Nigeria in the dissemination, costing and Implementation of the National Medical Laboratory Strategic Plan (APIN)	Dissemination, costing and implementing the costed plan	This support will help government to develop structures for lab program in the country. The support will include cost of monitoring and evaluation	[REDACTED]	[REDACTED]	[REDACTED]				Strengthen referral network of laboratories, increasing ART uptake		Support referral network of laboratories, thus increasing viral load access
Sample Shipment and Referral Networks											
9. Strengthening Sample referrals and shipment (training and cost of sample shipment from collection sites/labs to referral labs) for CD4, EID, Viral Load and TB in priority states		Development of a robust specimen referral system through network of laboratories and using private sector engagement for efficiency	[REDACTED]	[REDACTED]	[REDACTED]			Increase access to services	Increase uptake of ART	Increase access to prevention services	Increase access to VL services
10. FOG to local Professional Lab Assoc. to Implement Quality Management System and linkages with Public Facilities	Quality Improvement of Lab service delivery in Private sector Labs and strengthened referrals and linkages between private and public facilities for increased access to lab services	Quality Improvement of Lab service delivery in Private sector Labs and strengthened referrals and linkages between private and public facilities for increased access to lab services	[REDACTED]	[REDACTED]	[REDACTED]			Increase access to quality services in the private sector			
Laboratory Continuous Quality Improvement Activities:											
11. Implement HIV Rapid test quality improvement	Ensure all HIV testing points use standardized log books, run controls, participate in PT program and testers are certified.	Ensure all HIV testing points use standardized log books, run controls, participate in PT program and testers are certified.	[REDACTED]	[REDACTED]	[REDACTED]			Improve the quality of HIV testing			Improve the quality of HIV testing
Program Coordination activities at National and state levels											

6.1 Laboratory Strengthening											
1. Brief Activity Description	Deliverables		Budget Codes and allocation (s)		6. Imp. Mech. ID	7. Relevant Sustainability Element and Score	Impact on Epidemic Control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkages to Care (LTC)	10. ART Uptake	11. Other Combination Prevention	12. Viral Suppression
12. Quarterly meetings with Partners and GON on EID, Viral load and lab transition program implementation. This activity will enable USG closely monitor program implementation and hold partners accountable		Regular program implementation meetings with IPs and GON officials at all levels held. Hold 4 national and 6 zonal coordination meetings in a year	[REDACTED]	[REDACTED]	[REDACTED]		It will improve HIV testing	Increase access to quality services	It will improve ART uptake	Increase access to quality services	Increase access to quality services

6.2 Strategic information (SI)

In the spirit of country ownership and in order to facilitate sustainability, PEPFAR Nigeria will focus on strengthening the GON health information management system (HMIS). Deployment of an HIV module in the GON owned electronic District Health Information System (DHIS) will be supported. Technical assistance will be provided to the Federal and state level ministries of health on the management of the DHIS platform. Efforts will be made to support the development of an interactive dashboard in the DHIS system, so as to facilitate the presentation of data in a user-friendly format and subsequently improve data use for decision making.

Electronic Medical Record (EMR) systems in health facilities, with priority given to facilities located in scale-up LGAs. PEPFAR Nigeria also provides technical assistance to the Federal Ministry of Health in the deployment of the national data repository to which individual facility level electronic medical records will be linked, thus supporting patient retention irrespective of mobility. This system will also de-duplicate client records. Data audits will be carried out at supported facilities by implementing partners, USG staff, and a third-party contractor. The third-party auditor will be a neutral organization engaged by the PEPFAR Coordinator's Office and will focus on ensuring accuracy and validity of the program data.

In collaboration with State Ministries of Health, HIV/AIDS impact assessments/indicator surveys will be conducted in the scale-up LGAs to generate HIV/AIDS epidemiologic data which will guide HIV programming to the appropriate population and geographic locations. In addition, the results of the impact assessment in PEPFAR Nigeria scale up LGAs will serve as a baseline for future evaluation of impact and determination of success in HIV/AIDS epidemic control.

PEPFAR Nigeria will continue to provide technical assistance to the GON in the conduct of other surveys/surveillance and evaluation activities, including HIV service quality monitoring and evaluation, data quality assessments, and PMTCT cascade evaluation (including EID.) These activities are geared to determine the outcome/impact of PEPFAR program interventions and to make recommendations for program improvements. In addition, PEPFAR Nigeria will continue to support the Nigerian Ministry of Defence in the conduct of a long-term cohort (multi-country) study (AFRICOS), aimed at assessing the impact of clinical practices and other factors on HIV infection and disease progression in the African context.

S/N	1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mech. ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
		2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
1	Establishment of Routine Program Data Validation and Data Quality Assessments	Improved data quality (timeliness, completeness, accuracy) of program results	Improved data quality (timeliness, completeness, accuracy) of program results	[REDACTED]	[REDACTED]	[REDACTED]	Performance Data - 18.0	Yes		Yes		
2	Provision of technical support to the government of Nigeria to improve the structural robustness of government DHIS2 instance/system to include PEPFAR indicators, facility IDs, harmonization and updating of MFL, and other system strengthening.	Harmonized HIV/AIDS reporting (via DHIS) and updated MSL	Harmonized HIV/AIDS reporting (via DHIS) and updated MSL	[REDACTED]	[REDACTED]	[REDACTED]	Performance Data - 18.0	Yes		Yes		
3	Support the GON in the design, presentation and routine update of an analytical interphase/dashboard (graphic charts, mapping) that accommodates data from the Nigeria DHIS2 instance and other sources; including the facilitation of data demand and use.	Improve data quality, visualization and use by GON, PEPFAR and other stakeholders	Improve data quality, visualization and use by GON, PEPFAR and other stakeholders	[REDACTED]	[REDACTED]	[REDACTED]	Performance Data - 18.0					
4	Improve project performance through targeted evaluations and performance indicator assessment.	<ul style="list-style-type: none"> Mid-term and/or end of program evaluations performance indicator assessments conducted on selected indicators 	<ul style="list-style-type: none"> Mid-term and/or end of program evaluations performance indicator assessments conducted on selected indicators 	[REDACTED]	[REDACTED]	[REDACTED]	Performance Data - 18.0	Yes	Yes	Yes		

S/N	1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mech. ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
		2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
5	Support PEPFAR Nigeria with SI data gathering, analysis and reporting needs, including PEPFAR2 database management and reporting	<ul style="list-style-type: none"> Routine performance data reported through the USG PEPFAR2 by IPs cleaned, validated, and reports generated for routine PEPFAR reporting Regular data exchange into DATIM Provide Monthly and Quarterly Program Results (MPR) for use by OGAC and PEPFAR Nigeria. Implementation and deployment of the MER indicators USG PEPFAR2 and associated capacity building for the IPs, USG AORs/CORs and other program managers. Database maintenance including regular software and system updates/upgrades 	<ul style="list-style-type: none"> Routine performance data reported through the USG PEPFAR2 by IPs, cleaned, validated, and reports generated for routine PEPFAR reporting. Regular data exchange into DATIM. Provide Monthly and Quarterly Program Results (MPR) for use by OGAC and PEPFAR Nigeria. Database maintenance including regular software and system updates/upgrades 	[REDACTED]	[REDACTED]	[REDACTED]	Performance Data - 18.0	Yes	Yes	Yes	Yes -long term	Yes -Long term
6	Strengthen selected states and LGAs in Nigeria, including roll-out of PEPFAR2 national instance and regular reporting through the system, and establish/strengthen system for routine program and M & E and DQA activities through the Lead IP system	<ul style="list-style-type: none"> Established system and capacity at selected states and LGAs for routine M&E of PEPFAR/AIDS and TB programs and HMIS in general. DQA system established and implemented. Costed M& E plans developed and implemented. Facility-level reporting into NHMIS using national DHIS system 	<ul style="list-style-type: none"> Established system and capacity at selected states and LGAs for routine M&E of PEPFAR/AIDS and TB programs and HMIS in general. DQA system established and implemented. Costed M& E plans developed and implemented. Facility-level reporting into NHMIS using national PEPFAR system 	[REDACTED]	[REDACTED]	[REDACTED]	Performance Data - 18.0	Yes	Yes	Yes	Yes	Yes
7	Improve quality of data reported by Implementing Partners across agencies.	Conduct independent (non-agency) data audits on regular basis.	Conduct independent (non-agency) data audits on regular basis.	[REDACTED]	[REDACTED]	[REDACTED]	Performance Data - 18.0	Yes	Yes	Yes	Yes	Yes

S/N	1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mech. ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
		2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
8	USG SI regular review meetings/workshops with partners and GoN	Review meetings/workshops conducted, PEPFAR supported performance data reviewed, lessons learned shared and challenges discussed and courses of actions developed for implementation	Review meetings/workshops conducted, PEPFAR supported performance data reviewed, lessons learned shared and challenges discussed and courses of actions developed for implementation	[REDACTED]	[REDACTED]	[REDACTED]	Performance Data - 18.0	Yes	Yes	Yes	Yes	Yes
9	AIDS Indicator Survey in Kaduna	•Approved Study Protocol. •Complete and Comprehensive Enumeration area (EA) list and maps. •Field data collection commenced	•Field data collection – completed. •Data management and analysis. •Project Report production and dissemination	[REDACTED]	[REDACTED]	[REDACTED]	Epidemiology and Health Data - 14.4	Yes	yes	Yes -long term	Yes -long term	Yes -long term
10	AIDS Indicator Survey in Akwalbom	• Approved Study Protocol. • Complete and Comprehensive Enumeration area (EA) list and maps. • Field data collection commenced. • Implement Approved Study Protocol	• Field data collection – completed. • Data management and analysis. • Project Report production and dissemination. • Data management and analysis completed. • Project Report production and dissemination	[REDACTED]	[REDACTED]	[REDACTED]	Performance Data - 18.0	Yes	Yes	Yes -long term	Yes -long term	Yes -Long term
11	HIV/AIDS Impact Assessment in Priority Sub-national units 2		To determine baseline HIV/AIDs program impact	[REDACTED]	[REDACTED]	[REDACTED]	Performance Data - 18.0	Yes	Yes	Yes	Yes	Yes
12	Service Quality Monitoring and Evaluation (Nigeria Qual)	Improved services quality	Improved services quality	[REDACTED]	[REDACTED]	[REDACTED]		Yes	Yes	Yes	Yes	Yes
13	PMTCT cascade Evaluation (EID Evaluation),	Developed and approved Study Protocol	Determine outcome/impact of PEPFAR and make recommendation for improvement	[REDACTED]	[REDACTED]	[REDACTED]		Yes	Yes	Yes	Yes	Yes

S/N	1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mech. ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
		2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
14	National Electronic Health Data Repository	Data for decision on program improvement	Data for decision on program improvement	[REDACTED]	[REDACTED]	[REDACTED]	Performance Data - 18.0	Yes	Yes	Yes	Yes	Yes
15	Support for data management activities at NMOD sites	Provide oversight and program level support for NMOD sites. Includes capacity building, supportive supervision and mentoring	Provide oversight and program level support for NMOD sites. Includes capacity building, supportive supervision and mentoring	[REDACTED]	[REDACTED]	[REDACTED]	Performance Data - 18.0	Yes	Yes	Yes	Yes	Yes
16	Support for data management activities at NMOD sites (Data Clerks)	Provide direct data management support through data clerks for NMOD supported sites	Provide direct data management support through data clerks for NMOD supported sites	[REDACTED]	[REDACTED]	[REDACTED]	Performance Data - 18.0	No	Yes	Yes	Yes	No
17	RV329; The African Cohort Study (AFRICOS)	Multi-country study to assess the impact of clinical practices, biological factors and socio-behavioral issues on HIV infections and disease progression in an African context	Multi-country study to assess the impact of clinical practices, biological factors and socio-behavioral issues on HIV infections and disease progression in an African context	[REDACTED]	[REDACTED]	[REDACTED]	Performance Data - 18.0	No	No	Yes	No	Yes
	Total			[REDACTED]	[REDACTED]							

Table 6.3: Health Systems Strengthening (HSS)

Nigeria's health system is currently organized in a way that diffuses responsibility across a number of organizations and agencies. It is a system that has not worked well. We will continue to encourage the GON to create policies that will serve to simplify and strengthen state-level health systems to minimize confusion and gaps in services and maximize the quality of health care provided.

PEPFAR Nigeria will continue to focus on key HSS strategies that will mitigate the weaknesses of the Health System and support the delivery of a sustainable and comprehensive HIV/AIDS services. These weaknesses include:

- HRH issues due to largely mal-distribution of health care workers (HCW), and partly due to insufficient numbers of trained HIV care and management cadres;
- Weak involvement of CSOs and the private sector in HIV/AIDS programming; and
- Poor domestic funding of the health sector, including HIV programs.

Hence, the overarching focus of PEPFAR Nigeria HSS program is on *core* and *near-core* interventions and activities that will support the strengthening of institutional, organizational and technical capacities of the GON at the National, State, and more specifically, the identified scale-up LGAs.

PEPFAR Nigeria HRH interventions support the development of the Human Resource for Health Information System (HRIS), pre-service training (PST) and in-service training (IST) activities. The PEPFAR Nigeria 2015 Sustainability Index and Dashboard (SID) indicate a lack of information on the sufficiency of trained HCW cadres in HIV/AIDS to meet service delivery needs. The HRIS will provide the necessary information for HRH management that will help improve the recruitment, deployment and retention of HCW to ensure a consistent and sustainable supply of manpower in identified areas of critical need to support service delivery in scale-up LGAs and sustained-service states. This project is supported through a two-pronged approach: creation of a national database/registry with linkages to relevant health professional regulatory agencies, and State HRISs that will also be linked to the national registry. This ongoing activity is envisaged to be concluded in FY 2017. In order to increase the pool of HCW with competencies in HIV management, investments in pre-service training projects will be sustained across various PEPFAR Nigeria training mechanisms. It is envisaged that these new HCWs – including nurses, midwives, laboratory technicians and community HCWs, will be absorbed by the States and LGAs where they are needed. Advocacy activities with State governments for greater HRH investments are on-going. For continuous improvement of quality of service delivery, in addition to on-site mentoring, current frontline HCWs will be provided with opportunities to update their knowledge and skills in line with any new HIV/AIDS guidelines and management strategies.

These in-service trainings are being institutionalized in select government-owned training institutions.

Lead IPs will continue state-level engagements through the Lead IP Framework to galvanize greater state ownership and investments in their HIV programs. They will provide technical support to the States and build their capacity to plan, monitor and evaluate state programs. PEPFAR Nigeria will also support the strengthening and development of CSO's organizational and technical capacities to mobilize funds to support HIV service delivery. Capacity development programs for the CSOs will focus on leadership development to improve their management capacities. Their coordinating efforts will be enhanced through umbrella organizations and networks to strengthen the local community's ability to advocate and lobby for increased funding for sustainable HIV service delivery. These activities will operate at both Federal and State levels commencing with the PEPFAR priority States in FY 2016.

The PEPFAR Nigeria Health Finance strategy will help develop government's capacity to collect and analyze costing information and use such evidence to generate adequate internal resources to scale-up and sustain HIV/AIDS services. To address the severe dependency on donor-funds for the health sector including HIV/AIDS programming in Nigeria, PEPFAR will seek increased funding and ownership of the HIV/AIDS response from the GON through the President's Comprehensive Response Plan (PCRP). PEPFAR will also collaborate with State government structures and other local stakeholders to generate additional revenue for HIV/AIDS programming through the Lead IP platform earlier mentioned.

S/N	1. Activity Description	Deliverables		Budget codes and allocation (\$)		6. Imp. Mech. ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
		2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Human Resource for Health (HRH)												
1.	Computerized health workforce registry established and populated to track all health workers in scale-up LGAs, and moderate and high volume sites at the national and state levels (PEPFAR Nigeria priority states), and professional councils (Nursing & Midwifery Council, Community Practitioners Registration Board of Nigeria, Medical & Laboratory Council of Nigeria, and Health Records Officers Registration Council of Nigeria)	National Health Workforce Registry (NHWR) fully established and linked to State-level HRIS for HRH deployment, redeployment and budget planning to support moderate and high HIV burden sites; A baseline health workforce inventory for each facility generated; Complete health worker data entry, updates, and cleaning; Link the state registries to the NHWR to ensure maintenance, security and use of HRH data; Capacity built among key staff to be able to operationalize HRIS to inform the skill mix and distribution of HRH at moderate and high volume sites.	National Health Workforce Registry transitioned to GoN; Interoperable iHRIS systems to produce and review regular reports; State Health Workforce Registry transitioned to GoN	[REDACTED]	[REDACTED]	[REDACTED]	HRH: 8.0	X	X	X	X	X
2.	Employ WISN to determine the number of HRH needed at high- and moderate-volume sites	WISN conducted for selected cadres within the sites designated to provide HCT, pre-ART, ART, PMTCT, TB/HIV and HIV-related care at high- and moderate-volume facilities; Workforce projections in high- and moderate-volume sites developed; Strengthened State and LGA capacities to conduct localized human resources for health census to generate comprehensive human resource for health data; and to diagnose human resource for health needs via workload analysis and human resource for health satisfaction survey.	WISN data analyzed to recommend changes in health workforce investment and policy, including: change in number and type of health workers in moderate and high volume sites; revisions or additions to policies for health workers, such as task shifting or task sharing; and/or provide evidence to advocate for budget reallocation for health workers	[REDACTED]	[REDACTED]	[REDACTED]		X	X	X	X	X

S/N	1. Activity Description	Deliverables		Budget codes and allocation (\$)		6. Imp. Mech. ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
		2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
3.	The project will work with IPs and state-LGA- and site-level managers to develop an on-site patient feedback management strategy (at all moderate and high-volume sites), including defined and transparent roles for review of complaints, patient follow up, and integration of both positive and negative feedback into supportive supervision and performance management processes.	Local communities have access to health care workforce by developing a reporting system by which residents can report presence of HCW; Increased access to HIV care;	Increased patient satisfaction; Improved health workforce performance	[REDACTED]	[REDACTED]	[REDACTED]		X	X	X	X	X
4.	Support state government and moderate and high volume sites to implement task shifting guidelines as adopted	Mentoring and supervision structure and processes established to improve and monitor the technical skills and competence of health care workers to whom tasks are shifted; LGA- and/or state-level reporting of performance developed for task-sharing health care workers in moderate and high volume sites		[REDACTED]	[REDACTED]	[REDACTED]		X	X	X	X	X
5.	Facilitate healthcare worker deployment and retention in moderate and high volume sites	Capacity Plus's Rapid Retention Survey Toolkit applied to Doctors, Nurses, Midwives, Laboratory technologists and Community Health workers across priority states to support human resource managers and policy makers to determine what motivates health workers to live and work in certain types of settings or facilities; Appropriate & affordable strategies to incentivize health worker retention and distribution to moderate and high volume sites developed.		[REDACTED]	[REDACTED]	[REDACTED]		X	X	X	X	X

S/N	1. Activity Description	Deliverables		Budget codes and allocation (\$)		6. Imp. Mech. ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
		2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
6.	Collaborate with SMOH, LGAs, IPs and other state- and site-level actors to establish a sustainable local financing mechanism for health workers that provide HIV/AIDS services	5-year costed plans for ensuring adequate HRH at selected high- and moderate-volume sites developed; Advocacy packages and investment cases developed for increased funding for HRH and used to conduct advocacies to relevant stakeholders	Conduct upstream policy discussions with the FMOH, professional councils, World Bank, WHO, PEPFAR IPs and other stakeholders to share compelling evidence in support of increased HRH investments for improved HIV service delivery	[REDACTED]	[REDACTED]	[REDACTED]		X	X	X	X	X
7.	Pre-service Training program for strengthening skills and competencies of care providers for enhanced HIV service delivery (SCOPE). This activity will support the revision of pre-service training curriculum in-line with new national HIV guidelines and its application in select pre-service training institutions in States where PEPFAR Nigeria scale-up LGAs are located. This will be targeted at nurses, midwives and community health extension workers (CHEWs). The institutions will be enhanced with basic teaching supports and students provided with learning aids; in addition, training of trainers (ToT) for tutors of the institutions will be facilitated. Through advocacy of the Lead IPs in the specified states and utilizing the State Management Team platforms, the graduates will be engaged by the States and linked to the scale-up LGAs to support scale-up efforts. The task-sharing policy almost in	i) Revised pre-service training curriculum for nurses, midwives, CHEWs in-line with current national HIV management guidelines; ii) 45 tutors produced with knowledge and skills in HIV care management in-line with current national HIV management guidelines; iii) 400 new health care workers (HCWs) with knowledge and skills in HIV care management produced and linked to high disease burden service delivery sites in scale-up LGAs.	HRH_PRE: 400 Graduates;	[REDACTED]	[REDACTED]	[REDACTED]	HRH: 8.0	X	X	X	X	X

S/N	1. Activity Description	Deliverables		Budget codes and allocation (\$)		6. Imp. Mech. ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
		2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
	advance stage will allow the utilization of these cadres of staff for the provision of HIV services, already, it is being informally practiced.											
8.	<p>In-service Training program supporting the provision, strengthening and institutionalization of HIV/AIDS education to enhance skills and knowledge of service providers and improve quality of service delivery.</p> <p>Regional training hubs are strategically situated in the two major regions of the country (Northern and Southern Nigeria) in Federal institutions to serve the in-service training of needs of front-line HCWs in contiguous scale-up LGAs. Integrated curriculum for in-service training in HIV management (Adult and Pediatric ARVs, HTC, PMTCT, Lab.) will be revised in line with current national guideline and in collaboration with relevant national professional regulatory agencies. The hubs will be strengthened with basic modern teaching and learning aids and clinical demonstration materials as well as other requirements of training environment. Tutors will be facilitated to have a ToT, and supported to provide training to HCWs until the full integration of the project into the institutions' academic programs. Additional part of the institutionalization inputs is the development of a web-</p>	<p>i) Revised in-service training curriculum on Integrated HIV management in-line with current national guidelines;</p> <p>ii) Two established in-service regional training hubs for HIV care and management, one in the Northern and Southern parts of Nigeria to serve contiguous scale-up LGAs and priority states;</p> <p>iii) Developed national web-based portal for training and knowledge sharing in HIV/AIDS and TB management.</p>	<p>i) Established in-service regional training hubs for HIV care and management maintained to continue to serve the training needs of frontline healthcare workers in contiguous scale-up LGAs and PEPFAR priority states;</p> <p>ii) Developed national web-based portal for training and knowledge sharing in HIV/AIDS and TB management further expanded with additional curricula and accredited for Continuous Medical Education licensure.</p>	[REDACTED]	[REDACTED]	[REDACTED]	HRH: 8.0	X	X	X	X	X

S/N	1. Activity Description	Deliverables		Budget codes and allocation (\$)		6. Imp. Mech. ID	7. Relevant Sustainability Element and Score	Impact on epidemic control					
		2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression	
	based training portal and platform in HIV/AIDS and TB management, this will provide opportunity for on-the-desk knowledge update and CME acquisition for licensure of front-line HCWs to enable them continue to provide quality services.												
9.	<p>Improving the quality of HIV/AIDS service delivery through training support for HIV M&E, surveillance, survey and laboratory services.</p> <p>This activity, to be implemented at the national level under the platform of the Nigerian Field Epidemiology and Laboratory Training Program (NFELTP), will support the continuous monitoring of HIV service delivery at all facilities with focus on PEPFAR Nigeria 8 priority states through the involvement of residents in SIMS, DQA and other HIV monitoring systems. Residents will also be engaged in the conduct of essential surveys (e.g. AIDS Indicator) and studies (Lost to Follow-up, PMTCT cascade etc.) that will generate data for informed decision-making in planning and improvement of the quality of HIV service delivery. Although focused on HIV, this activity provides a platform and supports a resource whose competencies and capacities may be leveraged for effective response to outbreaks of other diseases of public health importance in line with PEPFAR's health systems strengthening goal.</p>	<p>i) 40 field and laboratory epidemiologists in HIV and other infectious diseases produced to provide specialist-level leadership in national HIV epidemiologic programming and other diseases of public health importance;</p> <p>ii) Capacity building of 100 Federal and State-level public health officials in Leadership and Management of HIV/AIDS programs through the Short-Course program;</p> <p>iii) Improved program results, data demand and use;</p> <p>iv) One AIDS Indicator survey conducted in scale-up LGA and other operational studies to guide national HIV programming;</p> <p>v) Reports of response to outbreaks of HIV complications (MDR TB) and other diseases of public health importance.</p>	<p>i) Sustained production of 40 field and laboratory epidemiologists in HIV and other infectious diseases to provide specialist-level leadership in national HIV epidemiologic programming and other diseases of public health importance;</p> <p>ii) Sustained capacity building of 100 Federal and State-level public health officials in Leadership and Management of HIV/AIDS programs through the Short-Course program;</p> <p>iii) Sustained improvement in program results, data demand and use;</p> <p>iv) One AIDS Indicator survey conducted in other scale-up LGAs and other operational studies to guide national HIV programming;</p> <p>v) Reports of response to outbreaks of HIV</p>	[REDACTED]	[REDACTED]	[REDACTED]	HRH 8.o	X	X	X	X	X	

S/N	1. Activity Description	Deliverables		Budget codes and allocation (\$)		6. Imp. Mech. ID	7. Relevant Sustainability Element and Score	Impact on epidemic control					
		2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression	
			complications (MDR TB) and other diseases of public health importance.										
10.	DOD_HJ: This pre-service training program for the military establishment will build the capacity of the Nigerian Armed Forces to train and improve the capacity healthcare workers on HIV/AIDS for deployment to various healthcare facilities through the incorporation of HIV/AIDS curriculum in line with the current national guidelines. The facility selected for this pre-service training program is the Armed Forces School of Medical Sciences (AFSMS) AFSMS trains military medical personnel for deployment to military medical facilities all over the country. Given the nature of the military of being a separate population of its own, this program will provide trained personnel for deployment all over the country. The institution will be provided with a basic upgrade of the 3 departments which will administer topics on HIV/AIDS. This upgrade will include learning tools for students, teaching aids and a training of trainers (ToT) program for instructors of the institution.	i) Review and integration of HIV/AIDS curriculum into existing training curricula of the Armed Forces school of medical sciences. ii) Number of healthcare workers graduating from pre-service institutions. iii) Number of health care workers from various PEPFAR healthcare facilities trained on HIV/AIDS.	i) Review and integration of HIV/AIDS curriculum into existing training curricula of the Armed Forces school of medical sciences. ii) Number of healthcare workers graduating from pre-service institutions. iii) Number of health care workers from various PEPFAR healthcare facilities trained on HIV/AIDS.	[REDACTED]	[REDACTED]	[REDACTED]	HRH 8.o	x	x	x	x		

S/N	1. Activity Description	Deliverables		Budget codes and allocation (\$)		6. Imp. Mech. ID	7. Relevant Sustainability Element and Score	Impact on epidemic control					
		2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression	
	This activity also improves the quality of service delivery through improved knowledge and skills of service providers												
11.	DOD_CA: This supports the strengthening of HRH mobilization and deployment to military health facilities in other to increase the availability of skilled health workers. A central training will be organized to train the health workers before deployment to military medical facilities all over the country. Training will be done for all cadres of staff in line with current medical guidelines.	Strengthened Human Resources for Health planning, management, leadership and partnership in the Nigerian military.	Strengthened Human Resources for Health planning, management, leadership and partnership in the Nigerian military.	[REDACTED]	[REDACTED]	[REDACTED]	HRH 8.o	x	x	x	x		
Governance													
12.	Lead IP state-level support for the strengthening of leadership and management capacities of State Management Teams and other HSS-related activities towards greater State investments and uptake of more responsibilities in PEPFAR priority geographical locations Utilizing the Lead IP Framework developed by PEPFAR Nigeria, the Lead IPs will be funded to facilitate their engagement with the States and their HIV State Management Team (SMT) to build their capacities to effectively plan and monitor the implementation of their HIV programs. Under this	i) State Management Teams (SMT) in PEPFAR prioritized states hosting the 32 scale-up LGAs established and strengthened; ii) 4 (quarterly) state-level advocacy meetings with State leadership/AIDS Control Programs (SACAs) held in PEPFAR priority geographical locations; iii) Greater State investment into State HIV programs; iv) Effective linkage, deployment and redeployment of HCWs to support scale-up LGAs		[REDACTED]		[REDACTED]	Oversight and Stewardship: 12.o	X	X	X	X		

S/N	1. Activity Description	Deliverables		Budget codes and allocation (\$)		6. Imp. Mech. ID	7. Relevant Sustainability Element and Score	Impact on epidemic control					
		2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression	
	platform, advocacies will be advanced for greater State-level ownership and investment into their programs especially in the deployment and linkage of the products of PEPFAR-supported pre-service training programs to scale-up LGAs and other high disease burden sites.												
13.	Capacity development program for CSOs to address the challenges of HIV/AIDS.	Training on Leadership Development Program provided for 45 key staff from 15 CSOs to improve their management capacities; Institutionalized governance structure to coordinate, regulate, train and supervise CHWs to increase the uptake of PMTCT in moderate and high volume sites.		[REDACTED]	[REDACTED]	[REDACTED]		X	X	X	X	X	
Health Finance													
14.	Generate financial evidence on the costs, impact and sustainability of HIV/AIDS programming	Conduct analysis and generate reports on the current financing trends in priority states;		[REDACTED]	[REDACTED]	[REDACTED]		X	X	X	X	X	
15.	Improve the capacity of GoN to budget more accurately for HIV/AIDS programs and negotiate appropriate level of resources	Develop investment cases and policy briefs; Mobilize domestic funds using evidence(s) generated; Tracking tool identified or developed for monitoring utilization of HIV/AIDS funds		[REDACTED]	[REDACTED]	[REDACTED]	Resource Generation: 10.0 Resource commitment 6.0	X	X	X	X	X	

S/N	1. Activity Description	Deliverables		Budget codes and allocation (\$)		6. Imp. Mech. ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
		2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
16.	Develop the HIV/AIDS Resource Mobilization Strategy with state level focus	Total resource need for the HIV/AIDS estimated for the priority states; and moderate & high volume sites; HIV/AIDS resources from all sources and financing gap estimated; Obtain private sector buy-in for funding of HIV/AIDS programs; Additional funds mobilized for HIV/AIDS programming		[REDACTED]	[REDACTED]	[REDACTED]		X	X	X	X	X
17	Supply Chain Management Systems	1) Total resource required by SCMS for quantification, forecasting and supply planning of PEPFAR HIV/AIDS commodities including designing a new logistics system for lab commodities. 2)Provide HIV/AIDS Logistics support to the State Logistics Management Coordination Units to improve logistics data reporting rates at facilities prepare state level requisition aggregates for bi-monthly resupply and prepare a quarterly stock-status report. 3)Improve Warehousing Practices at regional hubs and support FMOH to establish PPP arrangements for the two National Warehouses under construction in Lagos and Abuja. 4)Pre-service training of Health Professionals (Pharmacists, Health tech, Lab Scientists, etc. 5) In-service training of Supply Chain Personnel of the GF &GoN	1) Total resource required by SCMS for quantification, forecasting and supply planning of PEPFAR HIV/AIDS commodities including designing a new logistics system for lab commodities. 2)Provide HIV/AIDS Logistics support to the State Logistics Management Coordination Units to improve logistics data reporting rates at facilities prepare state level requisition aggregates for bi-monthly resupply and prepare a quarterly stock-status report. 3)Improve Warehousing Practices at regional hubs and support FMOH to establish PPP arrangements for the two National	[REDACTED]	[REDACTED]			X	X	X	X	X

S/N	1. Activity Description	Deliverables		Budget codes and allocation (\$)		6. Imp. Mech. ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
		2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
			Warehouses under construction in Lagos and Abuja. 4)Pre-service training of Health Professionals (Pharmacists, Health tech, Lab Scientists, etc. 5) In-service training of Supply Chain Personnel of the GF &GoN									

7.0 Staffing Plan

The PEPFAR Nigeria team has conducted an initial analysis and assessment of 1) programmatic alignment of staff towards sustained epidemic control and 2) the ability to successfully implement the new PEPFAR business model. The team found that PEPFAR staff and time had to be adjusted to more closely align with the data driven approach that strategically targets high burden geographic areas and populations. To achieve the greatest public health impact, the team reallocated staff support to core and near core activities in priority technical areas including clinical care and treatment and SI.

At a more granular level each PEPFAR agency has made changes to their staffing pattern. For example, USAID management has reorganized its office structure to reflect the program pivots discussed above through a project management approach to managing PEPFAR supported implementing mechanisms. The Office is comprised of a strategic technical team with divisions that reflect the facility based, community based and health systems components of the program. The Strategic Technical team will provide support to PEPFAR TWG structures, technical assistance to GON and overall programs, while the divisions will focus efforts on managing PEPFAR supported IPs to deliver on the strategies and results required. The office divisions will consist of project managers across the HIV/AIDS and TB cascade of prevention, care and treatment. The strategic technical team will interface between the PEPFAR TWGs, state and national governments as well as the project management teams. USAID'S SIMS effort will be complemented by an institutional contractor that will optimize site monitoring visits in coordination with program management staff.

CDC Nigeria took into consideration that a substantial portion of their partners are local indigenous groups or organizations, which require significant staff involvement. Due to their involvement with partners as well as additional reporting requirements, the CDC PEPFAR COP15 staffing plan seeks to maximize staff engagement through enhanced management of cooperative agreements, including site monitoring and technical and administrative support. CDC continues to strongly support the overarching goals of SIMS and has been able to deploy significant resources for visits because of its experience with the implementation of its SMS program, a precursor to SIMS. In Q1 of FY2015, CDC conducted 81 SIMS visits. Although Q2 visits were placed on hold because of Mission travel moratoriums surrounding the (original and rescheduled) presidential and gubernatorial elections, CDC has an aggressive schedule for meeting its Q3 SIMS obligations.

DOD is aligning its staffing to support PEPFAR goals and objectives focusing on data for decision making and improvement in site performance to provide quality HIV/AIDS services. DOD has four vacant positions at various stages of recruitment. The positions will support SI, laboratory, Care and Treatment TWG activities, and in conducting SIMS visits. Technical staff will focus more on military barracks and health facilities located in areas with high HIV to reduce its transmission.

At CDC, all program and CoAg management staff will support SIMS requirements. An administrative clerk and a lab position are being redefined as a care and treatment specialist and an SI data visualization, utilization, and dissemination position, respectively. There are presently 21 vacant positions, all of which are in varying stages of recruitment. All will be filled by September 30, 2015. Recruitment was delayed due to key leadership vacancies.

For USAID, all Office Project Managers and Assistants will support SIMS requirements; however, USAID staffing is not sufficient to conduct all required SIMS visits because of space limitations at the Embassy. Also, the Mission is not currently resourced to adequately support SIMS travel (cars, drivers, security) and simultaneously accomplish other U.S. strategic goals outlined in the Mission Strategic Resource Plan. Additionally, almost 80% of USAID-supported states are in high or medium-high security areas where visits require more lead time and resources and can be restricted at any time. As authorized at the COP15 review in Tanzania, USAID will engage an institutional contractor to support USAID efforts to conduct the required number of SIMS visits. USAID's plan is to have at least one USAID staff accompany the contractor on at least 20% of SIMS visits. Activities USAID staff will conduct during SIMS visits include direct participation in the SIMS exercise, supervision of the process and validation of the process.

To support the SIMS effort, USAID will repurpose one vacant position to hire a staff person who will be dedicated to the technical coordination, management and reporting of SIMS interventions as well as coordinating other related SI activities. The position will be filled by September 2015 along with the Senior Program Manager for south-south activities. Two other vacant Cashier/Voucher examiner positions have been advertised and are under recruitment. Joint inter-agency monitoring processes will also be stepped up to enhance and maintain program quality and data management.

Management has been working with the PEPFAR office to determine the impact to the ICASS platform in Abuja and Lagos related to full implementation of SIMS in Nigeria. Initial results based on the abbreviated FY15 SIMS action plan and implementation plan, current staffing and number of vehicles indicates additional driver, vehicle and security resources will be needed to fully support CDC, Walter Reed and USAID and teams have included these cost estimates in their proposed budgets.

APPENDIX A

Table A.1 Program Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	Laboratory Equipment Maintenance	Set-up Lab Management Information Systems	Streamlining of labs in sustained-service states
	Laboratory Quality Improvement/Quality Assurance	Implement Quality Improvement Processes for TB Reference Laboratories Leading to International Recognition (To be funded with HVTB Funds)	
	-	In-service and Pre-service Training in selected Universities and schools of health to improve the training curriculum of medical laboratory science program; Training of trainers for scale-up LGA states as well as sustained-service states	
		Integration of PEPFAR funded labs into mainstream labs (in secondary and target tertiary facilities) to facilitate host government funding and take-over of lab services support for HIV-Program	
Site level		Support the roll-out of EMR in selected facilities	
Site level	Update Treatment Audit Data (RADET)	PEPFAR Supported Sites routine Data Audit and DQA	
Site level	Provider Initiated Testing and Counselling (PITC) opt-in & opt-out approaches (including Pediatric HTC, Couples HTC) in scale up LGAs		
Site level	PITC for all first ANC attendees (in scale up LGAs only)	PMCT/FP integration - To improve access to FP by HIV positive women and HIV services for women accessing FP	Nutritional support for mothers - To prevent malnutrition amongst pregnant PLHIV
Site level (in scale up LGAs)	Mobile Community outreach for demand creation of HTC and PMTCT services in scale up LGAs	Referral for RH/FP services - HIV+ women of reproductive age	
Site level	Procurement of Drugs (ARVs and OI), RTKs, CD4 Reagents, Viral Load Reagents, EID Bundle Kits (pooled procurement with the GON and GF)		
Site level	Procurement of reagents for 24 PEPFAR procured PCR equipment		
Site level	PMTCT /TB Integration - Intensify TB case finding in PMTCT settings		
Site level	Provision of ARV to HIV + Pregnant women		Economic empowerment for women - Component of positive Health Dignity with prevention for HIV positive pregnant women
Site level	Close gaps in PMTCT cascade to ensure that at least, 95% of HIV Positive pregnant women identified are placed on ARV		
Site level	Improve/Strengthen EID services		

Table A.1 Program Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	Viral Load testing for monitoring patients on ART		
Site level	CD4 cell count for pre-ART patients to determine eligibility for ART		
Site level	Adherence support using innovative approaches		
Site level	Facility level trainings, site level quality improvement initiatives and CMEs in ART sites.		
Site level	Defaulter & LTFU tracking		
Site level	Linkage to OVC services and immunization services		
Site level	Positive Health, Dignity, Prevention (Adherence counseling, partner disclosure, risks reduction and condom provision etc)		
Site level	Nutritional support for malnourished children		
Site level	Strengthening Support Group activities and referral linkages to Social Services-Economic & Legal Services		
Site level	Procurement of GeneXpert cartridges and consumables		
Site level	Support sample logging across the National network of reference Labs for TB and HIV services (primarily GeneXpert, EID and Viral Load)		
Site level	Strengthen TB infection control at ART sites and support TB intensified case finding		
Site level	Build the capacity of households and communities to care for AIDS Orphans and Vulnerable Children		
		Support for the National Blood Transfusion program	
		Support for Injection Safety and Waste Management at facilities	
Sub-national level	Establish State level Logistics Management Coordinating Units (LMCU)	Support other PEPFAR Lead IP coordination activities at State Level	
Sub-national level			Conduct AIDS Indicator Survey in two PEPFAR priority states (Akwa Ibom and Kaduna)
Sub-national level		Deploy the National OVC Management Information System (NOMIS) in the remaining 29 states if the country.	
Sub-national level		Media messaging on prevention - Objective is to reinforce prevention messages and the adoption and maintenance of desirable behavior to reduce risk of new infections in Kaduna, Rivers, Nassarawa, Benue,	

Table A.1 Program Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
		FCT, Cross Rivers, Lagos, Akwa Ibom states.	
National and Sub-national level		Improve Human Resource monitoring at SNUs level through HRIS	Support the roll-out of the Community-Based Health Insurance scheme in Akwa-Ibom State
National and Sub-national level		Support the improved function of the National and State level HIV/AIDS Quality Assurance systems (NigeriaQual)	
National level	National Integrated Commodity Distribution and Supply Chain System - Warehouse and Distribute HIV/AIDS commodities to all PEPFAR supported sites	Regional Hubs Warehousing of HIV/AIDS Commodities	
National level	National Forecasting and Quantification of HIV/AIDS Commodities - National Requirements for HIV/AIDS Commodities. Estimate funding gaps (if any) and allocate resources with other stakeholders	Improve capacity in Supply Chain Management - <u>Pre-service training</u> of Health Professionals (Pharmacists, Health tech, Lab Scientists, etc.	Roll-out of new HIV algorithm
National level		Support NACA and the GON to improve Domestic resources for HIV/AIDS	
National level	Support for Phase III USG DHIS2 instance	Support the update and roll out of the national DHIS2 instance - National DHIS system updated to include the MER indicators Data exchange functionality with DATIM established Establish facility level-reporting into the NHMIS	
National level		National Electronic Health Data Repository - Central database that will assist in de-duplication of clients data, tracking of transfers and allows clients to access care from different facilities	
National level	Support Acquired Drug Resistance Monitoring	Program Evaluation: PMTCT cascade Evaluation (EID Evaluation), Option B+ evaluation,	
National level	Support the printing of R&R tools and IEC materials		
National level	Provide TA for TB/HIV TWGs	Support the process for TB/HIV policy documents Review	
National level		Strengthening of national and zonal reference laboratories including Defence Reference Laboratory for efficient shared network of labs	

Table A.1 Program Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
National level		Facilitate establishment of State Child Rights Implementation committees (CRICs) and train CRIC members on principles and implementation of the State Child Rights Act, and in child rights related budget advocacy, budget tracking and monitoring; towards effective adoption and roll out of the CRA in target states."	

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
HLAB	Support <u>Lab infrastructure and equipment maintenance and lab commodities procurements</u> (for commodities not procured through SCMS), in scale up locations	Implementation of low cost and sustainable <u>Lab Information System (LIMS/BLIS) in selected high volume sites</u>	Streamlining of labs in sustained-services states
HLAB	Support the maintenance of 19 PEPFAR procured Automated PCR machines		Transition support for 5 PEPFAR procured Automated PCR machines to GON support by End of Sept, 2015.
HLAB	Capacity building for <u>Continuous Quality Improvement (CQI) and Implementation of QMS</u> (this include PMV, EQA, SLMTA/SLIPTA, FOG) in all PEPFAR supported in designated Labs)	Transition the Implementation of Quality Improvement Processes for TB Reference Laboratories leading to International Recognition (To be funded with USAID core TB funds)
HLAB	<u>Quality Improvement: HIV Rapid testing Quality Improvement Initiative (RTQII)</u>	<u>In -service and Pre-service Training</u> in selected Universities and schools of health to improve the training curriculum of medical laboratory science program	
HLAB		<u>Operationalization of the Integration of PEPFAR funded labs</u> into mainstream labs (in secondary and targeted tertiary facilities) to facilitate host government funding and take-over of lab services support for HIV-Program	
HLAB		Strengthening of national and zonal reference laboratories including Defence Reference Laboratory for efficient shared network of labs	Roll-out of new HIV algorithm
OHSS		New Activity - PEPFAR Lead IPs State-level support for the strengthening of leadership and management capacities of Government-led State Program Management Teams and other HSS-related activities towards greater State investments and uptake of more	

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
		responsibilities Tier 1 and 2 States. 2016 Objectives/Milestones -i. Strengthened State Management Teams (SMTs) in Tier 1 and 2 States. ii. Established State HRIS in Tier 1 and 2 States	
OHSS		Capacity development program for CSOs to address the challenges of HIV/AIDS (Plan Health) - 2015 Objectives/Milestones (i) Training on Leadership Development Program provided for 45 key staff from 15 CSOs to improve their management capacities.	
OHSS		In-service Training program to support the provision, strengthening and institutionalization of HIV/AIDS education (to enhance skills and knowledge of service providers and improve quality of service delivery). In selected training Institutions. 2015 Objectives/Milestones - i. Review and Integrate National HIV/AIDS Training curriculum based on revised National Guidelines ii. Institutionalize in-service training for HIV/AIDS Clinical Care and Management in selected institutions iii. Develop a web-based portal for training and knowledge sharing in HIV/AIDS and TB management. 2016 Objectives/Milestones - ii. Institutionalize in-service training for HIV/AIDS Clinical Care and Management in Kaduna State and at least one other Tier 2 State. iii. Nation-wide expansion of access of the web-based HIV/AIDS and TB care and management training portal	Capacity development program for Public Sector Institutions to address the challenges of HIV/AIDS (Plan Health Project). 2015 Objectives/Milestones - (i) Develop M&E plan for Akwa Ibom state. 2016 Objectives/Milestones - (i) Institutionalize in-service training in Obafemi Awolowo University, Ile-Ife; (ii) Institutionalize governance structure to coordinate, regulate and supervise CHWs to increase the uptake of PMTCT and improved maternal and child health indices in Akwa Ibom State
OHSS		Capacity Plus Project (Focus on HRH). 2015 Objectives/Milestones - (i) Conduct HRH situational analysis in Akwa Ibom, Cross River, Lagos and Rivers states; (ii) Train staff of the Federal MOH/HRH branch to identify and implement feasible HRH retention strategies; and to develop and implement HRH plans; (iii) Deploy HRIS software to the SMOH in the selected states to track health workforce availability and mobility for better planning (iv) Technical assistance and resources provided to develop costed HRH plans in Akwa Ibom, Cross River, Lagos and Rivers states. 2016 Objectives/Milestones - (i)	Community Based health Insurance schemes (Plan Health Project) - 2015 Objectives/Milestones (i) Launch of Community Based health Insurance scheme in Akwa Ibom state. 2016 Objectives/Milestones - Develop demand generation and sustainability strategies for Community Based health Insurance scheme in Akwa Ibom state

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
		Human Resource Information Systems (HRIS) expanded to more states; (ii) Strengthened Human Resources for Health Planning, Management, Leadership and Partnership in selected states; (iii) Training of selected staff of State MOH in selected states to identify and implement feasible HRH retention strategies; and to develop and implement HRH plans	
OHSS		<u>Pre-service Training program</u> for strengthening skills and competencies of care providers for enhanced HIV service delivery (SCOPE) <u>and support for the development of HRIS. 2015 Objectives/Milestones</u> - Graduate 331 HCWs. 2016 Objectives/Milestone - Graduate 400 HCWs and Functional National HRIS Established	
OHSS		Support the establishment and strengthening of national and state level HIV/AIDS Quality Assurance system (NigeriaQual)	
OHSS		<u>Training program for the support of HIV/AIDS monitoring, evaluation, survey and laboratory services. 2015 Objectives/Milestones</u> - 1. Conduct 3 sessions of Short-course training in Leadership and Management of HIV/AIDS program and 2. One Long-course of FELTP training leading to HRH_PRE indicator count (Target = 40). 2016 Objectives/Milestones - HRH_PRE: 114 Graduates (Long course: 40; Short course: 74).	Improve CCM oversight functions (<u>Plan Health Project</u>)
OHSS		Health, Finance & Governance (Health Financing). 2015 Objectives/Milestones -(I) Conduct analysis and generate reports on the current financing trends in selected states; (ii) Second Health Finance Advisor to NACA's Resource Mobilization Unit; (iii) Support NACA to develop resource mobilization strategy. 2016 Objectives/Milestones - (i) Develop investment cases and policy briefs; (ii) Mobilize domestic funds using evidence(s) generated; (iii) Tracking tool identified of developed for monitoring utilization of funds	
HVSI	Support for Phase III USG DHIS2 instance	Support the update and roll out of the national DHIS2 instance - National DHIS system updated to include the MER indicators	

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
		Data exchange functionality with DATIM established Establish facility level-reporting into the NHMIS	
HVSI	USG SI regular review meetings/workshops with partners and GoN		
HVSI	Support for Routine Joint National Data Quality Assessments	National Electronic Health Data Repository - Central database that will assist in de-duplication of clients data, tracking of transfers and allows clients to access care from different facilities	
HVSI	Support State level M&E activities coordination, capacity building and system strengthening	AIDS Indicator Survey in two PEPFAR priority states (Akwa Ibom and Kaduna)	
HVSI		Support the Nigerian Ministry of Defense (NMOD) to deploy the current EMR system to supported sites Improved PMM and more efficient QI metrics	
HVSI	Continue support for Acquired Drug Resistance Monitoring Survey	Program Evaluation: PMTCT cascade Evaluation (EID Evaluation), Option B+ evaluation,	
HVSI	<i>Update Treatment Audit Data (RADET)*</i>	PEPFAR Supported Sites routine Data Audit and DQA	
HVSI		Service Quality Monitoring and Evaluation (NigeriaQual) - Also funded under OHSS	
HVCT	Provider Initiated Testing and Counselling (PITC) opt-in & opt-out approaches (including Pediatric HTC, Couples HTC		
HVCT	HTC service Integration in FP, STI, ANC & TB clinics		
HVCT	Mobile Community outreach for demand creation of HTC services in the 32 scale up LGAs		
HVCT	Strengthen linkages and referrals to the prevention and continuum of care services.		
HVCT	Capacity Building for HTC service providers.		
SCMS	Procurement of Drugs (ARVs and OI), RTKs, CD4 Reagents, Viral Load Reagents, EID Bundle Kits (pooled procurement with the GON and GF)		
SCMS	Procurement of reagents for 24 PEPFAR procured Automated PCR equipment		

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
SCMS	State level Logistics Management Coordinating Units (LMCU) - Provide HIV/AIDS Logistics support to the State LMCU to improve logistics data reporting rates at facilities, prepare state level requisition aggregates for bi-monthly resupply and prepare a quarterly stock-status report	Improve capacity in Supply Chain Management - 1. <u>In-service training</u> of Supply Chain Personnel of the State level GoN staff for the Logistics Management Units	
SCMS	National Integrated Commodity Distribution and Supply Chain System - Warehouse and Distribute HIV/AIDS commodities to all PEPFAR supported sites	Regional Hubs Warehousing of HIV/AIDS Commodities	
SCMS	National Forecasting and Quantification of HIV/AIDS Commodities - National Requirements for HIV/AIDS Commodities. Estimate funding gaps (if any) and allocate resources with other stakeholders	Improve capacity in Supply Chain Management - <u>Pre-service training</u> of Health Professionals (Pharmacists, Health tech, Lab Scientists, etc.	
SCMS	National Supply Planning and Stock Status Coordination - Collaborate with other stakeholders to plan deliveries in a timely manner to ensure continuous availability and track consumption to minimize expiries		
SCMS	Reverse-Logistics and disposal of expired commodities - Track commodity levels at facilities to minimize expiries. Retrieve expired commodities biannually for environmentally friendly disposal		
PMTCT	PITC for all first ANC attendees (in scale up LGAs only)	PMCT/FP integration - To improve access to FP by HIV positive women and HIV services for women accessing FP	Nutritional support for mothers - To prevent malnutrition amongst pregnant PLHIV
PMTCT	Provision of ARV to HIV + Pregnant women		Economic empowerment for women - Component of positive Health Dignity with prevention for HIV positive pregnant women
PMTCT	Interventions to close gaps in PMTCT cascade to ensure that at least, 95% of HIV Positive pregnant women identified are placed on ARV	Conduct PMTCT cascade evaluation	
PMTCT	Demand creation for PMTCT services and PMTCT Outreaches in 32 scale up LGAs		
PMTCT	Implement EID services		
PMTCT	Adherence Support interventions for PMTCT clients		
HTXS and PDTX	Early identification of HIV infection and appropriate Care	Screening for and management of ADR.	
HTXS and PDTX	Viral Load testing for monitoring patients on ART		

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
HTXS and PDTX	CD4 cell count for pre-ART patients to determine eligibility for ART		
HTXS and PDTX	Adherence support using innovative approaches		
HTXS and PDTX	Defaulter & LTFU tracking		
HTXS and PDTX	Linkage to OVC, immunization and RH/FP services for PLHIV as required		
HTXS and PDTX	Referral & Linkages for other community support services - All patients current on ART		
HTXS and PDTX	Facility level trainings, site level quality improvement initiatives and CMEs in ART sites.		
HBHC and PDCS	Provision of Co-trimoxazole Prophylaxis		STI Screening and referral
HBHC and PDCS	Positive Health, Dignity, Prevention (Adherence counseling, partner disclosure, risks reduction, condom provision and referral for family planning etc)		
HBHC and PDCS	Nutritional support for malnourished children		
HBHC and PDCS	Strengthening Support Group activities including linkages and referrals to Social Services-Economic & Legal Services		
HBHC and PDCS	Support for Early Infant Diagnosis (EID) Services		
HBHC and PDCS	Strengthening Adolescents focused programs		
HBHC and PDCS	Defaulter Tracking		
TB/HIV (HVTB)	Training of health care providers on TBHIV		
TB/HIV (HVTB)		Support for maintenance of all diagnostics technology	
TB/HIV (HVTB)	Support for sample transportation to Gene Xpert sites and TB reference labs for DST in the 32 scale up LGAs		
TB/HIV (HVTB)	Strengthen TB infection control at ART sites. (Capacity building, minor structural adjustments and provision of IEC materials)		

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
TB/HIV (HVTB)	Support TB intensified case finding through contact tracing, defaulter tracking and case finding in pediatric settings.		
TB/HIV (HVTB)	Provision of HIV testing and counselling to patients (adults and children) with presumptive and diagnosed TB at DOTS clinic		
TB/HIV (HVTB)	Provision of antiretroviral therapy for TB patients living with HIV at high volume DOTS sites	Logistics support for supply of IPT to ART sites	
TB/HIV (HVTB)		Support the printing of R&R tools and IEC materials	
TB/HIV (HVTB)	Provide TA for TB/HIV TWGs	Provide TA to Support the process for TB/HIV policy documents Review	
OVC/HKID	Assessing child & family socio-economic status. Baseline information to guide support to households.	Directly supporting IGAs with funds and other inputs.	
OVC/HKID	Developing care/ case management plans for children and families. Child and household-focused plans for support to families.		
OVC/HKID	Training in case management for CHV within PEPFAR catchment areas. Equip volunteers with skills to serve OVCs		
OVC/HKID	Promotion of EID and referral for confirmatory HIV testing of HIV-exposed infants. HIV status of OVC known		
OVC/HKID	Community based ART adherence assessment, counselling and support for HIV infected OVCs		
OVC/HKID	Facilitating uptake & completion of referrals (nutrition, child survival, TB/HIV, RH etc.).		
OVC/HKID	Providing food packages & nutritional support for malnourished vulnerable children		
OVC/HKID	Support community level child abuse prevention and response (including emergency food and shelter for abuse survivors)		
OVC/HKID	Support clinic-based child abuse response services (including emergency medical and protection report services)		
OVC/HKID	Institute Positive Parenting skills building (including topics on adolescent risk, HIV disclosure, childhealth & development knowledge).		
OVC/HKID	Address psychosocial health among children & caregivers through individual & group-based activities		
OVC/HKID	Facilitate group-based HES activities, such as savings groups		

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
OVC/HKID	Support access/uptake of social protection efforts (such as social grants, cash transfer programs, bursaries, etc.)		
OVC/HKID	Support vocational training and other individual HES activities, including carrying out market assessments and value-chain activities		
OVC/HKID	Facilitate access to primary and secondary education through temporary & targeted support for uniforms, school fees, exam fees, adult mentors, etc.)		
OVC/HKID	Provide temporary school block grants to promote enrollment and progression		
OVC/HKID	Support early childhood development (ECD) for children under five- (in coordination with PMTCT & Pediatric HIV)		
OVC/HKID	Improve education quality especially making classroom environments gender and HIV sensitive		
OVC/HKID		Fund the deployment and strengthen the use of OVC MIS at Sub-national level (NOMIS) - 29 states: Sokoto, Zamfara, Kebbi, Niger, Kwara, Kano, Jigawa, Bauchi, Yobe, Borno, Adamawa, Taraba, Anambra, Abia, Edo, Lagos, Kaduna, FCT, Nassarawa, Benue, Cross River, Akwa-Ibom, Benue, Ebonyi, Imo.	Financial support to community education councils and PTAs - Communities support enrollment and retention of OVC in school (in collaboration with State Ministries of Women Affairs and Education).
OVC/HKID	Special studies to identify gaps in programming impact. Provide data to improve program targeting	Map services within target communities and developing service directories - 28 states: Sokoto, Zamfara, Kebbi, Niger, Kwara, Kano, Jigawa, Bauchi, Yobe, Borno, Adamawa, Taraba, Anambra, Abia, Edo, Lagos, Kaduna, FCT, Nassarawa, Benue, Cross River, Akwa-Ibom, Benue, Ebonyi, Imo.	
OVC/HKID		Facilitate access to birth registration points for OVC without birth certificates.	
OVC/HKID		Support child rights awareness campaigns (including dissemination of child protection laws	
OVC/HKID		System strengthening activities for family placement and permanency for children	
OVC/HKID		Fund professional development programmes for social and para-social workers	
OVC/HKID		Provide direct financial support for food security initiatives.	

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
HVAB	Implementing the Minimum Prevention Package Interventions (MPPI). Objective is to increase knowledge and skill of target population for risk assessment, risk reduction and sustained behavior change in Kaduna, Rivers, Nassarawa, Benue, FCT, Cross Rivers, Lagos, Akwa Ibom states.		Community mobilization and dialogue. Objective is to analyze environmental context of target population activity, prioritize key issues to be addressed, build social capital for risk reduction among Key Population in 8 focus states (Kaduna, Akwa Ibom, Cross Rivers, Lagos, Nassarawa, FCT, Kano, Rivers)
HVAB	Demand creation for services - Objective is to generate a high level of demand for prevention services among Key Population in Kaduna, Rivers, Nassarawa, Benue, FCT, Cross Rivers, Lagos, Akwa Ibom states.		
HVAB		Media messaging on prevention - Objective is to reinforce prevention messages and the adoption and maintenance of desirable behavior to reduce risk of new infections in Kaduna, Rivers, Nassarawa, Benue, FCT, Cross Rivers, Lagos, Akwa Ibom states.	
HVOP	Implementing the Minimum Prevention Package Interventions (MPPI). Objective is to increase knowledge and skill of target population for risk assessment, risk reduction and sustained behavior change in Kaduna, Rivers, Nassarawa, Benue, FCT, Cross Rivers, Lagos, Akwa Ibom states.		Community mobilization and dialogue. Objective is to analyze environmental context of target population activity, prioritize key issues to be addressed, build social capital for risk reduction among Key Population in 8 focus states (Kaduna, Akwa Ibom, Cross Rivers, Lagos, Nassarawa, FCT, Kano, Rivers)
HVOP	STI screening and management - Objective is to reduce HIV infection rates		
HVOP	Demand creation for services - Objective is to generate a high level of demand for prevention services among Key Population in Kaduna, Rivers, Nassarawa, Benue, FCT, Cross Rivers, Lagos, Akwa Ibom states.		
HVOP		Media messaging on prevention - Objective is to reinforce prevention messages and the adoption and maintenance of desirable behavior to reduce risk of new infections in Kaduna, Rivers, Nassarawa, Benue, FCT, Cross Rivers, Lagos, Akwa Ibom states.	
HMBL		Actively scale-up recruitment of Non paid voluntary Blood Donors in 32 Scale-up LGAs to improve the availability of safe blood; demand creation for Blood donors	
HMBL		Test all blood units in a quality assured manner for 4 mandatory TTIs (HIV, Hepatitis B&C and Syphilis) using EIA	

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
HMBL		Strengthen Tertiary facilities (centers of excellence) through IPs supporting them to collect and properly use EIA to screen all blood for transfusion in these facilities, Continued participation in all relevant TWGs.	
HMBL		Standardize training across NBTS network; Training of Trainer's including step-down trainings to healthcare workers within the various catchment areas; Train Community volunteers in blood donor recruitment to improve blood collection in the 32 Scale-up LGAs, train medical personnel on the Appropriate Use of Blood	
HMBL		Implement a service-wide Quality Management program working towards Step 1 and AFBT accreditation by 2015	
HMIN		Build appropriate capacity for injection safety, phlebotomy and Health Care Waste Management especially at the Primary Health Care (PHC) facilities in partnership with the National Primary Health Care Development Agency (NPHCDA) as part of decentralization process in the 32 Scale-up LGAs.	
HMIN		Ensure quality single use injection supplies, consistent with local guidelines; Procure sharps containers, single dose diluents, and waste management commodities	
HMIN		Ensure proper waste management supplies at each site including biohazard bags, suitable sharps containers, and color coded bins	
HMIN		Encourage clear and consistent messaging in line with national strategy for Injection Safety and HCWM aimed at the community and health facilities (public and private sector)	
HMIN		Follow-up on states to provide incinerators; Support management of sharps waste that will be generated by the scale up of activities; Ensure establishment of Infection Control committee support sites to implement post exposure prophylaxis (PEP) protocol on site; Support implementation of the approved HCWM plan, policy and guidelines	

Table A.3 Transition Plans for Non-core Activities

S/No	Transitioning Activities	EC classification (Core, Near-core or Non-core)	Type of transition	Funding in COP 15	Estimated Funding in COP 16	# of IMs	Transition end date	Notes
A. OHSS								
1	Capacity Plus Project (HRH)							
	In-service training	Near-Core	Transitioning to GoN	[REDACTED]	[REDACTED]	1	Sept-2016	Consolidation of training curriculum; institutionalize trainings in selected health training institutions
	Improve quality of pre-service education for healthcare workers	Near-Core	Transitioning to GoN				Sept-2016	Establishment of TWGs forum for stakeholders at the sub-national level to meet and brainstorm as well as share experiences on best practices in advancing HRH in the various states. The outcome of the meetings of the sub-national HRH TWGs will inform discussion at the National HRH forum thereby improving the coordination of HRH activities in the country; Project Implementation Team that includes GoN staff to brainstorm on strategies and come up with recommendations for project efficiency and sustainability to give GoN sense of ownership & to cost share certain activities with the government
	Strengthen Human Resource Information Systems (HRIS) and Data Use	Near-Core	Transitioning to GoN				Sept-2016	
	Strengthen Human Resources for Health Planning, Management, Leadership and Partnership	Near-Core	Transitioning to GoN				Sept-2016	
	Facilitate healthcare worker deployment and retention in underserved areas	Near-Core	Transitioning to GoN				Sept-2016	
2	Plan Health (Governance)							
	Capacity development program for Public Sector Institutions to address the challenges of HIV/AIDS	Non-Core	Transitioning to GoN	[REDACTED]	[REDACTED]	1	Sep-15	Aligning interventions with government guidelines and ensuring that necessary management skills are transferred to local entities; Build the capacity (technical, institutional, organizational, financial etc.) of GoN and CSOs to adequately steward and take ownership of project with diminishing technical assistance from PEPFAR/Nigeria team
	Capacity development program for CSOs to address the challenges of HIV/AIDS	Near-Core	Transitioning to GoN and other donors				Sept-2016	
	Community Based health Insurance schemes	Non-Core	Transitioning to GoN				Sep-15	
Improve CCM oversight functions	Non-Core	Phasing out			Sep-15			
3	Health, Finance & Governance (Health Financing) - State Level							
	Evidence to generate adequate internal resources for the national program	Near-Core	Transition to GoN	[REDACTED]	[REDACTED]	1	Sept-2016	Transition of responsibilities will be modulated at a pace that ensures sustained health impact, according to the country context and evidence of increased capacity over time; Support GoN to develop strategies to improve Public Private Partnership (PPP) to increase access to resources from the private sector
	Improve the capacity of GoN to budget more accurately for HIV/AIDS programs and negotiate appropriate level of resources	Near-Core	Transition to GoN				Sept-2016	
	Obtain private sector buy-in for funding of HIV/AIDS programs	Near-Core	Transition to GoN				Sept-2016	

Table A.3 Transition Plans for Non-core Activities

S/No	Transitioning Activities	EC classification (Core, Near-core or Non-core)	Type of transition	Funding in COP 15	Estimated Funding in COP 16	# of IMs	Transition end date	Notes
4	Training program for the support of HIV/AIDS monitoring, evaluation, survey and laboratory services.	Near-Core	Transition to GoN	[REDACTED]	[REDACTED]	1	Sept-2016	Activity is considered near-core; collaborating universities will continue to support the program. GoN will increase its current funding; project will continue to leverage from other funding sources, viz: Global Immunization Program (GID) of the US DHH, President Malaria Initiative (PMI), etc.
5	Pre-service Training program for strengthening skills and competencies of care providers for enhanced HIV service delivery (SCOPE) and support for the development of Human Resource Information Systems (HRIS)	Near-Core	Transition to GoN	[REDACTED]	[REDACTED]	1	Sept-2016	Activity is considered near-core; health training institutions will continue to provide the training with continuous support from GoN and PEPFAR. PEPFAR's investment/contribution to decrease gradually towards complete transition to government entities overseeing the training institutions.
6	In-service Training program supporting the provision, strengthening and institutionalization of HIV/AIDS education to enhance skills and knowledge of service providers and improve quality of service delivery.	Near-Core	Transition to GoN	[REDACTED]	[REDACTED]	1	Sept-2016	Program has both core and near-core components. Core component which relates to provision of direct training for improved health workforce performance will continue to be supported by PEPFAR through relevant Prevention and Treatment mechanisms for improved service delivery. The near-core component which supports above-site activities relating to institutionalization of in-service training programs, review and update of training curricula will be gradually transitioned with decrease funding till program end-date.
7	Program for HIV Service Quality Monitoring and Evaluation (Nigeria Qual)	Near-Core	Transition to GoN	[REDACTED]	[REDACTED]	1	Sept-2016	Activity is considered near-core, and will be continued, but with local MOH providing the ongoing coordination while the partner will continue to provide technical guidance, coaching and capacity building.
8	<u>SCMS - Supply Chain Management Systems</u> Improve capacity in Supply Chain Management: In-service training of Supply Chain Personnel of the State level GoN staff for the Logistics Management Units	Near-Core	Transition to GoN	[REDACTED]	[REDACTED]	1	Sept-2016	The activity will need to be continued until all the 36+1 MOH LMCU staff has been trained. Ten states are covered per FY while one-on-one mentoring will continue from SCMS to further re-inforce the training.
9	<u>SCMS - Supply Chain Management Systems</u> Improve capacity in Supply Chain Management: Pre-service training of Health Professionals (Pharmacists, Health tech, Lab Scientists, etc.	Near-Core	Transition to GoN	[REDACTED]	[REDACTED]	1	Sept-2016	Activity is considered near-core; health training institutions will continue to provide the training with continuous support from GoN and PEPFAR. PEPFAR's investment/contribution to decrease gradually towards complete transition to government entities overseeing the training institutions.

B. HVSI

Table A.3 Transition Plans for Non-core Activities

S/No	Transitioning Activities	EC classification (Core, Near-core or Non-core)	Type of transition	Funding in COP 15	Estimated Funding in COP 16	# of IMs	Transition end date	Notes
1	Routine Data Validation and DQA	Near-Core	Transition to government	[REDACTED]	[REDACTED]	1	Sept-2016	Activity is considered near-core, and will be continued, but with local MOH providing the ongoing coordination. Costs expected to decrease after 2016
2	AIDS Indicator Survey	Near-Core	Transition to government (Periodic activity)	[REDACTED]	[REDACTED]	2	Sept-2016	Activity is considered near-core, and will be continued, but with local competence and MOH providing the ongoing coordination.
3	National Electronic Health Data Repository	Near-Core	Transition to government	[REDACTED]	[REDACTED]	1	Sept-2016	Activity is considered near-core, and will be transitioned to MOH for ongoing coordination/management.
4	HIV Incidence Survey	One-off activity	Transition to government (One-off activity)	[REDACTED]	[REDACTED]	1	Sept-2016	One-off activity
5	Service Quality Monitoring and Evaluation (Nigeria Qual)	Near-Core	Transition to government	[REDACTED]	[REDACTED]	1	Sept-2016	Activity is considered near-core, and will be continued, but with local MOH providing the ongoing coordination.
6	Program Evaluation: PMTCT cascade Evaluation (EID Evaluation), Option B+ evaluation	Near-Core	Transition to government (One-off activity)	[REDACTED]	[REDACTED]	1	Sept-2016	Activity is considered near-core, and will be continued periodically, but with local competence and MOH providing the ongoing coordination.

C. HTXS PDTX HBCS PDCS

1	Low yielding ART sites: Moving forward sites contributing to 80% of PEPFAR Nigeria achievement will be retained while low yielding sites will be transitioned.	Near-Core	Transition to host Government	[REDACTED]	[REDACTED]	11	Sept-2016	Proportion of sites to be transitioned will be based on a yield analysis using the 80/20 rule.
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NOTE: PEPFAR Nigeria Care & Treatment program during COP 14 planning identified and commenced phased discontinuation of 'non/near core' activities

D. HVTB

1	Support the process for TB/HIV policy documents Review	Near-Core	Phased transition to Government	[REDACTED]	[REDACTED]	12	Sept-2016	Most of the documents are in existence and PEPFAR NG can continue provision of TA for its review
2	Logistics support for supply of IPT and Rifabutin to ART sites	Near-Core	Phased transition to Government	[REDACTED]	[REDACTED]	12	Sept-2016	Currently PEPFAR support training of care providers and logistics of getting the drugs to the facilities, while the FMOH through NTBLCPC procure the INH and get it delivered to the zonal stores
3	Support for maintenance of all diagnostics technology	Near-Core	Phased transition to Government	[REDACTED]	[REDACTED]	13	Sept-2016	

E. HKID

Table A.3 Transition Plans for Non-core Activities

S/No	Transitioning Activities	EC classification (Core, Near-core or Non-core)	Type of transition	Funding in COP 15	Estimated Funding in COP 16	# of IMs	Transition end date	Notes
1	Financial assistance to community education councils and PTAs to ensure retention of OVC in school.	Non-Core	Phased transition to Government	[REDACTED]	[REDACTED]	7	Sept-2016	CBOs supported by PEPFAR work with community education councils and PTAs to advocate for exemption of OVCs from school fees and levies. This activity can be sustained by community structures
2	Funding for mapping services within target communities and developing service directories	Near-Core	Phased transition to Government	[REDACTED]	[REDACTED]	7	Sept-2016	Partners work with the MWASD to map service delivery points for referrals and produce directories of services. This can be taken up by the MWASD
3	Training to deploy the use of OVC MIS at Sub-national level (NOMIS).	Near-Core	Phased transition to Government	[REDACTED]	[REDACTED]	16	Sept-2016	PEPFAR supports deployment and training for NOMIS in target states. Some states have adopted it and manage it within the MWASD
4	Financing access to birth registration points for children who do not have birth certificates.	Near-Core	Phased transition to Government	[REDACTED]	[REDACTED]	16	Sept-2016	CBOs allocate funding to facilitate the process of obtaining birth certificates for OVC. This will be transitioned in collaboration with National Population Commission
5	Funding child rights awareness campaigns (including dissemination of child protection laws)	Near-Core		[REDACTED]	[REDACTED]	16	Sept-2016	PEPFAR supports dissemination of child rights information including training in child's rights for stakeholders.
6	Funding of advocacy meetings for family placement and permanency for children	Near-Core		[REDACTED]	[REDACTED]	7	Sept-2016	PEPFAR supports advocacy to the MWASD and Ministry of Justice to establish/strengthen placement systems for OVC.
7	Financing professional development programs for social and para-social workers	Near-Core		[REDACTED]	[REDACTED]	1	Sept-2016	Funded through Save the Children STEER project through a partnership with AIHA. Working to institutionalize training for para-social workers in school of social work.
8	Funding food security initiatives such as community food banks and farms.	Near-Core		[REDACTED]	[REDACTED]	7	Sept-2016	PEPFAR supports the establishment of food banks and community farms within communities with high prevalence of HIV and poverty. Plan is to work with government, community systems and private sector to identify alternative resources for food security initiatives
9	Directly supporting IGAs with funds and other inputs	Near-Core		[REDACTED]	[REDACTED]	16	Sept-2016	PEPFAR currently supports specific cases with IGA inputs. IPs will work with government, community systems and private sector to identify alternative resources for IGAs
F. HMIN								
1	Training of health workers in infection prevention control and healthcare waste management (HCWM)	Near - Core: Integrate into existing healthcare worker pre-service and in-service trainings include as part of a system approach that includes HCWM.		[REDACTED]	[REDACTED]	1	Sept-2016	Intensify activities to review IPC curricula and integrate this into the curriculum of schools of nursing, schools of health technology, etc.

Table A.3 Transition Plans for Non-core Activities

S/No	Transitioning Activities	EC classification (Core, Near-core or Non-core)	Type of transition	Funding in COP 15	Estimated Funding in COP 16	# of IMs	Transition end date	Notes
2	Provision of Injection Safety and HCWM commodities and equipment	Near - Core: Integrate HCWM procurement and supply chain within health facility commodity logistics systems include as part of a system approach that includes HCWM.			[REDACTED]	1	Sept-2016	Intensify work with health facilities, state MOHs and logistics management partner(s) to integrate supply chain for IS&HCWM commodities.
3	Infection Prevention and Control messaging and monitoring.	Near - Core: Transition to hospital IPC committees (under supervision of MOH)			[REDACTED]	1	Sept-2016	Support development and institutionalization of IPC monitoring tools and systems within facilities; advocacy to MOH for IPC monitoring unit.
4	Systems Strengthening for Health Care Waste Management	Near - Core: Phased transition to MOH and State Waste Management Authorities. Develop a model with private participation to sustain transition			[REDACTED]	1	Sept-2016	Work with MOH and state WMAs to develop sustainable HCWM systems (e.g. PPP Model in Lagos State).
G. HMBL								
1	Training - Supported by PEPFAR through Safe Blood for Africa Foundation TA CoAg	Near-Core	Transition to FMOH (GoN)		[REDACTED]	2	Sept-2016	Schedule meeting with relevant stakeholders and dissemination the information
2	Quality management - Supported by PEPFAR through National Blood Transfusion Service and Safe Blood for Africa Foundation	Near-Core	Transition to MOH (national & subnational) or other bilateral/ donor agencies		[REDACTED]	2	Sept-2016	Submit information memo to 57th NCH for adoption - Develop a memo that encourages State governments to establish State Blood Transfusion Services/ take ownership of existing NBTS centers in the States for submission to the 58th NCH.
3	Donor recruitment - Supported by PEPFAR through National Blood Transfusion Service and Safe Blood for Africa Foundation	Near-Core	Transition to MOH (national & subnational) or other bilateral/ donor agencies	[REDACTED]	[REDACTED]	2	Sept-2016	Schedule meeting with relevant stakeholders and dissemination the information - Develop a memo that encourages State governments to establish State Blood Transfusion Services/ take ownership of existing NBTS centers in the States for submission to the 58th NCH.
4	Blood collection and testing -	Near-Core	Transition to FMOH (GoN)		[REDACTED]	2	Sept-2016	Bill developed and reviewed by FMOH. To be further imputed by ministry of justice for onward transmission to the FEC. Facilitate/Fast track submission of the draft Blood Safety Bill to Federal Executive Council (FEC) as an executive bill and subsequently to the National Assembly (NASS)
5	Strengthen Hospital Linkage program -	Near-Core	Transition to FMOH (GoN)		[REDACTED]	2	Sept-2016	Bill developed and reviewed by FMOH. To be further imputed by ministry of justice for onward transmission to the FEC
H. HVOP								
1	Community mobilization and dialogue	Near-Core	Transition to government (NACA and SACAs)	[REDACTED]	[REDACTED]	12	Sept-2016	Currently supported by PEPFAR in the 8 focus states through various award mechanisms. Schedule meeting with relevant stakeholders and disseminate the information. Activity will be sustained through other

Table A.3 Transition Plans for Non-core Activities

S/No	Transitioning Activities	EC classification (Core, Near-core or Non-core)	Type of transition	Funding in COP 15	Estimated Funding in COP 16	# of IMs	Transition end date	Notes
								mechanisms
2	Media messaging on prevention	Near-Core	Transition to government (NACA and SACAs)	[REDACTED]	[REDACTED]	12	Sept-2016	Currently supported by PEPFAR in the 8 focus states through various award mechanisms. Schedule meeting with relevant stakeholders and disseminate the information. Activity will be sustained through other mechanisms
I. MTCT Near Core Transition Plan								
1	PMCT/FP integration	Near-Core	Provide TA to GON for FP/HIV integration and transit to FP/MNCH/RH unit	[REDACTED]	[REDACTED]	11	Sept-2016	Transition process requires a meeting with relevant stakeholders to disseminate the information. Review how many sites offer integrated FP/HIV services
2	Conduct PMTCT cascade evaluation	Near-Core	One-off	[REDACTED]	[REDACTED]	11	Sept-2016	This is a one off event that will be conducted in 2 states

APPENDIX B

B.1 Planned Spending in 2016

B.1.1 Total Funding Level		
Applied Pipeline **	New Funding	Total Spend
\$53,415,438	\$405,198,843	\$458,614,281

Table B.1.2 Resource Allocation by PEPFAR Budget Code				
PEPFAR Budget Code	Budget Code Description	New Funding	Applied Pipeline	Total Amount allocated
MTCT	Mother to Child Transmission	\$49,380,810	\$-	\$49,380,810
HVAB	Abstinence/Be Faithful Prevention	\$67,259	\$-	\$67,259
HVOP	Other Sexual Prevention	\$7,901,251	\$8,640,688	\$16,541,939
IDUP	Injecting and Non-Injecting Drug Use			
HMBL	Blood Safety	\$1,279,592	\$1,539,061	\$2,818,653
HMIN	Injection Safety	\$2,786,718	\$630,449	\$3,417,167
CIRC	Male Circumcision			\$0
HVCT	Counseling and Testing	\$39,217,593	\$7,740,258	\$46,957,851
HBHC	Adult Care and Support	\$27,793,938	\$-	\$27,793,938
PDCS	Pediatric Care and Support	\$8,067,455	\$-	\$8,067,455
HKID	Orphans and Vulnerable Children	\$37,128,400	\$-	\$37,128,400
HTXS	Adult Treatment	\$71,001,408	\$-	\$71,001,408
HTXD	ARV Drugs	\$106,666,089	\$-	\$106,666,089
PDTX	Pediatric Treatment	\$3,904,103	\$-	\$3,904,103
HVTB	TB/HIV Care	\$10,745,735	\$-	\$10,745,735
HLAB	Lab	\$14,447,900	\$6,182,239	\$20,630,139
HVSI	Strategic Information	\$4,543,187	\$6,208,054	\$10,751,241
OHSS	Health Systems Strengthening	\$9,845,709	\$2,322,059	\$12,167,768
HVMS	Management and Operations	\$10,421,696	\$20,152,630	\$30,574,326
TOTAL		\$405,198,843	\$53,415,438	\$458,614,281

B.1.3 Planned Spending in 2016 above Allocation*

Table B.1.1.2 Total Funding Level		
Applied Pipeline	New Funding	Total Spend
\$98,515,438	\$405,198,843	\$503,714,281

* Inclusive of \$23,100,000 one-off costs to SCMS in applied pipeline above allocation request to OGAC

B.2 Resource Projections to Estimate the Cost of Program

PEPFAR unit expenditures (UE) from the 2014 Expenditure Analysis and the PEPFAR Budget Allocation Calculator (PBAC) were used to calculate the required resources to support targets for HTC, care and treatment, PMTCT, key population prevention, and OVC. Adjustments to UEs were made to underscore the country team's intention to keep partner expenditure aligned with the operational policies that were rolled out in COP14. Principally, training costs were reduced except in instances where it was determined that there would be substantial changes to the program content to improve effectiveness and efficiency. Program management and SI costs were also adjusted downwards from what partners had reported. Commodity costs were removed from UE costs in HTC, care and treatment, PMTCT, key population prevention, and OVC and re-captured as lump sums based on actual procurement costs to the same budget codes. Laboratory costs linked to care and treatment and PMTCT services were re-distributed appropriately to those budget codes just as the estimated costs of demand generation activities were added to care and treatment and PMTCT as lump sum additions. Early Infant Diagnosis budget estimates were captured under the PDCS budget code.

Additional details of the resource projections have been captured in Table B.2 below.

Earmark Considerations

The budget allocations are in line with earmark requirements. For the OVC earmark which requires that at least **\$36,945,187** of total funding be allocated to the HKID budget code, the country has allocated **\$37,128,400** and for the Care and Treatment earmark which requires the allocation of at least **56% of new FY15 funds** to the care and treatment of people living with HIV, the country has allocated **60% of new FY15 funds**.

Estimated cost savings from transition of PMTCT and HTC sites

After undertaking a site-yield analysis, the Nigeria PEPFAR team proposes a phased approach to transitioning low yield testing sites. In the following description, the term "HIV positive individuals" will be in reference to those identified as positive in both the HTC and PMTCT settings (APR 14). This approach is due to the finding that more than 90% of all sites undertake both HTC and PMTCT testing. In the first phase of transition, all sites in the last year that identified four or fewer HIV positive individuals will no longer be supported by the end of FY15. The second phase of transition includes all sites that have been able to identify 11 or fewer HIV positive individuals in the last year. Support to these facilities will be phased out by the end of FY16. The following paragraphs explain the estimated savings from this phase out of sites.

In the first phase, Nigeria determined that 2,509 HTC sites (40% of all HTC sites) identified fewer than five HIV positive individuals. Transitioning out of these HTC sites would save an estimated \$4.66 million. Based on this same criterion, 2,938 PMTCT sites (45% of all PMTCT sites) were selected for transition and associated with an estimated savings of \$4.62 million.

In the second phase, all sites that identified fewer than 12 HIV positive individuals in the previous year would be transitioned. This would result in transitioning another 1,060 HTC sites (16% of all HTC sites) and saving an estimated additional \$2.78 million. For PMTCT, another 1,188 sites (18% of all PMTCT sites) would be transitioned, saving an estimated additional \$3.55 million.

Based on projections using the Site Expenditure Allocation Tool (SEAT), the proposed transition from these low yield HTC and PMTCT sites are estimated to free up a total of \$7.44 million and \$8.17 million, respectively (collectively totaling \$15.61 million).

Timeline	Number of HTC sites to be transitioned	Cost saving from transition of HTC sites	Number of PMTCT sites to be transitioned	Cost saving from transition of PMTCT sites
Phase 1 (end of FY 2015)	2,509	\$4.66 million	2,938	\$4.62 million
Phase 2 (end of FY 2016)	1,060	\$2.78 million	1,188	\$3.55 million
Total	3,569	\$7.44 million	4,126	\$8.17 million

Appendix B.2 Resource Allocation and Projection Table

PEPFAR Budget Code	Indicators carry cost to PEPFAR		COP 15 Targets	COP 15 UE	Costs tied to indicators (COP 15)	Program costs tied to indicators (COP 15)	Lump Sum Costs	Commodity Cost (for Pooled Procurement)	Total Budget (COP 15)	Comments
MTCT	PMTCT_STAT		2,022,163	\$ 4.56	\$ 9,221,063	\$ 30,639,040	\$ 4,665,069	\$ 13,716,419	\$49,020,528	
	PMTCT_ARV (excluding B+)	Facility Based	42,476	\$ 329.33	\$ 13,988,621					
	PMTCT_ARV (option B+ for scale-up LGAs)	Facility Based	22,559	\$ 329.33	\$ 7,429,355					
										[REDACTED]
HVAB			-	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
HVOP	KP_PREV disaggregation of FSW		\$ 197,480	\$ 70.00	\$ 13,823,600	\$ 15,148,810	\$ -	\$ 1,276,458	\$ 16,425,268	[REDACTED]
	KP_PREV disaggregation of MSM		10,700	\$ 94.00	\$ 1,005,800					[REDACTED]
	KP_PREV disaggregation of PWID		4,563	\$ 70.00	\$ 319,410					
IDUP			-	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
HMBL			-	\$ -	\$ -	\$ -	\$ 1,723,886	\$ 1,000,000	\$ 2,723,886	[REDACTED]
HMIN			-	\$ -	\$ -	\$ -	\$ 3,200,000	\$ 200,000	\$ 3,400,000	[REDACTED]
CIRC		-	\$ -	\$ -	\$ -	\$ -		\$ -	-	
HVCT	HTC_TST	Sustained-service LGA's	-	\$ 2.91	\$ -	\$ 33,148,763	\$ -	\$ 13,695,923	\$ 46,844,686	
	HTC_TST	Facility Based Scale up LGA's	6,724,885	\$ 2.91	\$ 19,569,415					
	HTC_TST	Community Based Scale up LGA's	1,610,836	\$ 8.43	\$ 13,579,347					
										[REDACTED]

Appendix B.2 Resource Allocation and Projection Table

PEPFAR Budget Code	Indicators carry cost to PEPFAR		COP 15 Targets	COP 15 UE	Costs tied to indicators (COP 15)	Program costs tied to indicators (COP 15)	Lump Sum Costs	Commodity Cost (for Pooled Procurement)	Total Budget (COP 15)	Comments
HBHC	CARE_CURR - TX_CURR (> 15 years old)	Facility Based Care and Support (Pre-ART)	189,213	\$ 62.72	\$ 11,867,439	\$ 25,646,447	\$ 1,931,636	\$ -	\$ 27,578,083.78	[REDACTED]
		Community Based Care and Support (Community Adherence support and Linkages)	175,194	\$ 78.65	\$ 13,779,008					
PDCS	CARE_CURR - TX_CURR (> 1year old but < 15 years old)	Sustained-service + Scale Up LGA's (Facility)	12,042	\$ 55.72	\$ 670,980	\$ 6,531,562	\$ 242,741	\$ 1,184,250	\$ 7,958,552.36	[REDACTED]
		Community based Care and Support for all LGAs	12,042	\$ 86.92	\$ 1,046,691					
	PMTCT_EID	Same as PMTCT ARVs	65,035	\$ 74.02	\$ 4,813,891					
HKID						\$ 3,256,108	\$ 3,689,080	\$ -	\$ 36,945,187	[REDACTED]
	OVC_SERV		950,175	\$ 35.00	\$ 33,256,108					
HTXS	TX_CURR (> 15 years old) - PMTCT_ARV	Facility Based Sustained-service (Low Volume)	29,899	\$ 15.98	\$ 477,785	\$ 43,245,365	\$ 16,076,040	\$ 11,431,637	\$ 70,753,042	[REDACTED]
	TX_CURR (> 15 years old) - PMTCT_ARV	Facility Based Sustained-service (Med & High [secondary] Volume)	289,743	\$ 56.31	\$ 16,315,405					
	TX_CURR (> 15 years old) - PMTCT_ARV	Facility Based Sustained-service LGA's Tertiary Facilities (High Volume)	124,384	\$ 46.39	\$ 5,770,195					
	TX_CURR (> 15 years old) - PMTCT_ARV	Facility Based Scale Up LGA (already on treatment)	176,142	\$ 81.00	\$ 14,267,534					

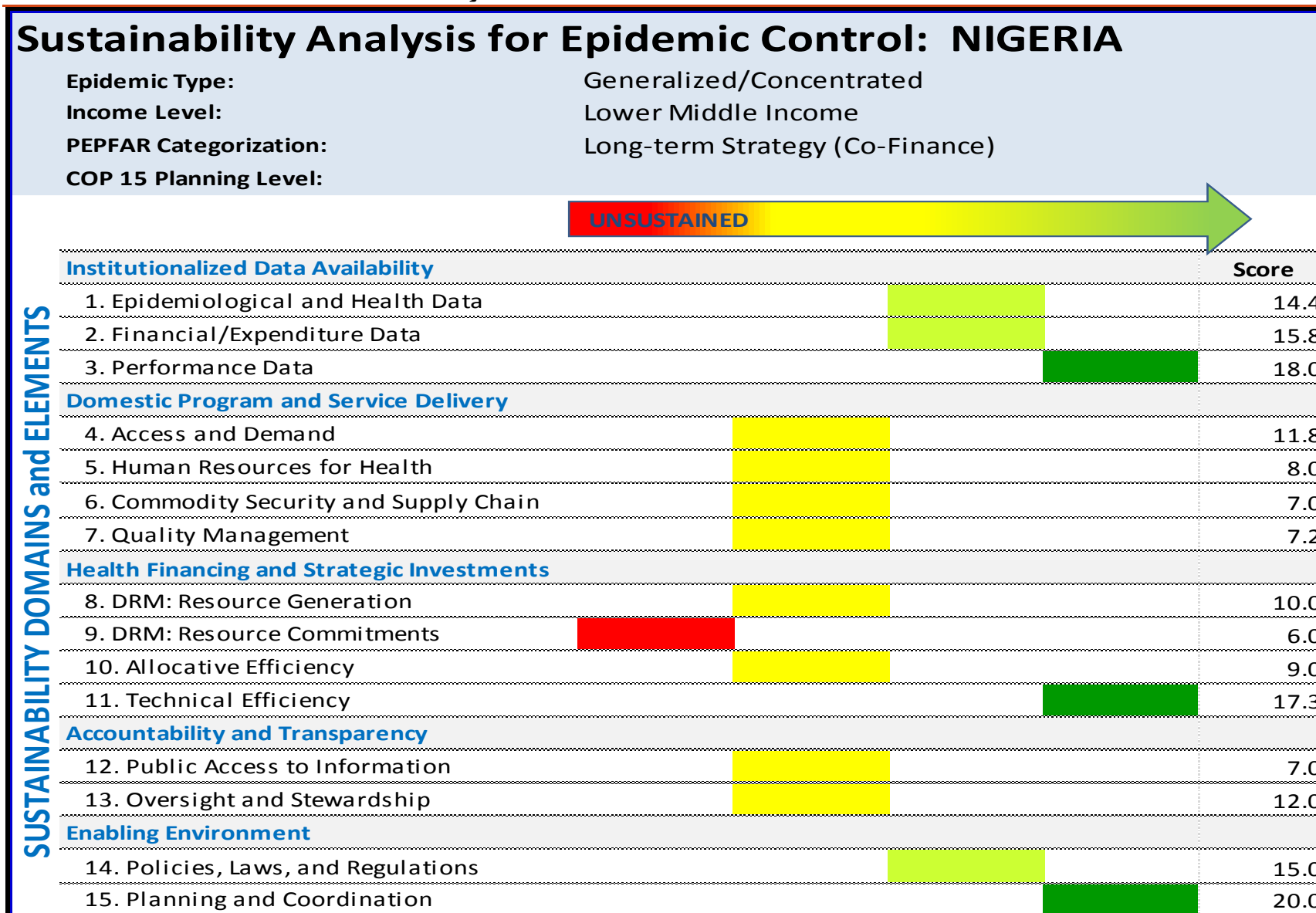
Appendix B.2 Resource Allocation and Projection Table

PEPFAR Budget Code	Indicators carry cost to PEPFAR		COP 15 Targets	COP 15 UE	Costs tied to indicators (COP 15)	Program costs tied to indicators (COP 15)	Lump Sum Costs	Commodity Cost (for Pooled Procurement)	Total Budget (COP 15)	Comments
	TX_CURR (> 15 years old) - PMTCT_ARV	Facility Based Scale Up - newly added with "Innovative Case Management"	44,036	\$ 145.67	\$ 6,414,446					
HTXD					\$ -	\$ -	\$ 106,657,620		\$ 106,657,620	
PDTX	TX_CURR (>1 year but <15 years old)	Facility Based Sustained-service LGA's (low volume)	2,056	\$ 17.31	\$ 35,590	\$ 3,657,131	\$ 139,795		\$ 3,796,926	[REDACTED]
	TX_CURR (>1 year but <15 years old)	Facility Based Sustained-service (Med & High [secondary] Volume)	19,925	\$ 58.18	\$ 1,159,208					
	TX_CURR (>1 year but <15 years old)	Facility Based Sustained-service LGA's Tertiary Facilities (High Volume)	8,553	\$ 50.20	\$ 429,383					
	TX_CURR (>1 year but <15 years old)	Facility Based Scale Up LGA's	14,106	\$ 87.71	\$ 1,237,237					
	TX_CURR (>1 year but <15 years old)	Community Based Scale Up LGA's	3,526	\$ 225.67	\$ 795,712					
HVTB					\$ -	\$ -	\$ 8,344,100	\$ 2,232,009	\$ 10,576,109	[REDACTED]
HLAB					\$ -	\$ -	\$ 19,998,673		\$ 19,998,673	[REDACTED]
HVSI					\$ -	\$ -	\$ 9,490,000		\$ 9,490,000	[REDACTED]
OHSS					\$ -	\$ -	\$ 6,285,047	\$ 5,641,120	\$ 11,926,167	

Appendix B.2 Resource Allocation and Projection Table										
PEPFAR Budget Code	Indicators carry cost to PEPFAR		COP 15 Targets	COP 15 UE	Costs tied to indicators (COP 15)	Program costs tied to indicators (COP 15)	Lump Sum Costs	Commodity Cost (for Pooled Procurement)	Total Budget (COP 15)	Comments
HVMS					\$ -	\$ -	\$ 34,519,552		\$ 34,519,552	[REDACTED]
Total					\$ 191,273,225	\$ 191,273,225	\$ 110,305,618	\$ 157,035,437	\$ 458,614,281	

Please note – The difference in budget code total between Table B.1.2 (Resource Allocation by PEPFAR Budget Code- which is a FACTs Info print-out) and the above Appendix B.2 (Resource Allocation and Projection Table) arise from salary and travel allocations from HVMS to the budget codes (as captured in FACTs Info).

APPENDIX C – Sustainability Index Dashboard



Nigeria COP15 Targets by LGA: Clinical Cascade

	Number of individuals who received HIV Testing and Counseling services for HIV and received their test results	Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Number of adults and children currently receiving antiretroviral therapy (ART)
Ikot Abasi Eduo Health Post	-	-	-	-	-
Aba North	-	-	-	-	-
Aba South	-	-	-	-	-
Abaji	28,704	128	638	103	510
Abak	1,181	75	336	50	269
Abakaliki	9,024	-	-	-	-
Abakaliki	668	-	-	-	-
Abeokuta North	1,887	-	-	-	-
Abeokuta South	39,500	571	3,233	456	2,585
Abi	1,303	-	-	-	-
Aboh Mbaise	4,951	224	923	179	739
Abua/Odual	4,201	-	-	-	-
Abuja Municipal Area Council	2,101,387	34,625	54,013	27,700	43,211
Adavi	2,848	-	-	-	-
Ado	1,082	-	-	-	-
Ado-Ekiti	22,911	267	770	214	616
Ado-Odo/Ota	7,242	-	-	-	-
Afijio	1,646	-	-	-	-
Afikpo North	2,534	-	-	-	-
Afikpo North	11,330	195	1,007	156	806
Afikpo South	1,936	-	-	-	-
Agai	-	-	-	-	-
Agatu	478	-	-	-	-
Agege	80,695	2,626	2,286	2,100	1,829
Aguata	6,967	148	586	118	469
Agwara	-	-	-	-	-
Ahiazu Mbaise	2,247	-	-	-	-
Ahoada East	12,257	993	5,299	795	4,239
Ahoada West	3,980	-	-	-	-
Aiyedade	-	-	-	-	-
Ajaokuta	5,272	93	421	75	337
Ajeromi-Ifeلودun	216,361	8,183	10,461	6,547	8,368
Ajingi	2,606	10	6	8	5
Akamkpa	2,447	49	1	39	1
Akinyele	2,690	-	-	-	-
Akko	2,734	3	11	2	9
Akoko Edo	2,372	-	-	-	-
Akoko North East	5,866	281	865	225	692
Akoko North West	-	-	-	-	-
Akoko South East	-	-	-	-	-
Akoko South West	4,868	-	-	-	-
Akpabuyo	6,583	129	484	103	388
Akuku Toru	130	-	-	-	-
Akure North	270	-	-	-	-
Akure South	3,891	111	356	378	284
Akwanga	57,074	1,240	6,892	992	5,513
Albasu	2,462	-	-	-	-
Aleiro	-	-	-	-	-
Alimosho	293,081	11,120	10,150	8,896	8,120
Alkaleri	-	-	-	-	-
Amuwo-Odofin	2,695	-	-	-	-
Anambra East	377	-	-	-	-
Anambra West	1,971	-	-	-	-
Anaocha	17,410	435	2,185	348	1,747
Andoni	888	-	-	-	-
Aninri	1,802	-	-	-	-
Aniocha North	-	-	-	-	-
Aniocha South	-	-	-	-	-
Ankpa	15,389	447	2,125	358	1,700
Apa	1,267	-	-	-	-
Apapa	28,893	2,485	2,320	1,988	1,856
Ardo-kola	-	-	-	-	-
Argungu	3,737	102	417	82	334
Arochukwu	-	-	-	-	-
Asa	-	-	-	-	-
Asari-Toru	2,355	-	-	-	-
Askira/Uba	665	-	-	-	-
Atakunmosa West	1,123	-	-	-	-

Nigeria COP15 Targets by LGA: Clinical Cascade

	Number of individuals who received HIV Testing and Counseling services for HIV and received their test results	Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Number of adults and children currently receiving antiretroviral therapy (ART)
Atiba	2,471	-	-	-	-
Atisbo	1,397	-	-	-	-
Augie	-	-	-	-	-
Awe	880	-	-	-	-
Awgu	8,361	109	399	87	320
Awka North	1,368	-	-	-	-
Awka South	14,107	479	2,715	384	2,172
Ayamelum	2,158	-	-	-	-
Badagry	46,453	1,400	8,221	1,120	6,577
Bade	-	-	-	-	-
Bagudo	-	-	-	-	-
Bagwai	-	-	-	-	-
Bakassi	1,393	-	-	-	-
Bakura	-	-	-	-	-
Balanga	6,388	80	378	65	302
Bali	-	-	-	-	-
Bama	2,466	98	415	78	333
Barkin Ladi	4,134	146	738	117	591
Bassa	6,178	121	604	97	484
Bassa	-	-	-	-	-
Batsari	-	-	-	-	-
Bauchi	35,637	1,516	8,516	1,212	6,813
Baure	-	-	-	-	-
Bayo	-	-	-	-	-
Bebeji	-	-	-	-	-
Bekwarra	1,055	5	3	4	2
Bende	-	-	-	-	-
Biase	8,635	112	527	90	421
Bichi	-	-	-	-	-
Bida	7,816	325	1,775	260	1,420
Billiri	12,357	389	1,716	312	1,373
Binji	-	-	-	-	-
Birnin Gwari	5,291	325	566	260	453
Birnin Kebbi	9,623	450	2,366	360	1,893
Birnin Kudu	8,792	335	1,809	268	1,446
Birnin Magaji	-	-	-	-	-
Biu	5,778	147	844	118	675
Bogoro	1,577	-	-	-	-
Boki	1,150	5	13	4	11
Bokkos	650	-	-	-	-
Boluwaduro	-	-	-	-	-
Bomadi	-	-	-	-	-
Bonny	3,940	261	461	209	369
Bosso	-	-	-	-	-
Brass	908	7	10	5	7
Buji	1,866	-	-	-	-
Bunkure	3,329	-	-	-	-
Bunza	-	-	-	-	-
Buruku	35,513	4,275	6,819	3,419	5,455
Burutu	-	-	-	-	-
Bussa/ New	1,905	132	496	106	397
Bwari	414,461	9,395	12,636	7,516	10,109
Calabar Municipal	54,402	2,375	7,543	1,900	6,035
Calabar South	115,410	6,306	6,780	5,046	5,425
Chanchaga	14,053	1,005	5,165	804	4,132
Chibok	4,364	-	-	-	-
Chikun	24,951	771	2,908	616	2,326
Dala	-	-	-	-	-
Damagum	-	-	-	-	-
Damaturu	-	-	-	-	-
Damban	-	-	-	-	-
Dambatta	773	2	8	2	6
Dan Musa	-	-	-	-	-
Dange-shnsi	-	-	-	-	-
Darazo	-	-	-	-	-
Dass	-	-	-	-	-
Daura	-	-	-	-	-
Dawakin Kudu	487	1	2	-	2
Dawakin Tofa	-	-	-	-	-
Degema	761	-	-	-	-

Nigeria COP15 Targets by LGA: Clinical Cascade

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Dekina	16,940	660	3,217	528	2,573
Demsa	3,317	-	-	-	-
Doguwa	220	-	-	-	-
Doma	27,731	3,644	5,525	2,915	4,418
Donga	-	-	-	-	-
Dukku	3,471	-	-	-	-
Dunukofia	3,204	187	795	150	635
Dutse	8,418	199	913	158	730
Eastern Obolo	614	33	3	26	2
Ebonyi	20,462	691	3,939	552	3,152
Ebonyi	1,669	-	-	-	-
Edati	-	-	-	-	-
Ede North	3,199	-	-	-	-
Ede South	1,043	-	-	-	-
Edu	-	-	-	-	-
Efon	-	-	-	-	-
Egbeda	3,600	-	-	-	-
Egbedore	-	-	-	-	-
Egor	15,515	1,002	4,686	802	3,749
Ehime Mbano	1,709	-	-	-	-
Ejigbo	-	-	-	-	-
Ekeremor	3,592	10	9	8	7
Eket	1,359	-	-	-	-
Ekiti East	4,041	-	-	-	-
Ekiti South-West	2,046	-	-	-	-
Ekiti West	-	-	-	-	-
Ekwusigo	675	-	-	-	-
Eleme	34,899	1,564	1,360	1,251	1,088
Emohua	2,665	-	-	-	-
Emure	-	-	-	-	-
Enugu East	36,628	570	3,122	456	2,497
Enugu East	-	-	-	-	-
Enugu North	13,071	542	2,632	433	2,105
Enugu South	4,386	-	-	-	-
Enugu South	1,618	-	-	-	-
Enugu West	-	-	-	-	-
Epe	3,438	-	-	-	-
Esan Central	7,766	450	2,110	260	1,123
Esan North-East	2,143	178	1,002	242	1,366
Esan South-East	2,199	-	-	-	-
Esan West	1,566	-	-	-	-
Ese-Odo	-	-	-	-	-
Esit Eket	494	-	-	-	-
Essien Udim	5,769	228	1,022	193	817
Etche	837	-	-	-	-
Ethiophe East	11,825	289	1,041	231	832
Ethiophe West	-	-	-	-	-
Eti-Osa	4,985	74	326	59	261
Etim Ekpo	4,316	245	1,281	196	1,026
Etinan	10,619	773	4,460	618	3,568
Etsako Central	-	-	-	-	-
Etsako East	1,155	-	-	-	-
Etsako West	6,975	473	2,269	379	1,816
Etung	878	-	-	-	-
Ezeagu	1,907	-	-	-	-
Ezinihitte	1,910	-	-	-	-
Ezinihitte	225	-	-	-	-
Ezza North	1,559	-	-	-	-
Ezza South	14,223	119	599	95	479
Fagge	13,183	980	5,792	783	4,633
Fika	5,760	-	-	-	-
Fufore	6,432	208	894	166	715
Funakaye	19,373	308	1,517	246	1,214
Fune	-	-	-	-	-
Funtua	6,958	582	3,219	465	2,575
Gamawa	-	-	-	-	-
Ganjuwa	4,828	-	-	-	-
Garko	2,411	5	6	4	5
Garum Mallam	2,010	-	-	-	-
Gashaka	-	-	-	-	-

Nigeria COP15 Targets by LGA: Clinical Cascade

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Gassol	-	-	-	-	-
Gaya	-	-	-	-	-
Gbako	-	-	-	-	-
Gboko	42,498	3,006	15,069	2,405	12,055
Gbonyin	1,610	-	-	-	-
Gezawa	1,104	-	-	-	-
Giade	2,921	-	-	-	-
Girei	2,400	-	-	-	-
Giwa	47,067	1,367	7,608	1,094	6,087
Gokana	2,382	-	-	-	-
Gombe	42,896	1,143	6,352	914	5,082
Gombi	6,078	236	1,193	189	955
Goronyo	-	-	-	-	-
Gujba	1,966	-	-	-	-
Guma	2,754	-	-	-	-
Gurara	1,978	244	1,066	195	852
Gusau	9,080	217	1,030	173	825
Guyuk	-	-	-	-	-
Guzamala	-	-	-	-	-
Gwagwalada	23,948	1,925	10,966	1,540	8,773
Gwale	-	-	-	-	-
Gwaram	5,194	-	-	-	-
Gwarzo	-	-	-	-	-
Gwer East	44,282	1,971	11,280	1,577	9,025
Gwer West	53,003	5,820	5,978	4,699	4,699
Gwiwa	2,470	-	-	-	-
Gwoza	995	112	678	90	542
Hadejia	9,017	248	1,433	198	1,147
Hawul	-	-	-	-	-
Hong	4,931	105	522	84	417
Ibadan North	60,244	1,564	10,673	1,473	8,700
Ibadan North-East	3,826	-	-	-	-
Ibadan North-West	19,323	906	3,307	503	2,483
Ibadan South-East	6,933	-	-	-	-
Ibadan South-West	1,965	-	-	-	-
Ibaji	1,973	-	-	-	-
Ibarapa Central	876	-	-	-	-
Ibarapa East	-	-	-	-	-
Ibarapa North	-	-	-	-	-
Ibeju/Lekki	7,188	339	223	271	178
Ibeno	551	3	3	2	3
Ibesikpo Asutan	1,573	-	-	-	-
Ibi	-	-	-	-	-
Ibiono Ibom	874	-	-	-	-
Idah	6,554	228	1,062	182	849
Idanre	-	-	-	-	-
Ideato North	195	-	-	-	-
Ideato South	1,851	-	-	-	-
Idemili North	8,843	186	841	149	673
Idemili South	9,337	433	1,887	346	1,509
Ido	1,308	-	-	-	-
Ido-Osi	10,424	351	841	281	672
Ifako-Ijaiye	474,376	6,165	5,921	4,930	4,736
Ife Central	11,833	341	1,691	273	1,354
Ife East	2,118	-	-	-	-
Ife North	327	-	-	-	-
Ife South	-	-	-	-	-
Ifedore	-	-	-	-	-
Ifelodun	-	-	-	-	-
Ifo	8,975	240	569	199	474
Igabi	6,692	-	-	-	-
Igalamela-Odolu	1,483	-	-	-	-
Igbo Eiti	2,541	-	-	-	-
Igbo Eze North	19,500	900	4,599	720	3,680
Igbo Eze South	1,878	-	-	-	-
Igueben	1,073	23	19	18	15
Ihiala	10,350	481	2,538	385	2,030
Ihitte/Uboma	1,658	-	-	-	-
Ijebu North-East	3,760	-	-	-	-
Ijebu Ode	8,088	425	2,072	334	1,641

Nigeria COP15 Targets by LGA: Clinical Cascade

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Ijero	189	-	-	-	-
Ijumu	433	3	20	2	15
Ika	1,149	75	21	60	17
Ika North East	-	-	-	-	-
Ika South	13,393	691	3,396	554	2,717
Ikara	-	-	-	-	-
Ikeduru	1,967	-	-	-	-
Ikeja	82,091	1,667	4,256	1,333	3,405
Ikenne	-	-	-	-	-
Ikere	800	-	-	-	-
Ikere-Ekiti	-	-	-	-	-
Ikole	942	-	-	-	-
Ikom	20,132	483	2,666	386	2,133
Ikono	859	-	-	-	-
Ikorodu	1,392	-	-	-	-
Ikot Abasi	1,056	-	-	-	-
Ikot Ekpene	58,865	5,912	10,122	4,729	8,098
Ikpoba-Okha	-	-	-	-	-
Ikwerre	2,346	-	-	-	-
Ikwo	560	-	-	-	-
Ikwuano	-	-	-	-	-
Ila	237	-	-	-	-
Ilaje	-	-	-	-	-
Ile Oluji/Okeigbo	2,577	-	-	-	-
Ilejemeje	785	-	-	-	-
Ilesha East	1,285	-	-	-	-
Ilesha West	-	-	-	-	-
Ilele	-	-	-	-	-
Ilorin East	-	400	2,278	320	1,823
Ilorin South	10,812	303	1,586	242	1,269
Ilorin West	20,768	100	570	80	456
Imeko/Afon	-	-	-	-	-
Ingawa	-	-	-	-	-
Ini	1,246	-	-	-	-
Ipokia	396	-	-	-	-
Irele	-	-	-	-	-
Irepo	619	-	-	-	-
Irepodun	-	-	-	-	-
Irepodun	-	-	-	-	-
Irepodun/Ifeledun	2,091	-	-	-	-
Irewole	94	-	-	-	-
Ise/Orun	1,834	-	-	-	-
Iseyin	2,850	-	-	-	-
Ishielu	1,295	-	-	-	-
Isiala Mbanjo	2,295	-	-	-	-
Isiala-Ngwa North	-	-	-	-	-
Isiala-Ngwa South	-	-	-	-	-
Isiuzo	1,942	-	-	-	-
Isokan	1,263	-	-	-	-
Isoko North	-	-	-	-	-
Isoko South	-	-	-	-	-
Isu	2,056	-	-	-	-
Isuikwuato	-	-	-	-	-
Itesiwaju	1,903	-	-	-	-
Itu	1,709	-	-	-	-
Ivo	1,571	-	-	-	-
Iwajowa	1,412	-	-	-	-
Iwo	2,865	131	430	105	343
Izzi	2,307	-	-	-	-
Jaba	25,117	690	3,410	552	2,728
Jada	3,072	-	-	-	-
Jahun	6,889	71	321	57	257
Jalingo	-	-	-	-	-
Jama'are	-	-	-	-	-
Jega	3,733	60	301	48	240
Jema'a	64,240	1,377	7,226	1,102	5,782
Jere	13,823	1,423	7,799	1,139	6,240
Jibia	-	-	-	-	-
Jos East	274	-	-	-	-
Jos North	130,726	5,209	30,104	4,169	24,083

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Jos South	10,071	224	922	180	738
Kabba/Bunu	3,896	219	1,043	176	835
Kabo	2,993	6	16	5	13
Kachia	17,736	294	1,370	235	1,096
Kaduna North	26,636	1,782	9,703	1,427	7,763
Kaduna South	63,630	2,347	12,712	1,879	10,171
Kafin Hausa	3,862	9	8	7	6
Kaga	1,116	-	-	-	-
Kagarko	2,395	-	-	-	-
Kajola	659	-	-	-	-
Kajuru	1,778	-	-	-	-
Kaltungo	12,531	225	988	180	791
Kanam	8,450	261	1,150	209	920
Kankara	-	-	-	-	-
Kanke	1,083	-	-	-	-
Kankia	3,139	346	398	277	319
Kano Municipal	63,884	2,713	14,549	2,170	11,639
Karaye	-	-	-	-	-
Karin-Lamido	-	-	-	-	-
Karu	95,573	8,297	17,334	6,644	13,924
Katagum	10,400	451	2,185	361	1,748
Katcha	-	-	-	-	-
Katsina	16,140	1,098	4,588	879	3,670
Katsina-Ala	32,111	7,210	14,211	5,768	11,369
Kaura	1,495	-	-	-	-
Kaura Namoda	-	-	-	-	-
Kauru	1,619	-	-	-	-
Kazaure	5,793	93	439	74	351
Keana	1,206	-	-	-	-
Keffi	12,253	434	301	294	121
Khana	6,438	410	867	328	694
Kirfi	2,726	-	-	-	-
Kiru	-	-	-	-	-
Kiyawa	3,315	-	-	-	-
Kogi	1,136	-	-	-	-
Koko/Besse	5,294	77	437	62	349
Kokona	5,895	290	1,379	232	1,103
Kolokuma/Opokuma	772	15	8	12	6
Konshisha	103,913	6,053	6,827	4,842	5,462
Kontagora	-	-	-	-	-
Kosofe	7,467	-	-	-	-
Kubau	4,936	-	-	-	-
Kudan	228	-	-	-	-
Kuje	8,770	100	126	80	100
Kumbotso	-	-	-	-	-
Kunchi	-	-	-	-	-
Kura	1,076	-	-	-	-
Kurfi	-	-	-	-	-
Kurmi	-	-	-	-	-
Kwali	780	-	-	-	-
Kwami	1,106	-	-	-	-
Kwande	29,474	2,086	10,889	1,669	8,712
Lafia	169,329	11,294	17,296	9,049	13,926
Lagelu	1,959	-	-	-	-
Lagos Island	119,556	1,484	8,737	1,187	6,990
Lagos Mainland	80,797	3,191	18,292	2,551	14,635
Langtang North	1,790	249	1,327	199	1,062
Langtang South	1,470	-	-	-	-
Lapai	6,687	137	633	109	507
Lavun	-	-	-	-	-
Lere	21,571	422	2,189	337	1,751
Logo	52,340	9,470	9,503	7,575	7,603
Lokoja	87,428	633	3,171	540	2,537
Madagali	2,496	-	-	-	-
Mafa	2,599	-	-	-	-
Magama	-	-	-	-	-
Mai'Adua	-	-	-	-	-
Maiduguri	3,091	295	1,555	236	1,245
Maiyama	-	-	-	-	-
Makarfi	2,366	456	2,539	365	2,029

Nigeria COP15 Targets by LGA: Clinical Cascade

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Makoda	3,355	-	-	-	-
Makurdi	129,594	4,583	28,384	3,625	22,791
Malumfashi	-	-	-	-	-
Mangu	9,913	380	1,613	302	1,290
Mani	-	-	-	-	-
Maradun	-	-	-	-	-
Mariga	-	-	-	-	-
Mashegu	-	-	-	-	-
Mayo-Belwa	971	-	-	-	-
Mbaitoli	522	-	-	-	-
Mbo	750	-	-	-	-
Michika	6,330	330	1,726	264	1,382
Mikang	5,904	121	490	97	392
Minjibir	-	-	-	-	-
Misau	9,847	173	853	139	682
Mkpat Enin	1,297	-	-	-	-
Moba	250	-	-	-	-
Mobbar	1,854	-	-	-	-
Mokwa	1,848	174	496	139	397
Mopa-Muro	-	-	-	-	-
Mubi South	11,570	746	4,255	597	3,403
Musawa	-	-	-	-	-
Mushin	436,477	20,794	27,915	16,635	22,333
Muya	-	-	-	-	-
Nafada/Bajoga	547	-	-	-	-
Nasarawa	148,409	8,950	8,002	7,192	6,375
Nasarawa Eggon	10,694	299	1,413	240	1,131
Nassarawa	23,719	521	906	417	725
Ndokwa East	-	-	-	-	-
Ndokwa West	-	-	-	-	-
Nembe	485	-	-	-	-
Ngala	-	-	-	-	-
Ngaski	-	-	-	-	-
Ngor Okpala	123	-	-	-	-
Ngor Okpala	427	-	-	-	-
Nguru	7,084	435	1,383	348	1,107
Ningi	7,232	-	-	-	-
Njaba	1,831	-	-	-	-
Njikoka	1,913	49	4	39	3
Nkanu East	2,044	-	-	-	-
Nkanu West	40,796	1,659	9,365	1,327	7,492
Nkwerre	1,089	-	-	-	-
Nnewi North	27,283	1,174	6,750	939	5,401
Nnewi South	518	-	-	-	-
Nsit Atai	2,302	30	11	24	9
Nsit Ibom	1,495	-	-	-	-
Nsit Ubium	661	-	-	-	-
Nsukka	1,038	-	-	-	-
Nsukka	3,910	193	671	154	537
Nwangele	566	-	-	-	-
Obanliku	1,055	11	8	9	6
Obi	2,495	-	-	-	-
Obi	171,850	8,853	7,955	7,083	6,364
Obingwa	-	-	-	-	-
Obio/Akpor	88,955	2,577	6,844	2,062	5,475
Obokun	-	-	-	-	-
Obot Akara	439	-	-	-	-
Obowo	511	-	-	-	-
Obubra	1,772	-	-	-	-
Obudu	5,672	150	599	121	479
Odeda	206	-	-	-	-
Odigbo	5,202	365	544	291	435
Odo-Otin	-	-	-	-	-
Odogbolu	-	-	-	-	-
Odukpani	2,579	20	23	16	18
Offa	3,762	135	700	108	560
Ofu	6,887	460	1,598	368	1,279
Ogba/Egbema/Ndoni	2,917	-	-	-	-
Ogbadibo	1,649	-	-	-	-
Ogbaru	2,777	-	-	-	-

Nigeria COP15 Targets by LGA: Clinical Cascade

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Ogbia	1,190	17	7	14	6
Ogbomoso North	11,649	189	1,007	151	806
Ogbomoso South	8,365	-	-	-	-
Ogo Oluwa	976	-	-	-	-
Ogoja	36,125	1,633	9,253	1,306	7,402
Ogori/Magongo	-	-	-	-	-
Ogu/Bolo	1,102	38	20	31	16
Ogun Waterside	829	-	-	-	-
Oguta	2,115	-	-	-	-
Ohafia	-	-	-	-	-
Ohaji/Egbema	1,917	-	-	-	-
Ohaozara	490	-	-	-	-
Ohaukwu	6,386	92	439	74	350
Ohimini	352	-	-	-	-
Oji River	6,342	100	431	80	345
Ojo	13,908	-	-	-	-
Oju	1,217	-	-	-	-
Okehi	6,805	119	450	96	360
Okene	10,139	313	1,375	250	1,100
Okigwe	10,296	160	858	128	687
Okitipupa	-	-	-	-	-
Okobo	116,190	6,755	6,056	5,405	4,844
Okpe	-	-	-	-	-
Okpokwu	39,017	647	3,090	518	2,472
Okrika	2,822	-	-	-	-
Ola-Oluwa	2,460	-	-	-	-
Olamaboro	5,882	219	901	175	721
Olorunda	3,524	325	1,194	260	956
Olorunsogo	183	-	-	-	-
Oluyole	3,110	-	-	-	-
Omala	4,243	193	639	154	511
Omumma	-	-	-	-	-
Ona Ara	3,424	-	-	-	-
Ondo East	-	-	-	-	-
Ondo West	7,646	441	738	352	590
Onicha	2,868	-	-	-	-
Onitsha North	4,567	431	2,417	470	1,933
Onitsha South	14,191	175	907	15	727
Onna	842	-	-	-	-
Onuimo	1,299	-	-	-	-
Opobo/Nkoro	-	-	-	-	-
Oredo	8,666	212	1,069	170	855
Orelope	1,307	-	-	-	-
Orhionmwon	401	8	10	7	8
Ori Ire	2,236	-	-	-	-
Orlu	6,798	305	1,461	244	1,169
Orolu	-	-	-	-	-
Oron	28,662	3,353	8,039	2,682	6,431
Orsu	1,578	-	-	-	-
Oru East	7,914	406	1,790	324	1,431
Oru West	1,547	-	-	-	-
Oruk Anam	1,102	-	-	-	-
Orumba North	2,067	-	-	-	-
Orumba South	2,019	-	-	-	-
Ose	2,325	-	-	-	-
Oshimili North	-	-	-	-	-
Oshimili South	28,252	983	4,191	879	3,352
Oshodi-Isolo	11,254	-	-	-	-
Osisioma	-	-	-	-	-
Osogbo	-	-	-	-	-
Otukpo	32,015	969	5,186	776	4,149
Ovia South-West	943	-	-	-	-
Owan East	2,155	18	11	15	9
Owan West	1,363	-	-	-	-
Owerri Municipal	9,168	419	2,203	335	1,762
Owerri Municipal	369	-	-	-	-
Owerri North	5,873	391	2,165	313	1,732
Owerri North	1,003	-	-	-	-
Owerri West	1,775	-	-	-	-
Owo	3,254	444	69	66	55

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Oye	2,333	-	-	-	-
Oyi	4,843	168	687	134	550
Oyigbo	1,497	-	-	-	-
Oyo East	1,591	-	-	-	-
Oyo West	1,708	-	-	-	-
Paikoro	-	-	-	-	-
Pankshin	5,289	350	1,135	280	907
Patani	-	-	-	-	-
Patigi	-	-	-	-	-
Port-Harcourt	67,206	3,136	5,607	2,509	4,485
Potiskum	20,038	362	1,719	290	1,375
Qua'an Pan	4,534	140	634	112	507
Rafi	4,307	135	707	108	567
Rano	744	-	-	-	-
Remo North	-	-	-	-	-
Rijau	11,172	166	885	133	708
Rimin Gado	48	-	-	-	-
Ringim	15,299	98	463	78	371
Riyom	-	-	-	-	-
Rogo	-	-	-	-	-
Roni	1,488	-	-	-	-
Sabo Birni	-	-	-	-	-
Sabon Gari	2,802	-	-	-	-
Sagamu	9,396	447	1,921	358	1,537
Sagbama	2,169	33	5	26	4
Saki East	1,473	-	-	-	-
Saki West	711	-	-	-	-
Sanga	13,038	698	3,413	558	2,730
Sapele	270	-	-	-	-
Sardauna	-	-	-	-	-
Shani	-	-	-	-	-
Shanono	2,649	-	-	-	-
Shelleng	2,744	-	-	-	-
Shendam	18,573	416	2,366	333	1,893
Shinkafi	-	-	-	-	-
Shira	4,377	-	-	-	-
Shiroro	3,766	117	495	94	396
Shomolu	7,226	-	-	-	-
Shongom	5,451	99	430	79	344
Silame	-	-	-	-	-
Soba	4,166	-	-	-	-
Sokoto North	-	-	-	-	-
Sokoto South	8,283	506	2,891	404	2,313
Song	7,703	264	1,255	211	1,004
Southern IJaw	2,690	55	13	44	10
Suleja	8,103	377	1,849	302	1,479
Sumaila	1,525	-	-	-	-
Surulere	1,956	-	-	-	-
Surulere	66,820	3,337	3,010	2,669	2,408
Tafa	2,422	300	1,527	240	1,221
Tafawa-Balewa	5,522	162	579	130	463
Tai	1,792	-	-	-	-
Takai	-	-	-	-	-
Takum	-	-	-	-	-
Tambuwal	-	-	-	-	-
Tarauni	1,654	353	1,806	283	1,445
Tarka	6,149	1,493	3,876	1,195	3,101
Taura	2,531	-	-	-	-
Toro	9,034	166	671	133	538
Toto	1,652	-	-	-	-
Toungo	-	-	-	-	-
Tsafe	-	-	-	-	-
Tsanyawa	-	-	-	-	-
Tudun Wada	5,099	120	618	96	495
Tureta	-	-	-	-	-
Udenu	1,257	-	-	-	-
Udi	20,764	216	942	173	754
Udu	-	-	-	-	-
Udung Uko	732	-	-	-	-
Ughelli North	-	-	-	-	-

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Ughelli South	-	-	-	-	-
Ugwunagbo	-	-	-	-	-
Uhunmwonde	1,676	-	-	-	-
Ukanafun	463	-	-	-	-
Ukum	87,306	4,108	22,326	3,285	17,862
Ukwa East	-	-	-	-	-
Ukwa West	-	-	-	-	-
Ukwuani	-	-	-	-	-
Umu Nneochi	-	-	-	-	-
Umuahia North	-	-	-	-	-
Umuahia South	-	-	-	-	-
Ungogo	4,924	103	614	82	492
Uruan	37,704	2,359	2,606	1,887	2,085
Urue-Offong/Oruko	530	-	-	-	-
Ushongo	84,548	5,662	5,810	4,530	4,648
Ussa	-	-	-	-	-
Uvwie	4,091	89	306	71	245
Uyo	72,623	3,481	8,736	2,785	6,989
Uzo Uwani	1,699	-	-	-	-
Vandeikya	54,395	2,576	14,987	2,061	11,989
Wamako	6,909	435	2,228	348	1,782
Wamba	15,705	164	658	131	526
Warawa	-	-	-	-	-
Warji	-	-	-	-	-
Warri North	3,540	125	436	100	349
Warri South	-	-	-	-	-
Warri South-West	-	-	-	-	-
Wase	2,296	-	-	-	-
Wudil	-	-	-	-	-
Wukari	-	-	-	-	-
Wushishi	1,775	76	365	61	292
Yabo	-	-	-	-	-
Yagba East	-	-	-	-	-
Yagba West	-	-	-	-	-
Yakuur	16,107	330	1,820	264	1,456
Yala	940	2	6	1	5
Yamaltu/Deba	15,901	227	1,236	182	991
Yankwashi	1,821	-	-	-	-
Yauri	4,146	165	887	132	710
Yenagoa	20,703	626	3,005	501	2,404
Yewa North	1,245	-	-	-	-
Yewa South	3,829	121	354	96	283
Yola North	13,363	1,312	7,267	1,050	5,813
Yola South	12,853	798	4,362	638	3,489
Yorro	-	-	-	-	-
Zaki	3,557	-	-	-	-
Zango-Kataf	16,537	419	1,946	336	1,556
Zaria	21,472	1,218	6,855	975	5,484
Zing	-	-	-	-	-
Zurmi	-	-	-	-	-
Zuru	-	-	-	-	-
Other_ Nigeria	140,742	11,095	34,388	8,876	27,511
Total	9,647,779	341,113	902,762	273,017	722,220

Nigeria COP15 Targets by LGA: Key, Priority, Orphan and Vulnerable Children Indicators

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Ikot Abasi Eduo Health Post	-	-	-
Aba North	-	-	-
Aba South	-	-	-
Abaji	-	-	-
Abak	-	-	-
Abakaliki	-	-	6,660
Abakaliki	-	-	3,745
Abeokuta North	-	-	-
Abeokuta South	-	-	703
Abi	-	-	-
Aboh Mbaise	-	-	-
Abua/Odual	-	-	-
Abuja Municipal Area Council	-	14,730	32,058
Adavi	-	-	-
Ado	-	-	2,750
Ado-Ekiti	-	-	-
Ado-Odo/Ota	-	-	-
Afijio	-	-	246
Afikpo North	-	-	-
Afikpo North	-	-	-
Afikpo South	-	-	-
Agaie	-	-	-
Agatu	-	-	-
Agege	-	2,256	10,035
Aguata	-	-	-
Agwara	-	-	-
Ahiazu Mbaise	-	-	-
Ahoada East	-	196	-
Ahoada West	-	196	-
Aiyedade	-	-	-
Ajaokuta	-	-	95
Ajeromi-Ifelodun	-	1,500	10,035
Ajingi	-	-	-
Akankpa	-	1,474	-
Akinyele	-	-	816
Akko	-	-	-
Akoko Edo	-	-	1,912
Akoko North East	-	-	-
Akoko North West	-	-	-
Akoko South East	-	-	-
Akoko South West	-	-	-
Akpabuyo	-	321	-
Akuku Toru	-	130	-
Akure North	-	-	-
Akure South	-	-	-
Akwanga	-	-	8,010
Albasu	-	-	-
Aleiro	-	-	-
Alimosho	-	4,946	10,000
Alkaleri	-	-	3,027
Amuwo-Odofin	-	2,200	1,184
Anambra East	-	-	889
Anambra West	-	-	-
Anaocha	-	-	-
Andoni	-	-	-
Aninri	-	-	-
Aniocha North	-	-	-
Aniocha South	-	-	-
Ankpa	-	-	7,433
Apa	-	-	8
Apapa	-	4,511	10,035
Ardo-kola	-	-	-
Argungu	-	-	926
Arochuku	-	-	-
Asa	-	-	-
Asari-Toru	-	-	-
Askira/Uba	-	-	-
Atakunmosa West	-	-	-

Nigeria COP15 Targets by LGA: Key, Priority, Orphan and Vulnerable Children Indicators

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Atiba	-	-	-
Atisbo	-	-	-
Augie	-	-	-
Awe	-	-	-
Awgu	-	-	-
Awka North	-	-	888
Awka South	-	-	-
Ayamelum	-	-	888
Badagry	-	4,382	929
Bade	-	-	-
Bagudo	-	-	-
Bagwai	-	-	1,594
Bakassi	-	321	-
Bakura	-	-	-
Balanga	-	-	54
Bali	-	-	-
Bama	-	-	-
Barkin Ladi	-	-	2,200
Bassa	-	-	2,960
Bassa	-	-	3,585
Batsari	-	-	-
Bauchi	-	-	19,174
Baure	-	-	-
Bayo	-	-	-
Bebeji	-	-	-
Bekwarra	-	-	-
Bende	-	-	-
Biase	-	-	-
Bichi	-	-	163
Bida	-	-	27
Billiri	-	-	127
Binji	-	-	1,000
Birnin Gwari	-	142	1,488
Birnin Kebbi	-	-	-
Birnin Kudu	-	-	-
Birnin Magaji	-	-	-
Biu	-	-	-
Bogoro	-	-	-
Boki	-	-	-
Bokkos	-	-	1,457
Boluwaduro	-	-	-
Bomadi	-	-	-
Bonny	-	130	-
Bosso	-	-	298
Brass	-	-	-
Buji	-	-	-
Bunkure	-	-	-
Bunza	-	-	925
Buruku	-	-	14,349
Burutu	-	-	-
Bussa/ New	-	-	31
Bwari	-	11,883	19,843
Calabar Municipal	-	5,056	11,150
Calabar South	-	3,256	11,151
Chanchaga	-	-	1,854
Chibok	-	-	-
Chikun	-	886	1,373
Dala	-	-	159
Damagum	-	-	-
Damaturu	-	-	2,662
Damban	-	-	-
Dambatta	-	-	159
Dan Musa	-	-	-
Dange-shnsi	-	-	3,864
Darazo	-	-	-
Dass	-	-	-
Daura	-	-	-
Dawakin Kudu	-	-	-
Dawakin Tofa	-	-	-
Degema	-	-	-

Nigeria COP15 Targets by LGA: Key, Priority, Orphan and Vulnerable Children Indicators

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Dekina	-	-	5,911
Demsa	-	-	-
Dogwuwa	-	-	-
Doma	-	-	11,135
Donga	-	-	-
Dukku	-	-	23
Dunukofia	-	-	3,999
Dutse	-	-	4,632
Eastern Obolo	-	-	-
Ebonyi	-	-	-
Ebonyi	-	-	-
Edati	-	-	-
Ede North	-	-	-
Ede South	-	-	-
Edu	-	-	3,538
Efon	-	-	-
Egbeda	-	-	259
Egbedore	-	-	-
Egor	-	-	-
Ehime Mbano	-	-	1,477
Ejigbo	-	-	-
Ekeremor	-	-	-
Eket	-	262	-
Ekiti East	-	-	-
Ekiti South-West	-	-	-
Ekiti West	-	-	-
Ekwusigo	-	-	-
Eleme	-	584	11,328
Emohua	-	391	1,643
Emure	-	-	-
Enugu East	-	-	5,159
Enugu East	-	-	-
Enugu North	-	-	4,600
Enugu South	-	-	-
Enugu South	-	-	-
Enugu West	-	-	-
Epe	-	2,191	4,649
Esan Central	-	-	-
Esan North-East	-	-	3,579
Esan South-East	-	-	1,830
Esan West	-	-	-
Ese-Odo	-	-	-
Esit Eket	-	-	-
Essien Udim	-	54	-
Etche	-	-	-
Ethiophe East	-	-	-
Ethiophe West	-	-	-
Eti-Osa	-	3,671	1,618
Etim Ekpo	-	-	-
Etinan	-	97	-
Etsako Central	-	-	-
Etsako East	-	-	-
Etsako West	-	-	5,312
Etung	-	-	-
Ezeagu	-	-	-
Ezinihitte	-	-	-
Ezinihitte	-	-	-
Ezza North	-	-	-
Ezza South	-	-	-
Fagge	-	-	2,392
Fika	-	-	-
Fufore	-	-	-
Funakaye	-	-	698
Fune	-	-	-
Funtua	-	-	-
Gamawa	-	-	-
Garjuwa	-	-	3,028
Garko	-	-	-
Garum Mallam	-	-	-
Gashaka	-	-	-

Nigeria COP15 Targets by LGA: Key, Priority, Orphan and Vulnerable Children Indicators

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Gassol	-	-	-
Gaya	-	-	-
Gbako	-	-	-
Gboko	-	5,819	18,778
Gbonyin	-	-	-
Gezawa	-	-	-
Giade	-	-	-
Girei	-	-	-
Giwa	-	-	3,563
Gokana	-	130	-
Gombe	-	-	14,211
Gombi	-	-	-
Goronyo	-	-	961
Gujba	-	-	-
Guma	-	946	-
Gurara	-	-	222
Gusau	-	-	193
Guyuk	-	-	-
Guzamala	-	-	-
Gwagwalada	-	12,932	4,799
Gwale	-	-	-
Gwaram	-	-	-
Gwarzo	-	-	159
Gwer East	-	1,568	3,983
Gwer West	-	1,420	14,664
Gwiwa	-	-	-
Gwoza	-	-	-
Hadejia	-	-	-
Hawul	-	-	-
Hong	-	-	-
Ibadan North	-	-	11
Ibadan North-East	-	-	744
Ibadan North-West	-	-	-
Ibadan South-East	-	-	-
Ibadan South-West	-	-	4,500
Ibaji	-	-	-
Ibarapa Central	-	-	-
Ibarapa East	-	-	442
Ibarapa North	-	-	-
Ibeju/Lekki	-	273	1,846
Ibena	-	48	-
Ibesikpo Asutan	-	40	-
Ibi	-	-	-
Ibiono Ibom	-	-	-
Idah	-	-	259
Idanre	-	-	-
Ideato North	-	-	-
Ideato South	-	-	-
Idemili North	-	-	-
Idemili South	-	-	-
Ido	-	-	206
Ido-Osi	-	-	-
Ifako-Ijaiye	-	4,495	8,500
Ife Central	-	-	-
Ife East	-	-	-
Ife North	-	-	-
Ife South	-	-	-
Ifedore	-	-	-
Ifelodun	-	-	-
Ifo	-	-	-
Igabi	-	1,012	22
Igalamela-Odolu	-	-	2,966
Igbo Etti	-	-	-
Igbo Eze North	-	-	-
Igbo Eze South	-	-	-
Igueben	-	-	-
Ihiala	-	-	-
Ihitte/Uboma	-	-	-
Ijebu North-East	-	-	-
Ijebu Ode	-	-	1,745

Nigeria COP15 Targets by LGA: Key, Priority, Orphan and Vulnerable Children Indicators

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Ijero	-	-	-
Ijumu	-	-	-
Ika	-	-	-
Ika North East	-	-	1,543
Ika South	-	-	-
Ikara	-	142	978
Ikeduru	-	-	-
Ikeja	-	10,225	15,500
Ikenne	-	-	-
Ikere	-	-	-
Ikere-Ekiti	-	-	-
Ikole	-	-	-
Ikom	-	1,486	-
Ikono	-	-	-
Ikorodu	-	547	73
Ikot Abasi	-	-	-
Ikot Ekpene	-	844	12,234
Ikpoba-Okha	-	-	5,752
Ikwerre	-	1,291	-
Ikwo	-	-	-
Ikwuano	-	-	-
Ila	-	-	-
Ilaje	-	-	-
Ile Oluji/Okeigbo	-	-	-
Ilejemeje	-	-	-
Ilesha East	-	-	-
Ilesha West	-	-	-
Illela	-	-	1,000
Ilorin East	-	-	1,306
Ilorin South	-	-	3,537
Ilorin West	-	-	1,451
Imeko/Afon	-	-	-
Ingawa	-	-	-
Ini	-	-	-
Ipokia	-	-	-
Irele	-	-	-
Irepo	-	-	-
Irepodun	-	-	-
Irepodun	-	-	1,739
Irepodun/Ifelodun	-	-	-
Irewole	-	-	-
Ise/Orun	-	-	-
Iseyin	-	-	-
Ishielu	-	-	-
Isiala Mbanu	-	-	-
Isiala-Ngwa North	-	-	-
Isiala-Ngwa South	-	-	-
Isiuzo	-	-	-
Isokan	-	-	-
Isoko North	-	-	-
Isoko South	-	-	-
Isu	-	-	-
Isuikwuato	-	-	-
Itesiwaju	-	-	-
Itu	-	195	-
Ivo	-	-	11,200
Iwajowa	-	-	-
Iwo	-	-	-
Izzi	-	-	-
Jaba	-	-	1,001
Jada	-	-	-
Jahun	-	-	-
Jalingo	-	-	-
Jama'are	-	-	-
Jega	-	-	-
Jema'a	-	142	1,977
Jere	-	-	-
Jibia	-	-	-
Jos East	-	-	849
Jos North	-	-	2,540

Nigeria COP15 Targets by LGA: Key, Priority, Orphan and Vulnerable Children Indicators

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Jos South	-	-	1,280
Kabba/Bunu	-	-	4,036
Kabo	-	-	-
Kachia	-	-	1,378
Kaduna North	-	710	3,048
Kaduna South	-	1,144	4,638
Kafin Hausa	-	-	-
Kaga	-	-	-
Kagarko	-	85	13
Kajola	-	-	-
Kajuru	-	-	-
Kaltungo	-	-	1,356
Kanam	-	-	1,184
Kankara	-	-	-
Kanke	-	-	749
Kankia	-	-	2,670
Kano Municipal	-	-	159
Karaye	-	-	-
Karin-Lamido	-	-	-
Karu	-	5,046	11,450
Katagum	-	-	3,028
Katcha	-	-	-
Katsina	-	-	3,886
Katsina-Ala	-	-	24,349
Kaura	-	-	613
Kaura Namoda	-	-	-
Kauru	-	85	-
Kazaure	-	-	-
Keana	-	-	1,402
Keffi	-	13,760	1,069
Khana	-	-	-
Kirfi	-	-	-
Kiru	-	-	159
Kiyawa	-	-	-
Kogi	-	-	-
Koko/Besse	-	-	-
Kokona	-	2,957	-
Kolokuma/Opokuma	-	-	-
Konshisha	-	-	14,778
Kontagora	-	-	260
Kosofe	-	5,112	929
Kubau	-	57	-
Kudan	-	-	298
Kuje	-	3,636	967
Kumbotso	-	-	3,277
Kunchi	-	-	-
Kura	-	-	-
Kurfi	-	-	-
Kurmi	-	-	-
Kwali	-	-	894
Kwami	-	-	-
Kwande	-	-	7,560
Lafia	-	10,177	30,537
Lagelu	-	-	1,383
Lagos Island	-	4,667	-
Lagos Mainland	-	7,255	4,463
Langtang North	-	-	643
Langtang South	-	-	1,035
Lapai	-	-	269
Lavun	-	-	-
Lere	-	142	2,278
Logo	-	-	14,720
Lokoja	-	-	5,421
Madagali	-	-	-
Mafa	-	-	-
Magama	-	-	-
Mai'Adua	-	-	-
Maiduguri	-	-	700
Maiyama	-	-	-
Makarfi	-	57	-

Nigeria COP15 Targets by LGA: Key, Priority, Orphan and Vulnerable Children Indicators

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Makoda	-	-	-
Makurdi	-	2,604	21,087
Malumfashi	-	-	-
Mangu	-	-	1,035
Mani	-	-	-
Maradun	-	-	325
Mariga	-	-	367
Mashegu	-	-	-
Mayo-Belwa	-	-	-
Mbaitoli	-	-	-
Mbo	-	80	-
Michika	-	-	-
Mikang	-	-	309
Minjibir	-	-	-
Misau	-	-	3,027
Mkpat Enin	-	25	-
Moba	-	-	-
Mobbar	-	-	-
Mokwa	-	-	50
Mopa-Muro	-	-	-
Mubi South	-	-	-
Musawa	-	-	-
Mushin	-	4,689	6,970
Muya	-	-	-
Nafada/Bajoga	-	-	-
Nasarawa	-	-	12,765
Nasarawa Eggon	-	2,324	4,807
Nassarawa	-	-	3,324
Ndokwa East	-	-	-
Ndokwa West	-	-	-
Nembe	-	-	-
Ngala	-	-	-
Ngaski	-	-	-
Ngor Okpala	-	-	740
Ngor Okpala	-	-	-
Nguru	-	-	-
Ningi	-	-	3,028
Njaba	-	-	-
Njikoka	-	-	-
Nkanu East	-	-	-
Nkanu West	-	-	-
Nkwere	-	-	-
Nnewi North	-	-	-
Nnewi South	-	-	-
Nsit Atai	-	-	-
Nsit Ibom	-	161	-
Nsit Ubium	-	80	-
Nsukka	-	-	-
Nsukka	-	-	1,534
Nwangele	-	-	-
Obanliku	-	-	-
Obi	-	-	-
Obi	-	-	18,771
Obingwa	-	-	-
Obio/Akpor	-	893	13,356
Obokun	-	-	-
Obot Akara	-	-	-
Obowo	-	-	-
Obubra	-	-	-
Obudu	-	321	-
Odeda	-	-	-
Odigbo	-	-	-
Odo-Otin	-	-	-
Odogbolu	-	-	-
Odukpani	-	1,283	-
Offa	-	-	714
Ofu	-	-	19
Ogba/Egbema/Ndoni	-	587	-
Ogbadibo	-	-	-
Ogbaru	-	-	-

Nigeria COP15 Targets by LGA: Key, Priority, Orphan and Vulnerable Children Indicators

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Ogbia	-	-	-
Ogbomoso North	-	-	184
Ogbomoso South	-	-	197
Ogo Oluwa	-	-	1,975
Ogoja	-	1,320	-
Ogori/Magongo	-	-	-
Ogu/Bolo	-	-	-
Ogun Waterside	-	-	-
Oguta	-	-	1,870
Ohafia	-	-	-
Ohaji/Egbema	-	-	740
Ohaozara	-	-	-
Ohaukwu	-	-	-
Ohimini	-	-	-
Oji River	-	-	-
Ojo	-	5,091	929
Oju	-	-	4,200
Okehi	-	-	38
Okene	-	-	5,099
Okigwe	-	-	1,070
Okitipupa	-	-	-
Okobo	-	-	11,150
Okpe	-	-	-
Okpoku	-	-	10,540
Okrika	-	32	-
Ola-Oluwa	-	-	-
Olamaboro	-	-	6,238
Olorunda	-	-	-
Olorunsogo	-	-	-
Oluyole	-	-	834
Omala	-	-	67
Omumma	-	-	-
Ona Ara	-	-	452
Ondo East	-	-	-
Ondo West	-	-	-
Onicha	-	-	-
Onitsha North	-	-	-
Onitsha South	-	-	-
Onna	-	-	-
Onuimo	-	-	-
Opobo/Nkoro	-	-	-
Oredo	-	-	5,850
Orelope	-	-	-
Orhionmwon	-	-	1,887
Ori Ire	-	-	771
Oriu	-	-	-
Orolu	-	-	-
Oron	-	1,157	11,150
Orsu	-	-	-
Oru East	-	-	-
Oru West	-	-	-
Oruk Anam	-	-	-
Orumba North	-	-	-
Orumba South	-	-	-
Ose	-	-	-
Oshimili North	-	-	1,800
Oshimili South	-	-	-
Oshodi-Isolo	-	3,746	2,098
Osisoma	-	-	-
Osoybo	-	-	1,758
Otukpo	-	3,701	18,596
Ovia South-West	-	-	-
Owan East	-	-	1,872
Owan West	-	-	-
Owerri Municipal	-	-	-
Owerri Municipal	-	-	-
Owerri North	-	-	-
Owerri North	-	-	-
Owerri West	-	-	740
Owo	-	-	-

Nigeria COP15 Targets by LGA: Key, Priority, Orphan and Vulnerable Children Indicators

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Oye	-	-	-
Oyi	-	-	-
Oyigbo	-	-	-
Oyo East	-	-	-
Oyo West	-	-	-
Paikoro	-	-	875
Pankshin	-	-	981
Patani	-	-	-
Patigi	-	-	-
Port-Harcourt	-	2,093	22,908
Potiskum	-	-	-
Qua'an Pan	-	-	1,605
Rafi	-	-	35
Rano	-	-	159
Remo North	-	-	-
Rijau	-	-	16
Rimin Gado	-	-	-
Ringim	-	-	-
Riyom	-	-	1,035
Rogo	-	-	-
Roni	-	-	-
Sabo Birni	-	-	950
Sabon Gari	-	154	-
Sagamu	-	-	-
Sagbama	-	-	-
Saki East	-	-	-
Saki West	-	-	-
Sanga	-	-	659
Sapele	-	-	-
Sardauna	-	-	-
Shani	-	-	-
Shanono	-	-	-
Shelleng	-	-	-
Shendam	-	-	4,024
Shinkafi	-	-	-
Shira	-	-	-
Shiroro	-	-	729
Shomolu	-	3,156	-
Shongom	-	-	-
Silame	-	-	950
Soba	-	142	17
Sokoto North	-	-	-
Sokoto South	-	-	-
Song	-	-	-
Southern Ijaw	-	-	-
Suleja	-	-	-
Sumaila	-	-	-
Surulere	-	-	286
Surulere	-	4,511	10,035
Tafa	-	-	-
Tafawa-Balewa	-	-	3,027
Tai	-	130	-
Takai	-	-	-
Takum	-	-	-
Tambuwal	-	-	1,000
Tarauni	-	-	2,327
Tarka	-	947	13,054
Taura	-	-	-
Toro	-	-	3,028
Toto	-	-	1,700
Toungo	-	-	-
Tsafe	-	-	-
Tsanyawa	-	-	-
Tudun Wada	-	-	-
Tureta	-	-	1,000
Udenu	-	-	-
Udi	-	-	333
Udu	-	-	-
Udung Uko	-	-	-
Ughelli North	-	-	-

Nigeria COP15 Targets by LGA: Key, Priority, Orphan and Vulnerable Children Indicators

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Ughelli South	-	-	-
Ugwunagbo	-	-	-
Uhunmwonde	-	-	-
Ukanafun	-	-	-
Ukum	-	-	6,190
Ukwa East	-	-	-
Ukwa West	-	-	-
Ukwuani	-	-	-
Umu Nneochi	-	-	-
Umuahia North	-	-	-
Umuahia South	-	-	-
Ungogo	-	-	-
Uruan	-	-	11,150
Urue-Offong/Oruko	-	-	-
Ushongo	-	-	14,447
Ussa	-	-	-
Uvwie	-	-	948
Uyo	-	439	28,130
Uzo Uwani	-	-	-
Vandeikya	-	-	8,045
Wamako	-	-	-
Wamba	-	-	926
Warawa	-	-	-
Warji	-	-	-
Warri North	-	-	-
Warri South	-	-	-
Warri South-West	-	-	-
Wase	-	-	1,035
Wudil	-	-	159
Wukari	-	-	-
Wushishi	-	-	-
Yabo	-	-	2,378
Yagba East	-	-	2,926
Yagba West	-	-	-
Yakuur	-	1,469	5,577
Yala	-	45	-
Yamaltu/Deba	-	-	-
Yankwashi	-	-	-
Yauri	-	-	-
Yenagoa	-	-	6,837
Yewa North	-	-	818
Yewa South	-	-	-
Yola North	-	-	7,020
Yola South	-	-	-
Yorro	-	-	-
Zaki	-	-	-
Zango-Kataf	-	-	1,570
Zaria	-	687	1,038
Zing	-	-	-
Zurmi	-	-	-
Zuru	-	-	925
Other_ Nigeria	-	6,667	-
Total	-	212,745	949,257

Nigeria COP15 Targets by LGA: Breastfeeding and Pregnant Women

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Ikot Abasi Eduo Health Post	-	-
Aba North	-	-
Aba South	-	-
Abaji	1,281	18
Abak	1,429	30
Abakaliki	677	19
Abakaliki	60	-
Abeokuta North	2,786	8
Abeokuta South	3,131	84
Abi	1,313	8
Aboh Mbaise	1,962	55
Abua/Odual	4,252	51
Abuja Municipal Area Council	41,575	2,461
Adavi	2,910	64
Ado	1,119	26
Ado-Ekiti	5,415	81
Ado-Odo/Ota	7,268	66
Afijio	1,658	25
Afikpo North	540	8
Afikpo North	1,275	20
Afikpo South	1,943	20
Agale	-	-
Agatu	413	8
Agege	24,848	197
Aguata	4,446	56
Agwara	864	15
Ahiazu Mbaise	2,262	13
Ahoada East	2,455	118
Ahoada West	3,722	145
Aiyedade	-	-
Ajaokuta	1,573	23
Ajeromi-Ifeلودun	48,610	923
Ajingi	2,595	7
Akamkpa	2,000	48
Akinyele	2,709	18
Akko	2,659	12
Akoko Edo	2,397	42
Akoko North East	3,943	102
Akoko North West	-	-
Akoko South East	-	-
Akoko South West	255	8
Akpabuyo	3,663	49
Akuku Toru	-	-
Akure North	51	1
Akure South	768	24
Akwanga	1,449	92
Albasu	2,468	56
Aleiro	1,165	3
Alimosho	12,025	147
Alkaleri	-	-
Amuwo-Odofin	500	2
Anambra East	381	17
Anambra West	1,989	39
Anaocha	3,976	76
Andoni	899	14
Aninri	1,818	61
Aniocha North	-	-
Aniocha South	-	-
Ankpa	3,788	97
Apa	1,309	6
Apapa	9,617	105
Ardo-kola	-	-
Argungu	3,651	36
Arochukwu	-	-
Asa	1,853	7
Asari-Toru	2,384	119
Askira/Uba	671	363

Nigeria COP15 Targets by LGA: Breastfeeding and Pregnant Women

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Atakunmosa West	1,134	12
Atiba	2,489	14
Atisbo	1,407	15
Augie	2,237	4
Awe	821	83
Awgu	2,547	44
Awka North	1,381	36
Awka South	2,232	27
Ayamelum	2,178	66
Badagry	2,368	29
Bade	-	-
Bagudo	4,555	33
Bagwai	-	-
Bakassi	1,074	51
Bakura	-	-
Balanga	2,899	17
Bali	-	-
Bama	1,473	31
Barkin Ladi	2,263	22
Bassa	2,051	22
Bassa	-	-
Batsari	-	-
Bauchi	9,122	103
Baure	-	-
Bayo	-	-
Bebeji	-	-
Bekwarra	1,239	4
Bende	-	-
Biase	2,001	23
Bichi	-	-
Bida	2,389	32
Billiri	3,656	109
Birji	-	-
Birnin Gwari	4,977	246
Birnin Kebbi	4,900	61
Birnin Kudu	2,215	14
Birnin Magaji	-	-
Biu	1,240	8
Bogoro	1,587	30
Boki	1,318	20
Bokkos	663	17
Boluwaduro	-	-
Bomadi	-	-
Bonny	3,116	198
Bosso	2,080	17
Brass	873	22
Buji	1,870	3
Bunkure	3,337	23
Bunza	-	-
Buruku	6,629	565
Burutu	-	-
Bussa/ New	2,550	52
Bwari	9,270	529
Calabar Municipal	5,539	178
Calabar South	5,499	315
Chanchaga	5,014	156
Chibok	4,407	104
Chikun	6,707	312
Dala	-	-
Damagum	-	-
Damaturu	-	-
Damban	-	-
Dambatta	714	2
Dan Musa	-	-
Dange-shnsi	3,573	10
Darazo	-	-
Dass	-	-
Daura	-	-
Dawakin Kudu	471	1
Dawakin Tofa	-	-

Nigeria COP15 Targets by LGA: Breastfeeding and Pregnant Women

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Degema	770	44
Dekina	3,233	123
Demsa	3,342	82
Dogua	221	1
Doma	5,212	551
Donga	-	-
Dukku	3,501	83
Dunukofia	1,349	59
Dutse	2,982	36
Eastern Obolo	604	24
Ebonyi	1,126	13
Ebonyi	1,744	23
Edati	-	-
Ede North	1,818	11
Ede South	1,054	14
Edu	-	-
Efon	-	-
Egbeda	3,627	50
Egbedore	-	-
Egor	3,933	239
Ehime Mbano	1,717	42
Ejigbo	-	-
Ekeremor	3,372	8
Eket	1,375	64
Ekiti East	3,932	47
Ekiti South-West	2,063	-
Ekiti West	-	-
Ekwusigo	681	3
Eleme	7,121	315
Emohua	2,657	104
Emure	-	-
Enugu East	3,910	54
Enugu East	-	-
Enugu North	3,436	111
Enugu South	418	4
Enugu South	1,207	31
Enugu West	-	-
Epe	3,468	5
Esan Central	1,695	104
Esan North-East	1,315	14
Esan South-East	2,222	26
Esan West	1,582	36
Ese-Odo	-	-
Esit Eket	835	56
Essien Udim	1,490	58
Etche	748	15
Ethiophe East	4,752	68
Ethiophe West	-	-
Eti-Osa	713	12
Etim Ekpo	1,501	33
Etinan	2,386	67
Etsako Central	-	-
Etsako East	1,167	28
Etsako West	2,553	104
Etung	885	5
Ezeagu	1,924	22
Ezinihitte	1,923	11
Ezinihitte	226	1
Ezza North	1,565	23
Ezza South	2,110	35
Fagge	2,288	12
Fika	5,823	20
Fufore	3,879	63
Funakaye	4,589	56
Fune	-	2
Funtua	4,017	50
Gamawa	-	-
Ganjuwa	4,857	34
Garko	2,366	4
Garum Mallam	2,015	6

Nigeria COP15 Targets by LGA: Breastfeeding and Pregnant Women

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Gashaka	-	-
Gassol	-	-
Gaya	-	-
Gbako	1,891	4
Gboko	3,886	463
Gbonyin	1,407	26
Gezawa	1,107	14
Giade	2,939	5
Girei	2,418	14
Giwa	4,971	131
Gokana	2,258	195
Gombe	4,414	81
Gombi	2,783	40
Goronyo	-	-
Gujba	1,987	24
Guma	2,737	245
Gurara	1,381	72
Gusau	4,591	34
Guyuk	-	-
Guzamala	-	-
Gwagwalada	2,965	80
Gwale	-	-
Gwaram	5,206	11
Gwarzo	-	-
Gwer East	4,557	243
Gwer West	3,602	360
Gwiwa	2,476	8
Gwoza	-	-
Hadejia	1,810	10
Hawul	-	-
Hong	3,151	20
Ibadan North	5,023	94
Ibadan North-East	3,856	37
Ibadan North-West	5,284	69
Ibadan South-East	2,018	26
Ibadan South-West	1,978	6
Ibaji	1,906	44
Ibarapa Central	882	7
Ibarapa East	-	-
Ibarapa North	-	-
Ibeju/Lekki	6,211	318
Ibendo	490	11
Ibesikpo Asutan	1,960	51
Ibi	-	-
Ibiono Ibom	880	18
Idah	1,050	53
Idanre	-	-
Ideato North	196	6
Ideato South	1,863	48
Idemili North	2,880	37
Idemili South	2,816	121
Ido	1,318	10
Ido-Osi	2,391	78
Ifako-Ijaiye	11,772	243
Ife Central	2,322	43
Ife East	2,140	65
Ife North	330	3
Ife South	-	-
Ifedore	-	-
Ifelodun	-	-
Ifo	5,558	138
Igabi	5,702	25
Igalamela-Odolu	1,514	6
Igbo Etiti	2,564	29
Igbo Eze North	3,441	145
Igbo Eze South	1,895	48
Igueben	976	21
Ihiala	4,196	62
Ihitte/Uboma	1,669	31
Ijebu North-East	3,741	106

Nigeria COP15 Targets by LGA: Breastfeeding and Pregnant Women

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Ijebu Ode	2,407	93
Ijero	162	5
Ijumu	-	-
Ika	1,046	76
Ika North East	-	-
Ika South	3,670	135
Ikara	-	-
Ikeduru	1,980	27
Ikeja	19,601	234
Ikenne	-	-
Ikere	770	26
Ikere-Ekiti	-	-
Ikole	950	6
Ikom	1,995	41
Ikono	751	39
Ikorodu	1,403	7
Ikot Abasi	1,329	161
Ikot Ekpene	4,424	303
Ikpoba-Okha	-	-
Ikwerre	1,514	45
Ikwo	565	16
Ikwuano	-	-
Ila	239	6
Ilaje	-	-
Ile Oluji/Okeigbo	2,412	332
Ilejemeje	645	27
Ilesha East	1,298	17
Ilesha West	-	-
Illela	-	-
Ilorin East	3,344	64
Ilorin South	4,106	42
Ilorin West	3,364	27
Imeko/Afon	-	-
Ingawa	-	-
Ini	1,419	14
Ipokia	397	6
Irele	-	-
Irepo	625	4
Irepodun	-	-
Irepodun	-	-
Irepodun/Ifelodun	1,905	31
Irewole	95	2
Ise/Orun	1,552	23
Iseyin	2,869	28
Ishielu	1,300	22
Isiala Mbano	2,310	13
Isiala-Ngwa North	-	-
Isiala-Ngwa South	-	-
Isiuzo	1,960	31
Isokan	1,276	44
Isoko North	-	-
Isoko South	-	-
Isu	2,069	42
Isuikwuato	-	-
Itesiwaju	1,917	24
Itu	1,768	76
Ivo	1,026	27
Iwajowa	1,422	4
Iwo	1,996	52
Izzi	2,282	18
Jaba	2,832	122
Jada	3,095	58
Jahun	4,302	19
Jalingo	-	-
Jama'are	-	-
Jega	3,529	11
Jema'a	5,299	187
Jere	1,684	136
Jibia	-	-
Jos East	279	1

Nigeria COP15 Targets by LGA: Breastfeeding and Pregnant Women

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Jos North	7,238	260
Jos South	3,120	85
Kabba/Bunu	2,105	50
Kabo	2,927	3
Kachia	4,200	72
Kaduna North	6,350	178
Kaduna South	6,538	234
Kafin Hausa	3,856	6
Kaga	1,127	1,522
Kagarko	1,978	34
Kajola	665	7
Kajuru	1,805	23
Kaitungo	2,879	61
Kanam	2,384	73
Kankara	-	-
Kanke	1,104	26
Kankia	2,783	300
Kano Municipal	9,611	347
Karaye	-	-
Karin-Lamido	-	-
Karu	7,895	985
Katagum	4,710	83
Katcha	1,824	6
Katsina	5,582	362
Katsina-Ala	8,020	1,623
Kaura	1,515	79
Kaura Namoda	510	2
Kauru	1,640	192
Kazaure	2,937	21
Keana	1,226	47
Keffi	904	43
Khana	4,383	284
Kirfi	2,743	8
Kiru	-	-
Kiyawa	3,323	7
Kogi	1,161	35
Koko/Besse	2,921	6
Kokona	1,408	60
Kolokuma/Opokuma	713	9
Konshisha	7,021	477
Kontagora	2,039	58
Kosofe	2,862	39
Kubau	5,002	11
Kudan	231	1
Kuje	1,031	51
Kumbotso	-	-
Kunchi	-	-
Kura	1,079	3
Kurfi	-	-
Kurmi	-	-
Kwali	680	9
Kwami	1,116	2
Kwande	4,344	263
Lafia	11,406	877
Lagelu	1,973	34
Lagos Island	2,196	30
Lagos Mainland	4,450	155
Langtang North	1,825	40
Langtang South	1,499	30
Lapai	1,778	33
Lavun	-	-
Lere	6,578	62
Logo	6,672	873
Lokoja	2,828	111
Madagali	2,515	38
Mafa	2,624	1,684
Magama	931	4
Mai'Adua	-	-
Maiduguri	2,171	39
Maiyama	-	-

Nigeria COP15 Targets by LGA: Breastfeeding and Pregnant Women

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Makarfi	2,400	19
Makoda	3,363	6
Makurdi	3,328	307
Malumfashi	-	-
Mangu	4,326	118
Mani	-	-
Maradun	-	-
Mariga	3,013	24
Mashegu	-	-
Mayo-Belwa	978	16
Mbaitoli	525	9
Mbo	661	43
Michika	2,870	46
Mikang	1,206	37
Minjibir	-	-
Misau	5,000	34
Mkpat Enin	1,305	85
Moba	193	-
Mobbar	1,872	117
Mokwa	3,557	95
Mopa-Muro	-	-
Mubi South	2,415	42
Musawa	-	-
Mushin	23,731	1,248
Muya	1,561	23
Nafada/Bajoga	552	3
Nasarawa	3,967	632
Nasarawa Eggon	2,015	63
Nassarawa	7,793	219
Ndokwa East	-	-
Ndokwa West	-	-
Nembe	489	8
Ngala	-	-
Ngaski	433	3
Ngor Okpala	59	5
Ngor Okpala	495	15
Nguru	4,169	220
Ningi	7,276	58
Njaba	1,843	30
Njikoka	1,885	46
Nkanu East	2,062	31
Nkanu West	1,954	108
Nkwerre	1,096	35
Nnewi North	1,778	46
Nnewi South	523	12
Nsit Atai	1,057	120
Nsit Ibom	1,438	83
Nsit Ubium	1,836	26
Nsukka	1,038	1
Nsukka	1,940	62
Nwangele	570	9
Obanliku	1,166	8
Obi	2,581	141
Obi	10,669	1,500
Obingwa	-	-
Obio/Akpor	16,808	573
Obokun	-	-
Obot Akara	442	2
Obowo	516	11
Obubra	1,786	20
Obudu	1,305	33
Odeda	1,730	8
Odigbo	3,944	289
Odo-Otin	1,111	17
Odogbolu	-	-
Odukpani	2,165	58
Offa	857	20
Ofu	2,695	204
Ogba/Egbema/Ndoni	2,863	115
Ogbadibo	1,318	64

Nigeria COP15 Targets by LGA: Breastfeeding and Pregnant Women

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Ogbaru	2,969	76
Ogbia	1,141	26
Ogbomoso North	2,120	20
Ogbomoso South	1,094	10
Ogo Oluwa	983	8
Ogoja	2,145	90
Ogori/Magongo	-	-
Ogu/Bolo	1,043	38
Ogun Waterside	-	-
Oguta	1,872	52
Ohafia	-	-
Ohaji/Egbema	1,929	39
Ohazara	492	7
Ohaukwu	2,064	20
Ohimini	386	15
Oji River	1,242	28
Ojo	2,974	39
Oju	555	13
Okehi	2,989	44
Okene	3,282	73
Okigwe	1,862	17
Okitipupa	-	-
Okobo	3,736	363
Okpe	-	-
Okpokwu	2,479	141
Okrika	2,847	227
Ola-Oluwa	479	12
Olamaboro	2,372	73
Olorunda	1,887	135
Olorunsogo	184	1
Oluyole	2,929	15
Omala	1,610	91
Omumma	-	-
Ona Ara	3,449	46
Ondo East	-	-
Ondo West	3,566	343
Onicha	2,879	34
Onitsha North	1,577	22
Onitsha South	1,554	38
Onna	796	37
Onuimo	1,307	10
Opobo/Nkoro	-	-
Oredo	2,765	31
Orelope	1,316	7
Orhionmwon	354	11
Ori Ire	2,252	12
Orlu	1,968	67
Orolo	-	-
Oron	2,618	221
Orsu	1,588	27
Oru East	1,516	61
Oru West	1,557	28
Oruk Anam	1,109	36
Orumba North	2,086	14
Orumba South	2,038	18
Ose	2,248	33
Oshimili North	-	-
Oshimili South	7,552	306
Oshodi-Isolo	7,717	96
Osioma	-	-
Osogbo	-	-
Otukpo	2,332	103
Ovia South-West	953	28
Owan East	2,072	17
Owan West	1,377	18
Owerri Municipal	2,387	55
Owerri Municipal	96	2
Owerri North	1,187	28
Owerri North	203	5
Owerri West	1,786	39

Nigeria COP15 Targets by LGA: Breastfeeding and Pregnant Women

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Owo	3,004	77
Oye	2,060	39
Oyi	2,325	56
Oyigbo	1,894	67
Oyo East	1,603	14
Oyo West	1,720	6
Paikoro	-	-
Pankshin	2,691	167
Patani	-	-
Patigi	6,665	88
Port-Harcourt	16,379	705
Potiskum	7,289	82
Qu'a'an Pan	2,830	46
Rafi	2,808	19
Rano	746	2
Remo North	-	-
Rijau	2,652	21
Rimin Gado	-	-
Ringim	3,576	22
Riyom	-	-
Rogo	-	-
Roni	1,491	3
Sabo Birni	-	-
Sabon Gari	2,840	19
Sagamu	3,177	127
Sagbama	2,102	26
Saki East	1,484	16
Saki West	715	7
Sanga	2,896	138
Sapele	270	4
Sardauna	-	-
Shani	-	-
Shanono	2,656	7
Shelleng	2,764	24
Shendam	2,957	24
Shinkafi	-	-
Shira	4,404	5
Shiroro	3,557	38
Shomolu	5,645	15
Shongom	2,635	24
Silame	-	-
Soba	4,222	26
Sokoto North	-	-
Sokoto South	2,657	22
Song	3,634	59
Southern IJaw	2,550	32
Suleja	2,735	74
Sumaila	1,529	5
Surulere	1,970	19
Surulere	23,928	150
Tafa	1,293	50
Tafawa-Balewa	4,095	69
Tai	1,814	138
Takai	-	-
Takum	-	-
Tambuwal	-	-
Tarauni	238	19
Tarka	2,822	455
Taura	2,537	2
Toro	6,518	58
Toto	1,681	120
Toungo	-	-
Tsafe	5,177	18
Tsanyawa	-	-
Tudun Wada	4,366	18
Tureta	1,314	13
Udenu	1,278	79
Udi	3,203	63
Udu	-	-
Udung Uko	737	55

Nigeria COP15 Targets by LGA: Breastfeeding and Pregnant Women

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Ughelli North	-	-
Ughelli South	-	-
Ugwunagbo	-	-
Uhunmwonde	1,694	21
Ukanafun	466	11
Ukum	2,786	390
Ukwa East	-	-
Ukwa West	-	-
Ukwuani	-	-
Umu Nneochi	-	-
Umuahia North	-	-
Umuahia South	-	-
Ungogo	4,936	112
Uruan	4,223	290
Urue-Offong/Oruko	533	35
Ushongo	6,769	770
Ussa	-	-
Uvwie	2,528	41
Uyo	10,318	611
Uzo Uwani	1,714	30
Vandeikya	1,284	88
Wamako	3,282	70
Wamba	1,083	58
Warawa	-	-
Warji	-	-
Warri North	1,623	49
Warri South	-	-
Warri South-West	-	-
Wase	2,341	23
Wudil	-	-
Wukari	-	-
Wushishi	1,233	17
Yabo	2,208	9
Yagba East	-	-
Yagba West	-	-
Yakuur	2,272	26
Yala	884	7
Yamaltu/Deba	3,093	17
Yankwashi	1,825	1
Yauri	1,500	15
Yenagoa	4,623	126
Yewa North	1,249	21
Yewa South	718	23
Yola North	3,777	112
Yola South	3,842	78
Yorro	-	-
Zaki	3,579	20
Zango-Kataf	5,920	98
Zaria	9,288	87
Zing	-	-
Zurmi	5,717	22
Zuru	3,176	7
Other_ Nigeria	43,170	2,809
Total	1,549,797	51,878

Nigeria COP15 Targets by LGA: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Ikot Abasi Eduo Health Post	-	-
Aba North	-	-
Aba South	-	-
Abaji	112	18
Abak	33	5
Abakaliki	57	9
Abakaliki	-	-
Abeokuta North	-	-
Abeokuta South	167	27
Abi	-	-
Aboh Mbaise	69	11
Abua/Odual	59	9
Abuja Municipal Area Council	1,456	301
Adavi	-	-
Ado	-	-
Ado-Ekiti	188	31
Ado-Odo/Ota	-	-
Afijio	-	-
Afikpo North	11	2
Afikpo North	100	16
Afikpo South	-	-
Agaaie	-	-
Agatu	57	9
Agege	61	13
Aguata	150	24
Agwara	-	-
Ahiazu Mbaise	-	-
Ahoda East	169	27
Ahoda West	-	-
Aiyedade	-	-
Ajaokuta	154	25
Ajeromi-Ifeodun	626	130
Ajingi	130	21
Akamkpa	164	26
Akinyele	-	-
Akko	10	2
Akoko Edo	-	-
Akoko North East	236	38
Akoko North West	26	4
Akoko South East	32	5
Akoko South West	12	2
Akpabuyo	293	47
Akuku Toru	-	-
Akure North	-	-
Akure South	191	30
Akwanga	583	94
Albasu	-	-
Aleiro	-	-
Alimosho	932	193
Alkaleri	-	-
Amuwo-Odofin	470	76
Anambra East	-	-
Anambra West	-	-
Anaocha	143	23
Andoni	28	5
Aninri	-	-
Aniocha North	-	-
Aniocha South	-	-
Ankpa	93	15
Apa	-	-
Apapa	433	90
Ardo-kola	-	-
Argungu	145	23
Arochukwu	-	-
Asa	-	-
Asari-Toru	-	-
Askira/Uba	-	-
Atakunmosa West	-	-

Nigeria COP15 Targets by LGA: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Atiba	-	-
Atisbo	-	-
Augie	-	-
Awe	-	-
Awgu	121	20
Awka North	-	-
Awka South	87	14
Ayamelum	-	-
Badagry	266	43
Bade	-	-
Bagudo	-	-
Bagwai	-	-
Bakassi	10	2
Bakura	-	-
Balanga	149	24
Bali	-	-
Bama	143	23
Barkin Ladi	209	34
Bassa	213	34
Bassa	-	-
Batsari	25	4
Bauchi	343	56
Baure	-	-
Bayo	-	-
Bebeji	39	6
Bekwarra	114	19
Bende	-	-
Biase	183	29
Bichi	-	-
Bida	26	4
Billiri	184	30
Binji	-	-
Birin Gwari	44	7
Birin Kebbi	187	30
Birin Kudu	138	22
Birin Magaji	-	-
Biu	93	15
Bogoro	-	-
Boki	70	12
Bokkos	-	-
Boluwaduro	-	-
Bomadi	-	-
Bonny	132	21
Bosso	-	-
Brass	9	2
Buji	-	-
Bunkure	-	-
Bunza	-	-
Buruku	370	77
Burutu	-	-
Bussa/ New	60	10
Bwari	425	88
Calabar Municipal	216	44
Calabar South	230	47
Chanchaga	116	19
Chibok	-	-
Chikun	200	33
Dala	-	-
Damagum	-	-
Damaturu	-	-
Damban	-	-
Dambatta	24	4
Dan Musa	-	-
Dange-shnsi	-	-
Darazo	-	-
Dass	-	-
Daura	-	-
Dawakin Kudu	54	9
Dawakin Tofa	-	-
Degema	39	6

Nigeria COP15 Targets by LGA: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Dekina	97	16
Demsa	-	-
Dogwuwa	-	-
Doma	225	47
Donga	-	-
Dukku	-	-
Dunukofia	48	8
Dutse	40	6
Eastern Obolo	49	7
Ebonyi	57	9
Ebonyi	-	-
Edati	26	4
Ede North	-	-
Ede South	-	-
Edu	-	-
Efon	-	-
Egbeda	-	-
Egbedore	-	-
Egor	221	36
Ehime Mbano	-	-
Ejigbo	-	-
Ekeremor	161	26
Eket	42	7
Ekiti East	-	-
Ekiti South-West	-	-
Ekiti West	-	-
Ekwusigo	-	-
Eleme	167	35
Emohua	36	6
Emure	-	-
Enugu East	139	24
Enugu East	51	8
Enugu North	150	24
Enugu South	36	6
Enugu South	-	-
Enugu West	-	-
Epe	-	-
Esan Central	108	20
Esan North-East	38	3
Esan South-East	-	-
Esan West	-	-
Ese-Odo	-	-
Esit Eket	-	-
Essien Udim	129	20
Etche	-	-
Ethiope East	375	60
Ethiope West	-	-
Eti-Osa	139	22
Etim Ekpo	84	14
Etinan	136	22
Etsako Central	-	-
Etsako East	-	-
Etsako West	126	20
Etung	-	-
Ezeagu	-	-
Ezinihitte	-	-
Ezinihitte	-	-
Ezza North	-	-
Ezza South	102	16
Fagge	117	19
Fika	-	-
Fufore	255	41
Funakaye	215	35
Fune	-	-
Funtua	87	14
Gamawa	-	-
Ganjuwa	-	-
Garko	170	27
Garum Mallam	-	-
Gashaka	-	-

Nigeria COP15 Targets by LGA: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Gassol	-	-
Gaya	-	-
Gbako	-	-
Gboko	485	72
Gbonyin	-	-
Gezawa	-	-
Giade	-	-
Girei	-	-
Giwa	303	49
Gokana	-	-
Gombe	236	38
Gombi	180	29
Goronyo	-	-
Gujba	-	-
Guma	-	-
Gurara	59	9
Gusau	96	15
Guyuk	-	-
Guzamala	-	-
Gwagwalada	261	42
Gwale	-	-
Gwaram	-	-
Gwarzo	88	14
Gwer East	306	49
Gwer West	233	59
Gwiwa	-	-
Gwoza	147	24
Hadejia	57	9
Hawul	-	-
Hong	208	33
Ibadan North	585	93
Ibadan North-East	-	-
Ibadan North-West	121	20
Ibadan South-East	-	-
Ibadan South-West	-	-
Ibaji	-	-
Ibarapa Central	-	-
Ibarapa East	-	-
Ibarapa North	-	-
Ibeju/Lekki	353	57
Ibeno	6	1
Ibesikpo Asutan	-	-
Ibi	-	-
Ibiono Ibom	-	-
Idah	98	16
Idanre	-	-
Ideato North	-	-
Ideato South	-	-
Idemili North	134	22
Idemili South	104	17
Ido	-	-
Ido-Osi	173	29
Ifako-Ijaiye	160	33
Ife Central	234	38
Ife East	-	-
Ife North	-	-
Ife South	-	-
Ifedore	-	-
Ifelodun	-	-
Ifo	38	6
Igabi	-	-
Igalamela-Odolu	-	-
Igbo Etti	-	-
Igbo Eze North	159	26
Igbo Eze South	-	-
Igueben	45	7
Ihiala	151	24
Ihitte/Uboma	-	-
Ijebu North-East	-	-
Ijebu Ode	264	43

Nigeria COP15 Targets by LGA: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Ijero	-	-
Ijumu	39	6
Ika	59	10
Ika North East	-	-
Ika South	215	20
Ikara	-	-
Ikeduru	-	-
Ikeja	583	120
Ikenne	-	-
Ikere	-	-
Ikere-Ekiti	-	-
Ikole	-	-
Ikom	176	28
Ikono	32	5
Ikorodu	-	-
Ikot Abasi	32	5
Ikot Ekpene	127	26
Ikpoba-Okha	-	-
Ikwerre	-	-
Ikwo	-	-
Ikwuano	-	-
Ila	26	4
Ilaje	-	-
Ile Oluji/Okeigbo	-	-
Ilejemeje	-	-
Ilesha East	-	-
Ilesha West	-	-
Illela	-	-
Ilorin East	-	-
Ilorin South	100	16
Ilorin West	94	15
Imeko/Afon	-	-
Ingawa	-	-
Ini	-	-
Ipokia	-	-
Irele	-	-
Irepo	-	-
Irepodun	-	-
Irepodun	-	-
Irepodun/Ifelodun	-	-
Irewole	-	-
Ise/Orun	-	-
Iseyin	-	-
Ishielu	-	-
Isiala Mbanu	-	-
Isiala-Ngwa North	-	-
Isiala-Ngwa South	-	-
Isiuzo	27	4
Isokan	-	-
Isoko North	-	-
Isoko South	-	-
Isu	-	-
Isuikwuato	-	-
Itesiwaju	-	-
Itu	-	-
Ivo	11	2
Iwajowa	-	-
Iwo	91	15
Izzi	13	2
Jaba	164	27
Jada	-	-
Jahun	49	8
Jalingo	-	-
Jama'are	-	-
Jega	119	19
Jema'a	132	22
Jere	112	18
Jibia	23	4
Jos East	-	-
Jos North	104	17

Nigeria COP15 Targets by LGA: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Jos South	354	57
Kabba/Bunu	91	15
Kabo	149	24
Kachia	198	32
Kaduna North	206	33
Kaduna South	292	47
Kafin Hausa	105	17
Kaga	-	-
Kagarko	-	-
Kajola	-	-
Kajuru	-	-
Kaltungo	134	22
Kanam	372	60
Kankara	25	4
Kanke	-	-
Kankia	109	18
Kano Municipal	220	35
Karaye	89	14
Karin-Lamido	-	-
Karu	406	77
Katagum	166	27
Katcha	-	-
Katsina	67	11
Katsina-Ala	408	84
Kaura	-	-
Kaura Namoda	-	-
Kauru	-	-
Kazaure	59	9
Keana	-	-
Keffi	5	5
Khana	114	18
Kirfi	-	-
Kiru	-	-
Kiyawa	-	-
Kogi	-	-
Koko/Besse	67	11
Kokona	155	25
Kolokuma/Opokuma	46	7
Konshisha	410	85
Kontagora	-	-
Kosofe	-	-
Kubau	-	-
Kudan	-	-
Kuje	-	-
Kumbotso	64	10
Kunchi	-	-
Kura	27	4
Kurfi	-	-
Kurmi	-	-
Kwali	-	-
Kwami	-	-
Kwande	397	64
Lafia	256	48
Lagelu	-	-
Lagos Island	812	131
Lagos Mainland	253	41
Langtang North	171	27
Langtang South	-	-
Lapai	70	11
Lavun	15	2
Lere	117	19
Logo	307	64
Lokoja	285	47
Madagali	-	-
Mafa	-	-
Magama	44	8
Mai'Adua	-	-
Maiduguri	277	45
Maiyama	-	-
Makarfi	-	-

Nigeria COP15 Targets by LGA: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Makoda	-	-
Makurdi	603	79
Malumfashi	-	-
Mangu	129	21
Mani	24	4
Maradun	-	-
Mariga	-	-
Mashegu	-	-
Mayo-Belwa	-	-
Mbaitoli	-	-
Mbo	-	-
Michika	191	31
Mikang	358	58
Minjibir	54	9
Misau	109	18
Mkpat Enin	43	7
Moba	-	-
Mobbar	-	-
Mokwa	99	16
Mopa-Muro	-	-
Mubi South	158	26
Musawa	-	-
Mushin	433	90
Muya	-	-
Nafada/Bajoga	-	-
Nasarawa	665	138
Nasarawa Eggon	332	53
Nassarawa	173	27
Ndakwa East	-	-
Ndakwa West	-	-
Nembe	-	-
Ngala	-	-
Ngaski	-	-
Ngor Okpala	-	-
Ngor Okpala	-	-
Nguru	58	9
Ningi	-	-
Njaba	-	-
Njikoka	74	12
Nkanu East	-	-
Nkanu West	90	14
Nkwerre	-	-
Nnewi North	75	12
Nnewi South	-	-
Nsit Atai	60	10
Nsit Ibom	-	-
Nsit Ubium	-	-
Nsukka	-	-
Nsukka	118	19
Nwangele	-	-
Obanliku	120	19
Obi	-	-
Obi	298	62
Obingwa	-	-
Obio/Akpor	197	40
Obokun	-	-
Obot Akara	31	5
Obowo	-	-
Obubra	-	-
Obudu	163	26
Odeda	-	-
Odigbo	103	16
Odo-Otin	-	-
Odogbolu	-	-
Odukpani	50	8
Offa	53	9
Ofu	33	6
Ogba/Egbema/Ndoni	84	14
Ogbadibo	63	10
Ogbaru	-	-

Nigeria COP15 Targets by LGA: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Ogbia	30	5
Ogbomoso North	292	47
Ogbomoso South	-	-
Ogo Oluwa	-	-
Ogoja	185	30
Ogori/Magongo	-	-
Ogu/Bolo	171	28
Ogun Waterside	-	-
Oguta	44	7
Ohafia	-	-
Ohaji/Egbema	-	-
Ohaozara	-	-
Ohaukwu	130	21
Ohimini	35	6
Oji River	65	11
Ojo	233	37
Oju	-	-
Okehi	30	5
Okene	138	23
Okigwe	68	11
Okitipupa	-	-
Okobo	93	19
Okpe	-	-
Okpokwu	289	47
Okrika	-	-
Ola-Oluwa	-	-
Olamaboro	243	40
Olorunda	64	10
Olorunsogo	-	-
Oluyole	-	-
Omala	122	20
Omumma	-	-
Ona Ara	-	-
Ondo East	-	-
Ondo West	37	6
Onicha	-	-
Onitsha North	63	-
Onitsha South	67	21
Onna	30	5
Onuimo	-	-
Opobo/Nkoro	-	-
Oredo	189	30
Orelope	-	-
Orhionmwon	10	2
Ori Ire	-	-
Oriu	49	8
Orolu	-	-
Oron	78	16
Orsu	-	-
Oru East	45	7
Oru West	-	-
Oruk Anam	42	7
Orumba North	-	-
Orumba South	-	-
Ose	128	21
Oshimili North	-	-
Oshimili South	473	77
Oshodi-Isolo	-	-
Osioma	-	-
Osogbo	27	4
Otukpo	397	75
Ovia South-West	-	-
Owan East	100	16
Owan West	-	-
Owerri Municipal	44	7
Owerri Municipal	-	-
Owerri North	34	6
Owerri North	14	2
Owerri West	-	-
Owo	72	11

Nigeria COP15 Targets by LGA: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Oye	-	-
Oyi	84	14
Oyigbo	-	-
Oyo East	-	-
Oyo West	-	-
Paikoro	-	-
Pankshin	118	19
Patani	-	-
Patigi	-	-
Port-Harcourt	82	17
Potiskum	99	16
Qu'a'an Pan	250	40
Rafi	73	12
Rano	-	-
Remo North	-	-
Rijau	84	13
Rimin Gado	117	19
Ringim	59	10
Riyom	-	-
Rogo	25	4
Roni	-	-
Sabo Birni	-	-
Sabon Gari	-	-
Sagamu	48	8
Sagbama	112	18
Saki East	-	-
Saki West	-	-
Sanga	243	40
Sapele	-	-
Sardauna	-	-
Shani	-	-
Shanono	-	-
Shelleng	-	-
Shendam	160	26
Shinkafi	-	-
Shira	-	-
Shiroro	81	13
Shomolu	-	-
Shongom	138	23
Silame	-	-
Soba	-	-
Sokoto North	-	-
Sokoto South	218	35
Song	237	38
Southern Ijaw	191	31
Suleja	108	17
Sumaila	-	-
Surulere	-	-
Surulere	548	114
Tafa	99	16
Tafawa-Balewa	130	21
Tai	-	-
Takai	-	-
Takum	-	-
Tambuwal	-	-
Tarauni	67	11
Tarka	144	30
Taura	-	-
Toro	208	33
Toto	-	-
Toungo	-	-
Tsafe	-	-
Tsanyawa	24	4
Tudun Wada	127	20
Tureta	-	-
Udenu	-	-
Udi	143	23
Udu	-	-
Udung Uko	-	-
Ughelli North	-	-

Nigeria COP15 Targets by LGA: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Ughelli South	-	-
Ugwunagbo	-	-
Uhunmwonde	-	-
Ukanafun	31	5
Ukum	342	56
Ukwa East	-	-
Ukwa West	-	-
Ukwuani	-	-
Umu Nneochi	-	-
Umuahia North	-	-
Umuahia South	-	-
Ungogo	187	30
Uruan	105	22
Urue-Offong/Oruko	-	-
Ushongo	391	72
Ussa	-	-
Uvwie	149	39
Uyo	276	57
Uzo Uwani	-	-
Vandeikya	377	70
Wamako	69	11
Wamba	214	34
Warawa	-	-
Warji	-	-
Warri North	107	17
Warri South	-	-
Warri South-West	-	-
Wase	-	-
Wudil	-	-
Wukari	-	-
Wushishi	38	6
Yabo	-	-
Yagba East	-	-
Yagba West	-	-
Yakuur	212	34
Yala	5	1
Yamaltu/Deba	207	33
Yankwashi	-	-
Yauri	209	34
Yenagoa	204	33
Yewa North	-	-
Yewa South	125	20
Yola North	244	39
Yola South	239	38
Yorro	-	-
Zaki	-	-
Zango-Kataf	248	41
Zaria	264	43
Zing	-	-
Zurmi	-	-
Zuru	-	-
Other_ Nigeria	165	34
Total	48,086	8,276



HIV/AIDS Sustainability Index and Dashboard

To assist PEPFAR and government partners in better understanding each country's sustainability landscape and making informed investment decisions, PEPFAR teams and stakeholders completed the inaugural **Sustainability Index and Dashboard (SID)** during COP 2015. This new tool assesses the current state of sustainability of national HIV/AIDS responses across 15 critical elements, scores for which are displayed on a color-coded dashboard. As the SID is completed over time, it will allow stakeholders to track progress across these components of sustainability. On the pages that follow, you will find the 2015 country dashboard as well as the questionnaire responses that determined the scores. The legend for the colors depicted on the dashboard is below.

Dark Green Score (17-20 pts) (sustainable and requires no additional investment at this time)
Light Green Score (13-16.9 pts) (approaching sustainability and requires little or no investment)
Yellow Score (7-12.9 pts) (emerging sustainability and needs some investment)
Red Score (0-6.9 pts) (unsustainable and requires significant investment)

Sustainability Analysis for Epidemic Control: NIGERIA

Epidemic Type: Generalized/Concentrated
Income Level: Lower Middle Income
PEPFAR Categorization: Long-term Strategy (Co-Finance)
COP 15 Planning Level:

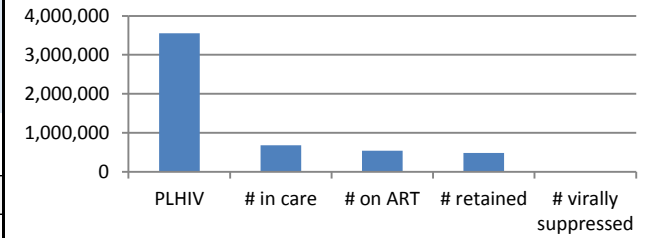


SUSTAINABILITY DOMAINS AND ELEMENTS

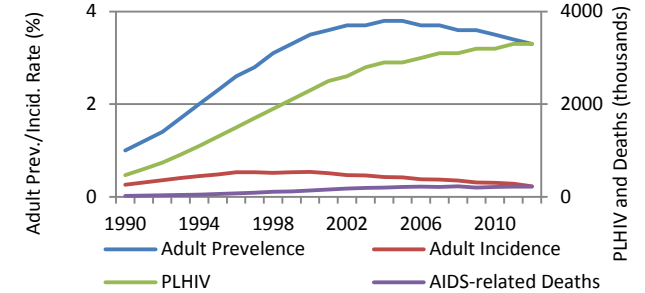
Institutionalized Data Availability		Score
1. Epidemiological and Health Data		14.4
2. Financial/Expenditure Data		15.8
3. Performance Data		18.0
Domestic Program and Service Delivery		
4. Access and Demand		11.8
5. Human Resources for Health		8.0
6. Commodity Security and Supply Chain		7.0
7. Quality Management		7.2
Health Financing and Strategic Investments		
8. DRM: Resource Generation		10.0
9. DRM: Resource Commitments		6.0
10. Allocative Efficiency		9.0
11. Technical Efficiency		17.3
Accountability and Transparency		
12. Public Access to Information		7.0
13. Oversight and Stewardship		12.0
Enabling Environment		
14. Policies, Laws, and Regulations		15.0
15. Planning and Coordination		20.0

CONTEXTUAL DATA

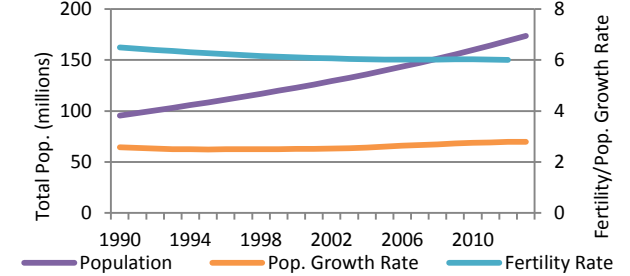
Care and Treatment Cascade



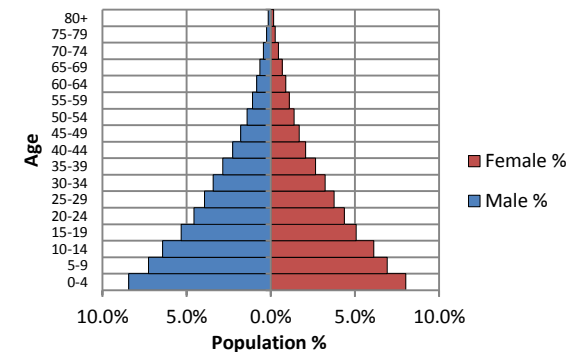
Epidemiological Data



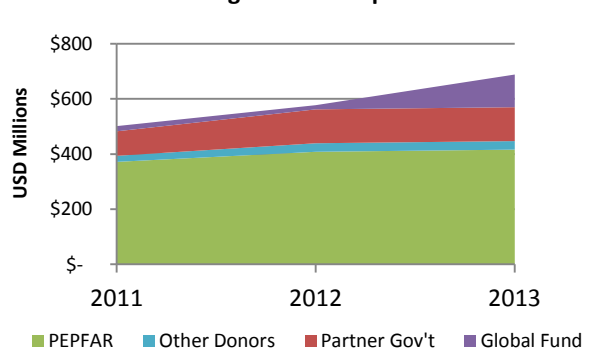
Population and Fertility



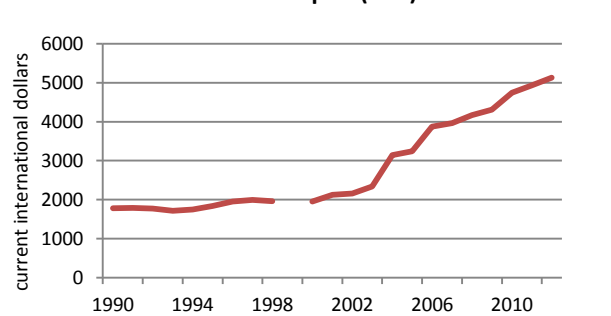
Population Pyramid (2014)



Financing the HIV Response



GNI Per Capita (PPP)



CONTEXTUAL DATA

Domain A: Institutionalized Data Availability

What Success Looks Like: Using local and national systems, the Host Country Government collects and makes available timely, comprehensive, and quality HIV/AIDS data (including epidemiological, economic/financial, and performance data) that can be used to inform policy, program and funding decisions.

1.Epidemiological and Health data: Host Country Government routinely collects, analyzes and makes available data on the HIV/AIDS epidemic and its effects on health outcomes. HIV/AIDS epidemiological and health data include size estimates of key populations, PLHIV and OVC, HIV incidence, HIV prevalence, viral load, AIDS-related mortality rates, and co-infection rates.

		Source of data	Notes/Comments	
<p>Q1. Who leads: Who leads/manages the planning and implementation of HIV/AIDS epidemiological surveys and/ or surveillance (convenes all parties and makes key decisions)?</p>	<p><input checked="" type="radio"/> A. Host Country Government/other domestic institution</p> <p><input type="radio"/> B. External agency with host country government</p> <p><input type="radio"/> C. External agency, organization or institution</p> <p><input type="radio"/> D. Not conducted</p>	4.5	<p>1. Report on the Status of the Nigerian National HIV Monitoring and Evaluation System 2010 : Assessment Using 12 Components System Strengthening Tool http://www.cpc.unc.edu/measure/publications/sr-10-61</p> <p>2. National HIV/AIDS Strategic Plan 2010-2015</p>	
<p>Q2. Who finances: Within the last three years, what proportion of the latest HIV/AIDS epidemiological data survey did the host country government fund?</p>	<p><input type="radio"/> A. 80-100% of the total cost of latest survey was financed by Host Country Government</p> <p><input type="radio"/> B. 60-79% of the total cost of latest survey financed by Host Country Government</p> <p><input checked="" type="radio"/> C. 40-59% of the total cost of latest survey financed by Host Country Government</p> <p><input type="radio"/> D. 20-39% of the total cost of latest survey financed by Host Country Government</p> <p><input type="radio"/> E. 10-19% of the total cost of latest survey financed by Host Country Government</p> <p><input type="radio"/> F. 0-9% of the total cost of latest survey financed by Host Country Government</p>	3	<p>Data is not available. The Stakeholder task team responding to this made an estimate of about 18%.</p> <p>The Government's contribution is an estimate based on HR contributions to the process and the consideration of WB credits as domestic investments.</p>	
<p>Q3. Comprehensiveness of Prevalence and Incidence Data: Does Host Country Government collect HIV prevalence and or incidence data?</p>	<p><input type="radio"/> No, the government does not collect HIV prevalence or incidence data</p> <p><input checked="" type="radio"/> Yes, the government collects (check all that apply):</p> <p><input checked="" type="checkbox"/> A. HIV prevalence</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Collected by age</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected for children</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Collected by sex</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Collected by key population</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Sub-national data</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Collected every 3 years</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Data analyzed for trends</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Data made publicly available</p> <p><input checked="" type="checkbox"/> B. HIV incidence</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Collected by age</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Collected for children</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Collected by sex</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected by key population</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Sub-national data</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Collected every 3 years</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Data analyzed for trends</p>	4.8	<p>1. UNAIDS Spectrum 2014</p> <p>2. National HIV&AIDS and Reproductive Health Survey 2012</p> <p>3. IBSSS 2012</p> <p>4. National HIV Sero-Prevalence Sentinel Survey 2010</p>	<p>Nigeria is conducting incidence study for the first time. This is on going and it is being supported through the CDC COAg. Key population is not identified at this level; Currently for 2 states only</p> <p>This does not include LGA level prevalence and incidence estimates</p>

	<input checked="" type="checkbox"/> Data made publicly available			
Q4. Comprehensiveness of Viral Load Data: Does Host Country Government collect viral load data?	<input checked="" type="radio"/> No, the government does not collect viral load data <input type="radio"/> Yes, the government collects viral load data (check all that apply): <input type="checkbox"/> Collected by age <input type="checkbox"/> Collected for children <input type="checkbox"/> Collected by sex <input type="checkbox"/> Collected by key population <input type="checkbox"/> Sub-national data <input type="checkbox"/> Collected every 3 years <input type="checkbox"/> Data analyzed to understand trends	0	In country source such as government report: Clarify...	Viral load is only collected at service delivery point. No one is identified as key population. Analysis of data and delivery is done at the service delivery point level. Not currently documented
Q5. Key Populations: Does the Host Country Government conduct size estimation studies for key populations?	<input type="radio"/> No, the host country government does not conduct size estimation studies for key populations <input checked="" type="radio"/> Yes, the government conducts key population size estimates (check all that apply): <input checked="" type="checkbox"/> Men who have sex with men (MSM) <input checked="" type="checkbox"/> Female sex workers <input type="checkbox"/> Transgender <input checked="" type="checkbox"/> People who inject drugs (PWID) <input checked="" type="checkbox"/> Government finances at least 50% of the size estimation studies <input checked="" type="checkbox"/> Government leads and manages the size estimation studies	2.1	In country source such as government report: National Epi Analysis 2013	The only estimation study was by NACA through World Bank support; USAID supported study through SFH. The current estimation was not done in 10 states and the process is not yet routine

Epidemiological and Health Data Score: 14.4

2. Financial/Expenditure data: Government collects, tracks and analyzes financial data related to HIV/AIDS, including the financing and spending on HIV/AIDS from all financing sources, costing, and economic evaluation for cost-effectiveness.		Source of data	Notes/Comments
Q1. Expenditure Tracking: Does the host country government have a nationally agreed upon expenditure tracking system to collect HIV/AIDS expenditure data?	<input type="radio"/> No, it does not have a national HIV/AIDS expenditure tracking system <input checked="" type="radio"/> Yes, the government has a system to collect HIV/AIDS expenditure data (check all that applies): <input checked="" type="checkbox"/> A. Collected by source of financing, i.e. domestic public, domestic private, out-of-pocket, Global Fund, PEPFAR, others <input checked="" type="checkbox"/> B. Collected by expenditures per program area, such as prevention, care, treatment, and health systems strengthening <input checked="" type="checkbox"/> C. Collected sub-nationally <input type="checkbox"/> D. Collected annually <input checked="" type="checkbox"/> E. Data is made publicly available	4 NASA and NHA	NASA and NHA are done fairly routinely

<p>Q2. Quality of Expenditure Tracking: Is the Host Country Government tracking expenditures based on international standards? What type of expenditure data are available in the country, i.e. NHA, NASA, others:</p>	<p><input type="radio"/> No, they are not using any international standards for tracking expenditures</p> <p><input checked="" type="radio"/> Yes, the national government is using international standards such as WHO National Health Accounts (NHA), National AIDS Spending Assessment (NASA), and/or methodology comparable to PEPFAR Expenditure Analysis or the Global Fund new funding tracking model.</p>		<p>5</p> <p>1. National AIDS Spending Assessment 2011/2012 http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/data-and-analysis/tools/nasa/20141017/nigeria_2011-2012_en.pdf 2. National Health - Two rounds of NHA completed for the years 1998 to 2002, and 2002 to 2005</p>	
<p>Q3. Transparency of Expenditure Data: Does the host country government make HIV/AIDS expenditure data (or at a minimum a summary of the data) available to the public?</p>	<p><input type="radio"/> No, they do not make expenditure data available to the public</p> <p>Yes, check the one that applies:</p> <p><input type="radio"/> A. Annually</p> <p><input checked="" type="radio"/> B. Bi-annually</p> <p><input type="radio"/> C. Every three or more years</p>		<p>3</p> <p>1. National AIDS Spending Assessment 2011/2012</p>	<p>Clarify if Bi-Annual means every two years</p>
<p>Q4. Economic Studies: Does the Host Country Government conduct special health economic studies or analyses for HIV/AIDS, i.e. costing, cost-effectiveness, efficiency?</p>	<p><input type="radio"/> No, they are not conducting special health economic studies for HIV/AIDS</p> <p><input checked="" type="radio"/> Yes, check all that apply:</p> <p><input checked="" type="checkbox"/> A. Costing studies or analyses</p> <p><input checked="" type="checkbox"/> B. Cost-effectiveness studies or analyses</p> <p><input checked="" type="checkbox"/> C. Efficiency studies or analyses</p> <p><input type="checkbox"/> D. Cost-benefit studies or analyses</p>	<p>3.75</p>	<p>Currently underway ORPHEA Study</p>	<p>Optimizing the Response of Prevention: HIV Efficiency in Africa (ORPHEA) - The overall objective of the ORPHEA study is to gather, analyze and share evidence on the technical efficiency of, and the determinants of efficient HIV service provision that can be used by the Nigerian Government and their national and international partners to improve efficiency in the delivery of ART, PMTCT, HTC and HIV prevention among FSWS.</p>

Financial/Expenditure Data Score: 16

<p>3. Performance data: Government collects, analyzes and makes available HIV/AIDS service delivery data. Service delivery data is analyzed to track program performance, i.e. coverage of key interventions, results against targets, and the continuum of care and treatment cascade, including adherence and retention.</p>		<p>Source of data</p>	<p>Notes/Comments</p>	
<p>Q1. Collection of service delivery data: Does the host country government have a system to routinely collect/report HIV/AIDS service delivery data?</p>	<p><input type="radio"/> No, the government does not have an HIV/AIDS service delivery data collection system</p> <p><input checked="" type="radio"/> Yes, service delivery data are collected/reported for (check all that apply):</p> <p><input checked="" type="checkbox"/> A. For HIV Testing</p> <p><input checked="" type="checkbox"/> B. For PMTCT</p> <p><input checked="" type="checkbox"/> C. For Adult Care and Support</p> <p><input checked="" type="checkbox"/> D. For Adult Treatment</p> <p><input checked="" type="checkbox"/> E. For Pediatric Care and Support</p> <p><input checked="" type="checkbox"/> F. For Pediatric Treatment</p> <p><input type="checkbox"/> G. For AIDS-related mortality</p>	<p>6</p>	<p>1. The Nigeria National Response Information Management System (NNRIMS) 2011-2016. http://sbccvch.naca.gov.ng/sites/default/files/NNRIMS%20Operational%20Plan%202011-2016.pdf</p>	<p>Huge challenges based on the parallel reporting systems</p>
<p>Q2. Analysis of service delivery data: Does the Host Country Government routinely analyze service delivery data to measure Program performance? i.e. continuum of care cascade, coverage, retention, AIDS</p>	<p><input type="radio"/> No, the government does not routinely analyze service delivery data to measure performance</p> <p><input checked="" type="radio"/> Yes, service delivery data are being analyzed to measure (check all that apply):</p> <p><input checked="" type="checkbox"/> A. Continuum of care cascade, including testing, care, treatment, retention and adherence</p> <p><input checked="" type="checkbox"/> B. Results against targets</p>	<p>4</p>	<p>Nigeria Qual performance measurement report 2013 and 2014; NASCP Service report Data are reported at quarterly meetings. Not routinely published outside of GAPPR</p>	

Care cascade, coverage, retention, AIDS-related mortality rates?	<input checked="" type="checkbox"/> C. Coverage <input checked="" type="checkbox"/> D. Site specific yield for HIV testing (HTC and or PMTCT) <input type="checkbox"/> E. AIDS-related death rates			
Q3. Comprehensiveness of service delivery data: Does the host country government collect HIV/AIDS service delivery data in a manner that is timely, accurate and comprehensive?	<input type="radio"/> No <input checked="" type="radio"/> Yes, service delivery data are being: (check all that apply): <input checked="" type="checkbox"/> A. Collected at least quarterly <input checked="" type="checkbox"/> B. Collected by age <input checked="" type="checkbox"/> C. Collected by sex <input checked="" type="checkbox"/> D. Collected from all clinical sites <input checked="" type="checkbox"/> E. Collected from all community sites <input checked="" type="checkbox"/> F. Data quality checks are conducted at least once a year	6	1. Report on the Status of the Nigerian National HIV Monitoring and Evaluation System 2010 : Assessment Using 12 Components System Strengthening Tool http://www.cpc.unc.edu/measure/publications/sr-10-61	There are 2 major parallel reporting systems. GON has a methodology for DQA and are convinced that the data reported is accurate.
Q4. Transparency of service delivery data: Does the host country government make HIV/AIDS program performance and service delivery data (or at a minimum a summary of the results) available to the public routinely?	<input type="radio"/> No, they do not make program performance data available to the public Yes, check the one that applies: <input checked="" type="radio"/> A. At least annually <input type="radio"/> B. Bi-annually <input type="radio"/> C. Every three or more years	2	Nigeria Global AIDS Response Report 2014	
Performance Data Score:			18	

THIS CONCLUDES THE SET OF QUESTIONS ON THE INSTITUTIONALIZING DATA AVAILABILITY DOMAIN

Domain B. Domestic Program and Service Delivery

What Success Looks Like: Host country institutions (inclusive of government, NGOs, civil society, and the private sector), the domestic workforce, and local health systems constitute the primary vehicles through which HIV/AIDS programs and services are managed and delivered. Optimally, national, sub-national and local governments have achieved high and appropriate coverage of a range of quality, life-saving HIV/AIDS prevention, care and treatment services and interventions. There is a high demand for HIV/AIDS services, which accessible and affordable to poor and vulnerable populations at risk of infection (i.e. key populations, discordant couples, exposed infants), are infected and or are affected by the HIV/AIDS epidemic.

4. Access and Demand: There is a high uptake of HIV/AIDS prevention, care and treatment services and programs among key populations and individuals infected and affected by HIV/AIDS, especially among those in the lowest socio-economic quintiles.		Source of data	Notes/Comments
<p>Q1. Access to ART: What percent of facilities in high prevalence/burden locations are provided ART prescription and client management services?</p>	<p><input type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p> <p><input checked="" type="radio"/> A. More than 80% of facilities in high prevalence/burden locations are providing ART.</p> <p><input type="radio"/> B. 50-79% of facilities in high prevalence/burden locations are providing ART.</p> <p><input type="radio"/> C. 21-49% of facilities in high prevalence/burden locations are providing ART.</p> <p><input type="radio"/> D. 20% or less of facilities in high prevalence/burden locations are providing ART.</p>	<p>Q1 Score: 4</p>	<p>National Directory of HIV Treatment Centers in Nigeria 2014</p> <p>Tertiary and Public Secondary health facilities were considered to have potential for ART services</p>
<p>Q2. Access to PMTCT: What percent of facilities in high prevalence/burden locations are providing PMTCT (Option B+)?</p>	<p><input type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. More than 80% of facilities in high prevalence/burden locations are providing Option B+.</p> <p><input checked="" type="radio"/> B. 50-79% of facilities in high prevalence/burden locations are providing Option B+.</p> <p><input type="radio"/> C. 21-49% of facilities in high prevalence/burden locations are providing Option B+.</p> <p><input type="radio"/> D. 20% or less of facilities in high prevalence/burden locations are providing Option B+.</p>	<p>Q2 Score: 2</p>	<p>2014 Integrated National Guidelines for HIV/AIDS Treatment in Nigeria maintains Option B as the recommended PMTCT regimen</p> <p>Option B is retained in the 2014 Integrated National Guideline.</p>
<p>Q3. Who is delivering HIV/AIDS services: What percent of Care and Treatment clients are treated at public service delivery sites? These can include government-supported or accredited domestic private, civil society, or faith-based operated services. (i.e. those sites that receive commodities from the government and/or follow government protocols).</p>	<p><input type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p> <p><input checked="" type="radio"/> A. 80% or more of HIV/AIDS care and treatment clients are treated at public service delivery sites</p> <p><input type="radio"/> B. 50-79% of HIV/AIDS care and treatment clients are treated at public service delivery sites</p> <p><input type="radio"/> C. 20-49% of HIV/AIDS care and treatment clients are treated at public service delivery sites</p> <p><input type="radio"/> D. Less than 20% of HIV/AIDS care and treatment clients are treated at public service delivery sites</p>	<p>Q3 Score: 3</p>	<p>National Directory of HIV Treatment Centers in Nigeria 2014</p> <p>Almost all facilities reporting data to the National platform receive commodities from government (pool procurement) and follow government protocols</p>
<p>Q4. Key Populations: What percent of Key Populations are receiving treatment in public health facilities?</p>	<p><input checked="" type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p>	<p>Q4 Score: 0</p>	<p>In country source, i.e., report on Key Populations.</p> <p>Key populations receiving treatment in public health facilities are not identified. The anti-same sex</p>

<p>Q4. Services to key populations: What percent of key population HIV/AIDS prevention program clients receive services at public service delivery sites? These can include government-supported or accredited domestic private, civil society, or faith-based operated services. (i.e. those sites that receive commodities from the government and/or follow government protocols).</p>	<p><input type="radio"/> A. 80% or more of key population HIV/AIDS prevention program clients receive services at public service delivery sites</p> <p><input type="radio"/> B. 50-79% of key population HIV/AIDS prevention program clients receive services at public service delivery sites</p> <p><input type="radio"/> C. 20-49% of key population HIV/AIDS prevention program clients receive services at public service delivery sites</p> <p><input type="radio"/> D. Less than 20% of key population HIV/AIDS prevention program clients receive services at public service delivery sites</p>			<p>marriage act is a major limitation</p>
<p>Q5. Uptake of services: What percent of PLHIV are currently receiving ART? _____%</p>	<p><input type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. 80% or more of PLHIV are currently receiving ART</p> <p><input type="radio"/> B. 50-79% of PLHIV are currently receiving ART</p> <p><input type="radio"/> C. 20-49% of PLHIV are currently receiving ART</p> <p><input checked="" type="radio"/> D. Less than 20% of PLHIV are currently receiving ART</p>	<p>Q5 Score 1</p>	<p>19.8% - Nigeria GARPR 2014</p>	<p>President's Comprehensive Response Plan (PCRPR) 2013 - states 30% by comparing with number eligible based on CD4 of 350 or less. The new treatment guideline (2014) bases eligibility on CD4 of 500 or less</p>
<p>Q6. Rights to Access Services: Recognizing the right to nondiscriminatory access to HIV services and support, does the government have efforts in place to educate and ensure the rights of PLHIV, key populations, and those who may access HIV services about these rights?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> No, the government does not recognize a right to nondiscriminatory access to HIV services for all populations.</p> <p><input checked="" type="radio"/> Yes, there are efforts by the government (check all that apply):</p> <p><input checked="" type="checkbox"/> educates PLHIV about their legal rights in terms of access to HIV services</p> <p><input type="checkbox"/> educates key populations about their legal rights in terms of access to</p> <p><input checked="" type="checkbox"/> National policy exists for de-stigmatization in the context of HIV/AIDS</p> <p><input checked="" type="checkbox"/> national law exists regarding health care privacy and confidentiality protections</p> <p><input type="checkbox"/> government provides financial support to enable access to legal services if someone experiences discrimination, including redress where a violation is found</p>	<p>Q6 Score 1.8</p>	<p>1). HIV/AIDS Antidiscrimination law signed by the President Jan 3, 2015. 2) National Health Act 2014</p>	<p>The anti-same sex marriage act is a major limitation still</p>

Access and Demand Score

11.8

<p>5. Human Resources for Health: HRH staffing decisions for those working on HIV/AIDS are based on use of HR data and are aligned with national plans. Host country has sufficient numbers and categories of competent health care workers and volunteers to provide quality HIV/AIDS prevention, care and treatment services in health facilities and in the community. Host country trains, deploys and compensates health workers providing HIV/AIDS services through local public and/or private resources and systems. Host country has a strategy or plan for transitioning staff funded by donors.</p>	<p>Source of data</p>	<p>Notes/Comments</p>
<p>Check the one answer that best describes the current situation:</p> <p><input checked="" type="radio"/> This information is not available</p>	<p>Q1 Score: 0</p>	<p>The data on number health workers trained in HIV/AIDS is not collected at any level</p>

<p>Q1. HRH Sufficiency: Does the country have sufficient numbers of health workers trained in HIV/AIDS to meet the HIV service delivery needs?</p>	<p><input type="radio"/> A. No, HIV service sites do not have adequate numbers of staff to meet the HIV positive patient demand</p> <p><input type="radio"/> B. Yes, HIV service sites do have adequate numbers of staff to meet the HIV patient demand (check all that apply)</p> <p><input type="checkbox"/> HIV facility-based service sites have adequate numbers of staff to meet the HIV patient demand</p> <p><input type="checkbox"/> HIV community-based service sites have adequate numbers of staff to meet the HIV patient demand, and CHWs have appropriate linkages to high HIV burden/ volume community and facility sites</p>			
<p>Q2. HRH Transition: What is the status of transitioning PEPFAR and other donor supported HIV/AIDS health worker salaries to local financing/compensation?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. There is no inventory or plan for transition of donor-supported health workers</p> <p><input checked="" type="radio"/> B. There is an inventory and plan for transition of donor-supported workers but it has not been implemented to date</p> <p><input type="radio"/> C. There is an inventory and plan for transition of donor-supported workers, but it has been only partially implemented to date.</p> <p><input type="radio"/> D. There is an inventory and plan for donor-supported workers to be transitioned, and staff are being transitioned according to this plan</p> <p><input type="radio"/> E. No plan is necessary because all HIV/AIDS health worker salaries are already locally financed/compensated</p>	<p>Q2 Score: 1</p>	<p>PEPFAR Nigeria Policy Statement on Operational Support to Health Facilities Providing HIV/AIDS Services Effective from October 1, 2014. Implementing Partners were directed to engage with Government and Hospital managers to integrate the most critical skilled workers with a 12 months timeline. Only critical volunteer staff are currently supported by PEPFAR.</p>	<p>Discussions about PEPFAR transitioning on HCWs salaries started in April 2013 as part of the preparation for the PEPFAR Rationalization process which was completed in October 2013. A policy directive was then communicated to the partners through agency channels and later at an Implementing Partners meeting in May, 2014. Several high-level and technical-level discussions were held with NACA, NASCP and other stakeholders between May and September, 2014 about the transition process and agency teams also joined similar conversations in some states.</p>
<p>Q3. HRH Financial reform: Has financial reform been undertaken in the last 5 years to address government financing of health workers?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. No financial reform has been undertaken in the last 5 years to address government financing of health workers</p> <p><input checked="" type="radio"/> B. Financial reforms have been undertaken in the last 5 years to address government financing of health workers (check all that apply):</p> <p><input checked="" type="checkbox"/> Wage reform to increase salaries and or benefits of health workers</p> <p><input checked="" type="checkbox"/> Increase in budget allocation for salaries for health workers</p>	<p>Q3 Score: 2</p>	<p>1. Government payment circular 2013 2. Fapohunda et.al (2012), Minimum Wage Implementation and Management in a Post-Recession Economy: The Nigerian Experience http://www.howwemadeitinafrica.com/new-minimum-wage-bill-in-nigeria-to-drive-consumption-levels/8257/</p>	
<p>Q4. Pre-Service: Does current pre-service education curricula for health workers providing</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. HIV/AIDS content used by pre-service institutions is out of date (has not been updated within the last 3 years) - For example, an average national score of RED in SIMS AS-SF "Pre-Service Education" CEE</p> <p><input checked="" type="radio"/> B. Pre-service institutions have updated HIV/AIDS content within the last three years (check all that apply):</p> <p><input type="checkbox"/> content updated for all HIV/AIDS services</p>	<p>Q4 Score: 1</p>	<p>Nigeria Undergraduate Medical and Dental Curriculum Template 2012</p>	<p>Available evidence reflects updated pre service education curriculum for Medical & Dental undergraduate but limited to HCT only</p>

<p>HIV/AIDS services include HIV content that has been updated in last three years?</p>	<p><input type="checkbox"/> updated content reflects national standards of practice for cadres offering HIV/AIDS-related services</p> <p><input type="checkbox"/> updated curriculum is problem based/competency based</p> <p><input type="checkbox"/> updated curriculum includes practicums at high volume clinical/ social services sites</p> <p><input type="checkbox"/> institutions that track students after graduation</p>			
<p>Q5. In-Service: To what extent is the country institutionalizing PEPFAR/other donor supported HIV/AIDS in-service training (IST) into local training systems?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. National IST curricula institutionalizes PEPFAR/other donor-supported HIV/AIDS training.</p> <p><input type="radio"/> B. There is a strategy for institutionalizing PEPFAR/other donor-supported IST training and it is being implemented.</p> <p><input type="radio"/> C. There is a strategy in place for institutionalizing PEPFAR supported IST training but it is not being fully implemented to date.</p> <p><input checked="" type="radio"/> D. There is not a strategy in place for institutionalizing PEPFAR/other donor supported IST training.</p>	<p>Q5 Score: 0</p>	<p>Feedback received from National Stakeholder Task team which worked on the SID confirms this.</p>	<p>Network of higher institutions selected & accredited by GON for institutionalizing IST. Also, HRH forum with secretariat at DHPRS review and approve IST curriculum for institutions. Measure Evaluation and some other PEPFAR partners have similar engagement with some higher institutions but a National strategy is not yet in place.</p>
<p>Q6. HRIS: Does the government have a functional Human Resource Information System (HRIS) for the health sector?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input checked="" type="radio"/> A. No, there is no HRIS</p> <p><input type="radio"/> B. Yes, the government does have a HRIS (check all that apply)</p> <p><input type="checkbox"/> The HRIS is primarily funded by host country institutions</p> <p><input type="checkbox"/> There is a national interoperability strategy for the HRIS</p> <p><input type="checkbox"/> The government produces HR data from the HRIS at least annually</p> <p><input type="checkbox"/> The government uses data from the HRIS for HR planning and management</p>	<p>Q6 Score: 0</p>	<p>Feedback received from National Stakeholder Task team which worked on the SID confirms this.</p>	<p>No functional National HRIS; however, most professional regulatory bodies (E.g. Medical & Dental Council of Nigeria, Nursing Council, Pharmacy Council of Nigeria) keep a database of accredited professionals</p>
<p>Q7. Domestic funding for HRH: What proportion of health worker (doctors, nurses, midwives, and CHW) salaries are funded with domestic resources?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> This information is not known</p> <p><input type="radio"/> A. Less than 20%</p> <p><input type="radio"/> B. 20-49%</p> <p><input type="radio"/> C. 50-79%</p> <p><input checked="" type="radio"/> D. 80% or more</p>	<p>Q7 Score: 4</p>	<p>NASA 2011 2012</p>	<p>Almost all Health workers salaries are funded with domestic resources; 63% of the total federal health spending went to staff costs</p>

Human Resources for Health Score

8

6. Commodity Security and Supply Chain: The National HIV/AIDS response ensures a secure, reliable and adequate supply and distribution of quality products, including drugs, lab and medical supplies, health items, and equipment required for effective and efficient HIV/AIDS prevention, care and treatment. Host country efficiently manages product selection, forecasting and supply planning, procurement, warehousing and inventory management, transportation, dispensing and waste management reducing costs while maintaining quality.		Source of data	Notes/Comments
<p>Q1. ARV domestic financing: What is the estimated obligated funding for ARV procurement from domestic public revenue (not donor) sources?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> This information is not known</p> <p><input checked="" type="radio"/> A. 0-9% obligated from domestic public sources</p> <p><input type="radio"/> B. 10-29% obligated from domestic public sources</p> <p><input type="radio"/> C. 30-79% obligated from domestic public sources</p> <p><input type="radio"/> D. 80% or more obligated from domestic public sources</p>	Q1 Score: 0	Bi-annual National Supply Plan Update Report 2014/2015 The estimate is at 3.8% based on the data from national supply plan update 2014/2015
<p>Q2. Test Kit domestic financing: What is the estimated obligated funding for Rapid Test Kits from domestic public revenue (not donor) sources?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> This information is not known</p> <p><input type="radio"/> A. 0-9% obligated from domestic public sources</p> <p><input checked="" type="radio"/> B. 10-29% obligated from domestic public sources</p> <p><input type="radio"/> C. 30-79% obligated from domestic public sources</p> <p><input type="radio"/> D. 80% or more obligated from domestic public sources</p>	Q2 Score: 1	Bi-annual National Supply Plan Update Report 2014/2016 The estimate is at 25% based on the data from national supply plan update 2014/2015.
<p>Q3. Condom domestic financing: What is the estimated obligated funding for condoms from domestic public revenue (not donor) sources?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> This information is not known</p> <p><input type="radio"/> A. 0-9% obligated from domestic public sources</p> <p><input checked="" type="radio"/> B. 10-29% obligated from domestic public sources</p> <p><input type="radio"/> C. 30-79% obligated from domestic public sources</p> <p><input type="radio"/> D. 80% or more obligated from domestic public sources</p>	Q3 Score: 1	Family Planning Department of the FMOH Annual Supply Planning Report 2014 GoN investment last year was about 2million USD
<p>Q4. Supply Chain Plan: Does the country have an agreed-upon national supply chain plan with an implementation plan or a thorough annually-reviewed supply chain SOP?</p>	<p><input type="radio"/> A. No, there is no plan or thoroughly annually reviewed supply chain SOP</p> <p><input checked="" type="radio"/> B. Yes, there is a Plan/SOP. It includes these components: (check all that apply)</p> <p><input checked="" type="checkbox"/> Human resources</p> <p><input checked="" type="checkbox"/> Training</p> <p><input checked="" type="checkbox"/> Warehousing</p> <p><input checked="" type="checkbox"/> Distribution</p> <p><input checked="" type="checkbox"/> Reverse Logistics</p> <p><input checked="" type="checkbox"/> Waste management</p> <p><input checked="" type="checkbox"/> Information system</p> <p><input checked="" type="checkbox"/> Procurement</p> <p><input checked="" type="checkbox"/> Forecasting</p> <p><input checked="" type="checkbox"/> Supply planning and supervision</p>	Q4 Score: 4	Bi-annual National Supply Plan Update Report 2014/2015 The Country has an Annual National HIV/AIDS Procurement and Supply Management Calendar that is updated annually and shared with stakeholders. However, there is no detailed implementation strategy in place. In addition, there is national SOP for HIV/AIDS commodity Management that contains job aid and forms for performance of supply chain functions; also used for monitoring and supportive visit to health facilities
	<p><input checked="" type="radio"/> A. No, storage facilities report having commodities stocked according to plan (above the minimum and below the maximum stock level) less than 90% of the time</p>	Q5 Score: 0	National HIV/AIDS Stock Status Report 2014 While there has not been major stock out of HIV/AIDS commodities in the last year, the storage facilities

<p>Q5. Stock: Do Public and Private Sector Storage facilities (Central and intermediate level) report having HIV and AIDS commodities stocked according to plan (above the minimum and below the maximum stock level) 90% of the time?</p>	<p><input type="radio"/> B. Yes, storage facilities report having commodities stocked according to plan (above the minimum and below the maximum stock level) 90% or more of the time</p> <p><input type="checkbox"/> Both public and (if they exist in the country) private storage facilities at central level</p> <p><input type="checkbox"/> Both public and (if they exist in the country) private storage facilities at intermediate level</p>			<p>has not maintained stocks within acceptable level for 90% of the time in the last year but this has been over 50% of the time.</p>
<p>Q6. Assessment: Was an overall score of above 80% achieved on the SCMS National Supply Chain Assessment?</p> <p>(If a different credible assessment of the national supply chain has been conducted, you may use this as the basis for response. Note the details and date of the assessment in the "source of data" column.)</p>	<p><input type="radio"/> A. No assessment has been conducted nor do they have a system to oversee the supply chain</p> <p><input checked="" type="radio"/> B. Yes, an assessment was conducted but they received below 80%</p> <p><input type="radio"/> C. No assessment was conducted, but they have a system to oversee the supply chain that reviews:</p> <p><input type="checkbox"/> Commodity requirements</p> <p><input type="checkbox"/> Commodity consumption</p> <p><input type="checkbox"/> Coordinates procurements</p> <p><input type="checkbox"/> Delivery schedules</p> <p><input type="radio"/> D. Yes, an assessment was conducted and they received a score that was 80% or higher</p>	<p>Q6 Score: 1</p>	<p>Preliminary Report of National Supply Chain Assessment conducted Nov/Dec 2014</p>	<p>Preliminary results indicates that the country overall score will be less than 80%. Preliminary results on the performance of the various functional areas is reported as follows: Forecasting and Supply Planning (40%), Procurement (45%), Warehousing and inventory management (50%), on time delivery (89%), Data management (83%)</p>

Commodity Security and Supply Chain Score

7

<p>7. Quality Management: Host country ensures that HIV/AIDS services are managed and provided in accordance with established national/global standards and are effective in achieving positive health outcomes (reduced AIDS-related deaths, reduced incidence, and improved viral load/adherence). Host country has institutionalized quality management approaches in its HIV/AIDS Program that ensure continued quality during and following donor to government transitions.</p>	<p>Source of data</p>	<p>Notes/Comments</p>	
<p>Q1. Existence of System: Does the government have a functional Quality Management/Quality Improvement (QM/QI) infrastructure?</p> <p><input type="radio"/> A. No, there is no QM/QI infrastructure within national HIV/AIDS program or MOH</p> <p><input checked="" type="radio"/> B. Yes, there is a QM/QI infrastructure within national HIV/AIDS program or MOH. The infrastructure (check all that apply):</p> <p><input type="checkbox"/> Routinely reviews national HIV/AIDS performance and clinical outcome data</p> <p><input type="checkbox"/> Routinely reviews district/regional HIV/AIDS performance and clinical outcome data</p> <p><input type="checkbox"/> Prioritizes areas for improvement</p>	<p>Q1 Score: 1</p>	<p>Nigeria Qual Performance Measurement Report 2013 and 2014; NASCP Service report Data reported at quarterly meetings. Not routinely published outside of GAPPR</p>	<p>The Nigeria Qual is the Nigerian Government model of the PEPFAR-funded HIV Qual programme. It is led by the HIV/AIDS Division (NASCP) of the FMOH. A QM/QI framework has been set-up and was piloted in 2010. There has been a gradual scale-up since then but it is yet to be fully implemented. The country focal lead reports that they have been conducting reviews but could not produce any evidence to back this claim.</p>
<p>Q2. Strategy: Is there a current (updated within the last 2 years) national QM/QI strategy that is</p> <p><input type="radio"/> No, there is no HIV/AIDS-related QM/Q strategy</p> <p><input checked="" type="radio"/> B. Yes, there is a QM/QI strategy that includes HIV/AIDS but it is not current (updated within the last 2 years)</p>	<p>Q2 Score: 2</p>	<p>Nigeria Qual Performance Measurement Report 2013 and 2014; NASCP Service report Data reported at quarterly meetings. Not routinely</p>	<p>same as above</p>

<p>either HIV/AIDS program-specific or includes HIV/AIDS program-specific elements?</p>	<p><input type="radio"/> C. Yes, there is a current QM/QI strategy that includes HIV/AIDS program specific elements</p> <p><input type="radio"/> D. Yes, there is a current HIV/AIDS program specific QM/QI strategy</p>		<p>meetings. Not routinely published outside of GAPPR</p>		
<p>Q3. Guidelines: Does national HIV/AIDS technical practice follow current WHO guidelines for PMTCT and ART?</p>	<p><input type="radio"/> A. No, the national practice does not follow current WHO guidelines for PMTCT or ART</p> <p><input checked="" type="radio"/> B. Yes, the national practice does follow current WHO guidelines for:</p> <p><input checked="" type="checkbox"/> PMTCT (option B+)</p> <p><input checked="" type="checkbox"/> Adult ART</p> <p><input checked="" type="checkbox"/> Pediatric ART</p> <p><input checked="" type="checkbox"/> Adolescent ART</p> <p><input type="checkbox"/> Test and treat for specific populations</p>	<p>Q3 Score: 3.2</p>	<p>2014 National Integrated Guideline for HIV Prevention, Care & Treatment</p>	<p>The country has not adopted Option B+. Option B is retained in the current (2014) guideline. Adolescent ART guideline are part of the continuum</p>	
<p>Q4. QI Data use: Does the host country government monitor and use data for HIV/AIDS quality improvement?</p>	<p><input type="radio"/> A. No, there is no monitoring for HIV/AIDS quality improvement</p> <p><input checked="" type="radio"/> B. Yes, there is monitoring for HIV/AIDS quality improvement. Monitoring includes:</p> <p><input type="checkbox"/> All sites</p> <p><input type="checkbox"/> Use of data to determine quality of program or services</p> <p><input type="checkbox"/> Making recommendations and action plan for mid-course corrections</p>	<p>Q4 Score: 1</p>	<p>Nigeria Qual Performance Measurement Report 2013 and 2014; NASCP Service report Data reported at quarterly meetings. Not routinely published outside of GAPPR</p>	<p>The framework and infrastructure exists but is not yet done routinely in all sites.</p>	
<p>Q5. Post-transition: Does the host country government monitor whether the quality of HIV/AIDS service outcome is maintained at sites where PEPFAR/other donors have transitioned from a direct implementation role?</p>	<p><input checked="" type="radio"/> A. No, there is no quality monitoring at sites post-transition</p> <p><input type="radio"/> B. Yes, there is quality monitoring at transition sites. Monitoring includes:</p> <p><input type="checkbox"/> All transition sites</p> <p><input type="checkbox"/> Review of service outcomes</p> <p><input type="checkbox"/> Client feedback on changes in quality</p> <p><input type="checkbox"/> Quality improvement action plan</p> <p><input type="radio"/> C. PEPFAR/other donors have never supported direct service delivery in the country</p>	<p>Q5 Score: 0</p>	<p>Country Team knowledge</p>	<p>Yet to transition any site to the host government. So not applicable</p>	
<p>Quality Management Score</p>		<p>7.2</p>			

THIS CONCLUDES THE SET OF QUESTIONS ON THE DOMESTIC PROGRAM AND SERVICE DELIVERY DOMAIN

Domain C. Health Financing and Strategic Investment

What Success Looks Like: Host country government is aware of the financial resources required to effectively and efficiently meet its national HIV/AIDS prevention, care and treatment targets. HCG actively seeks, solicits and/or generates the necessary financial resources, ensures sufficient resource commitments, and uses data to strategically allocate funding and maximize investments.

8. Domestic Resource Mobilization: Resource Generation: The host-country government costs its national HIV/AIDS response, solicits and generates revenue (including but not limited to tax revenues, public sector user fees, insurance, loans, private sector and other strategic partnerships, and/or other innovative sources of financing) and allocates resources to meet the national budget for HIV/AIDS.		Source of data	Notes/Comments
Q1. Domestic budget: Is there a budget line item for HIV/AIDS in the national budget?	<input type="radio"/> A. No, there is no budget line item for HIV/AIDS in the national budget <input checked="" type="radio"/> B. Yes, there is an HIV/AIDS budget line item under the Health budget <input type="radio"/> C. Yes, there is an HIV/AIDS program-based budget across ministries <input type="radio"/> D. Yes, there is an HIV/AIDS program-based budget across ministries and the budget contains HIV/AIDS program indicators	Q1 Score: 3	National budget There is also a budget line under the office of the Secretary to the Government of the Federation (SGF) for NACA and HIV funds under the Subsidy Re-investment Programme. Also a HIV budget under several line Ministries
Q2. Budgetary Framework: Does the country's budgeting process utilize a Medium-Term Expenditure Framework (MTEF) or Medium-Term Fiscal Framework (MTFF)?	<input type="radio"/> A. No <input checked="" type="radio"/> B. Yes, but it does not include a separate costing of the national HIV/AIDS strategy or program <input type="radio"/> C. Yes, and it includes a separate costing of the national HIV/AIDS strategy or program	Q2 Score: 3	2015 - 2017 Medium Term Expenditure Framework and Fiscal Strategy Paper http://www.yourbudgit.com/wp-content/uploads/2014/09/2014-2016-MTEF-Expenditure-Paper.pdf
Q3. Fiscal Policy: Does the country pass the MCC scorecard indicator for fiscal policy? (Countries without an MCC scorecard: Is general government net lending/borrowing as a percent of GDP averaged across 2011-2013 greater than (i.e. more positive than) -3.1 percent?)	<input checked="" type="radio"/> Yes <input type="radio"/> No	Q3 Score: 4	OGAC-provided data sheet (follows tab E) Nigeria scored 75% on the MCC scorecard in FY15.
Q4. Domestic public revenue: What was annual domestic government revenue as a percent of GDP in the most recent year available? (domestic	Check the appropriate box for your country's income category: <u>FOR LOW INCOME</u> <input type="radio"/> A. More than 16.4% (i.e. surpasses category mean) <input type="radio"/> B. 14.8%-16.4%, (i.e. 90-100% of category mean) <input type="radio"/> C. Less than 14.8%, (less than 90% of category mean) <u>FOR LOW MIDDLE INCOME</u> <input type="radio"/> D. More than 22.3% (i.e. surpasses category mean)	Q4 Score: 0	McKinsey Report by Acha Leke, Reinaldo Fiorini, Richard Dobbs, Fraser Thompson, Aliyu Suleiman and David Wright (), 'Nigeria's renewal: Delivering inclusive growth in Africa's largest economy. McKinsey Global Institute July 2014 accessed online at www.mckinsey.com/mgi . 1)Nigeria GDP rebasing report. 2) National Bureau of statistics website

revenue excludes external grants)	<input type="radio"/> E. 20.1-22.3% (i.e. 90-100% of category mean) <input checked="" type="radio"/> F. Less than 20.1% (less than 90% of category mean) FOR UPPER MIDDLE INCOME <input type="radio"/> G. More than 27.8% (i.e. surpasses category mean) <input type="radio"/> H. 25.0%-27.8% (i.e. 90-100% of category mean) <input type="radio"/> I. Less than 25.0% (less than 90% of category mean)			
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Score for Domestic Resource Mobilization: Resource Generation:	10
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9. Domestic Resource Mobilization: Resource Commitments: Host country government makes adequate multiyear resource commitments to achieve national HIV/AIDS goals for epidemic control and in line with the available fiscal space. These commitments for the national HIV/AIDS program ensure a well-trained and appropriately deployed workforce, functioning health systems, sufficient commodities and drugs, and local institutions at all levels able to perform activities and carry out responsibilities.		Source of data	Notes/Comments
Q1. Benchmarks for health spending: African countries: Is the government meeting the Abuja commitment for government health expenditure (at least 15% of General Government Expenditure)? Non-African countries: Is government health expenditure at least 3 percent of GDP?	<input type="radio"/> A. Yes <input checked="" type="radio"/> B. No	Q1 Score: 0 1. Abuja +12: Shaping the future of health in Africa Report 2013 http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/unaidspublication/2013/JC2524_Abuja_report_en.pdf 2. WHO Global health expenditure database (2014 Updates) 3. National Budget 2015	Nigerian health budget is at 6% of General Government Expenditure
Q2. Domestic spending: What proportion of the annual national HIV response are domestic HIV expenditures financing (excluding out-of-pocket)? _____%	<input type="radio"/> A. Less than 10% <input type="radio"/> B. 10-24% <input checked="" type="radio"/> C. 25-49% <input type="radio"/> D. 50-74% <input type="radio"/> E. 75% or Greater	Q2 Score: 5 1. National AIDS Spending Assessment 2011- 2012	Nigeria is currently at 27.5 % of domestic expenditure on the national HIV response
Q3. Key population spending: What percent of key population-specific interventions are financed	<input type="radio"/> A. None or information is not available <input checked="" type="radio"/> B. 1-9% <input type="radio"/> C. 10-24%	Q3 Score: 1 NASA 2011-2012 report states 0.1%	

with domestic public and domestic private sector funding (excluding out of pocket expenditure)?	<input type="radio"/> 25-49% <input type="radio"/> 50-74% <input type="radio"/> 75% or Greater			
Score for Domestic Resource Mobilization: Resource Commitments:			6	



10. Allocative Efficiency: The host country analyzes and uses relevant HIV/AIDS epidemiological, health, health workforce, and economic data to inform HIV/AIDS investment decisions. For maximizing impact, data are used to choose which high impact program services and interventions are to be implemented, where resources should be allocated, and what populations demonstrate the highest need and should be targeted (i.e. the right thing at the right place and at the right time).	Source of data	Notes/Comments
Q1. Data-driven allocation: Does the host country government routinely use existing data to drive annual HIV/AIDS program investment decisions?	<input type="radio"/> A. No, data are not used annually <input checked="" type="radio"/> B. Yes, data are used annually. Check all that apply: <input checked="" type="checkbox"/> Epidemiological data are used <input checked="" type="checkbox"/> Health/service delivery data are used <input checked="" type="checkbox"/> Financial data are used <input type="checkbox"/> There is integrated analysis across data streams <input type="checkbox"/> Multiple data streams are used to model scenarios	Q1 Score: 6
1.The President’s Comprehensive Response Plan 2013-2015 2. National Operational Plan for the Elimination of Mother to Child Transmission (eMTCT) of HIV in Nigeria 2015–2016 http://www.emtct-iatt.org/wp-content/uploads/2014/11/National-Operational-Plan-for-EMTCT-Nigeria-Nov-2014.pdf 3. The National HIV Prevention Plan 2014-2015 http://sbccvch.naca.gov.ng/sites/default/files/National%20HIV%20PrevPlan%202014-2015%281%29.pdf	Other considerations beyond data also used.	
Q2. Geographic allocation: Does the host country government use data to determine the appropriate number and location of HIV/AIDS service sites (proportional to yield or burden data)?	<input type="radio"/> A. The government does not consider yield or burden when deciding on the number and location of HIV/AIDS service sites <input checked="" type="radio"/> B. Less than 20% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients <input type="radio"/> C. 20-49% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients <input type="radio"/> D. 50-79% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients <input type="radio"/> E. 80% or more of HIV/AIDS service delivery sites yield 80% or more of new positive HIV test results or ART clients	Q2 Score: 1
This information is only based on the Site Yield Analysis conducted by PEPFAR in COP16 Planning process. Preliminary reports of a similar exercise by the Government of Nigeria agrees with PEPFAR findings.	The country bases its strategic plans for HIV/AIDs on yield from SNU's not health facilities. There are also political considerations for HIV/AIDS programming beyond yield analysis	

<p>Q3.Data driven reprogramming: Do host country government policies/systems allow for reprogramming investments based on new or updated program data during the government funding cycle?</p>	<p><input type="radio"/> A. No, there is no system for funding cycle reprogramming</p> <p><input type="radio"/> B. Yes, there is a policy/system that allows for funding cycle reprogramming but it is seldom used</p> <p><input checked="" type="radio"/> C. Yes, there is a system that allows for funding cycle reprogramming and reprogramming is done as per the policy but not based on data</p> <p><input type="radio"/> D. Yes, there is a policy/system that allows for funding cycle reprogramming and reprogramming is done as per the policy and is based on data</p>	<p>Q3 Score: 2</p>	<p>NIL</p>	<p>Our Government sources report that there is a system for this - but could not produce evidence to validate this claim.</p>
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Allocative Efficiency Score:			9	
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<p>11. Technical Efficiency: Through enhanced processes, economies of scale, elimination of waste, prevention of new infections, expenditure analysis, strategic targeting, and other technical improvements, the host country is able to achieve improved HIV/AIDS outcomes within the available resource envelope (or achieves comparable outcomes with fewer resources). Thus, maximizing investments to attain epidemic control.</p>	Source of data	Notes/Comments
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<p>Q1. Unit costs: Does the Host Country Government use expenditure data or cost analysis to estimate unit costs of HIV/AIDS services?</p> <p>(note: full score of five points can be achieved without checking all disaggregate boxes).</p>	<p><input type="radio"/> A. No</p> <p><input checked="" type="radio"/> B. Yes (check all that apply):</p> <p><input type="checkbox"/> Annually</p> <p><input checked="" type="checkbox"/> For HIV Testing</p> <p><input checked="" type="checkbox"/> For Care and Support</p> <p><input checked="" type="checkbox"/> For ART</p> <p><input checked="" type="checkbox"/> For PMTCT</p> <p><input type="checkbox"/> For VMMC</p> <p><input type="checkbox"/> For OVC Service Package</p> <p><input checked="" type="checkbox"/> For Key population Interventions</p>	<p>Q1 Score: 4.25</p>	<p>1. GF NFM Concept Note 2014</p>	<p>The GoN utilized the PEPFAR Expenditure Analysis (EA) data for TGF NFM concept note submission. There are ongoing costing studies commissioned by the GoN such as : ORPHEA</p>
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	<p>Check all that apply:</p> <p><input type="checkbox"/> Using findings from cost-effectiveness or efficiency studies to modify operations or interventions</p>	<p>Q2 Score: 2</p>	<p>1. Gustafsson-Wright, E. & Schellekens, O. (2013) 'Achieving Universal Health Coverage in Nigeria One State at a Time: A Public-Private Partnership Community-Based', Brooke Shearer Working Paper Series: Working Paper 2 [Online]</p>	
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<p>Q2. Improving efficiency: Which of the following actions is the Host Country Government taking to improve technical efficiencies?</p>	<p><input type="checkbox"/> Streamlining management to reduce overhead costs</p> <p><input checked="" type="checkbox"/> Reducing fragmentation to lower unit costs, i.e. pooled procurement, resource pooling</p> <p><input type="checkbox"/> Improving procurement competition</p> <p><input checked="" type="checkbox"/> Integration of HIV/AIDS into national or subnational insurance schemes (private or public)</p> <p><input checked="" type="checkbox"/> Scaling up evidence-based, high impact interventions and reducing interventions without evidence of impact</p> <p><input checked="" type="checkbox"/> Geographic targeting in high burden/high yield sites to increase impact</p> <p><input type="checkbox"/> Analysis of expenditure data to establish appropriate range of unit costs</p>		<p>General Working Paper 2 (GWP2). Available from http://www.brookings.edu/~media/Research/Files/Papers/2013/06/achieving-universal-health-coverage-nigeria-gustafsson-wright/Achieving-Universal-Health-Coverage-in-Nigeria.pdf?la=en</p> <p>2. Community-based Health Insurance (2011). Conference Brief. http://www.healthpolicyproject.com/pubs/97_communitybasedhealthinsurance.pdf</p> <p>3. Innovative & Alternative Financing for HIV/AIDS Response in Nigeria. Presentation by NACA-Resource Mobilization Department at the Expanded Theme Group Meeting of 3rd February, 2015 (Available on request).</p>	
<p>Q3. Loss ratio: Does host country government have a system to measure the proportion of domestic public HIV/AIDS spending that supports direct service delivery (not administrative/overhead costs)?</p>	<p><input type="radio"/> A. No</p> <p><input checked="" type="radio"/> B. Yes</p>	<p>Q3 Score: 3</p>	<p>Unpublished NASA 2012</p>	
<p>Q4. Benchmark prices: Are prices paid by the government for first-line ARVs and Test Kits within 5% variance of international benchmark prices (UNAIDS Investment Case)?</p>	<p>Check boxes that apply:</p> <p><input type="checkbox"/> They are not paying for any ARVs</p> <p><input type="checkbox"/> They are not paying for any test kits</p> <p><input checked="" type="checkbox"/> They are paying no more than 5% above the international benchmark price for first line ARVs</p> <p><input checked="" type="checkbox"/> They are paying no more than 5% above the international benchmark price for test kits</p>	<p>Q4 Score: 4</p>	<p>http://apps.who.int/hiv/amds/price/hdd/Default.aspx</p>	<p>FMOH contacts informed us that the information is procurement sensitive. However, SCMS was able to deduce from the quantity procured that the ARVs and RTKs are within the 5% margin of International benchmark price (Product cost for treatment 2013-2015). No evidence was produced to buttress this claim.</p>
<p>Q5. ART unit costs: Have average unit costs for providing ART in the country reduced within the last two years?</p> <p>Unit cost 2 years ago: \$ _____</p> <p>Current unit cost: \$ _____</p>	<p><input type="radio"/> A. No</p> <p><input checked="" type="radio"/> B. Yes</p>	<p>4</p>	<p>WHO, Global Price Reporting Mechanism - http://apps.who.int/hiv/amds/price/hdd/</p>	<p>There has been a 9% decrease in the average unit costs of ART in the past 2 years under the National Pooled Procurement framework.</p>
<p>Technical Efficiency Score: 17.25</p>				

THIS CONCLUDES THE SET OF QUESTIONS ON THE HEALTH FINANCING AND STRATEGIC INVESTMENT DOMAIN

Domain D. Accountability and Transparency

What Success Looks Like: Host government upholds a transparent and accountable resolve to be responsible to its citizens and international stakeholders (donors) for achieving planned HIV/AIDS results, is a good steward of HIV/AIDS finances, widely disseminates program progress and results, and provides mechanisms for eliciting feedback.

12. Public Access to Information: Host government widely disseminates timely and reliable information on the implementation of HIV/AIDS policies and programs, including goals, progress and challenges towards achieving HIV/AIDS targets, as well as fiscal information (public revenues, budgets, expenditures, large contract awards, etc.) related to HIV/AIDS. Program and audit reports are published publically.	Source of data	Notes/Comments
<p>Q1. OBI: What is the country's "Open Budget Index" score? (Alternative for countries lacking an OBI score: What was the country's score on the most recent Public Expenditure and Financial Accountability Assessment (PEFA) for PI-10: "Public Access to Fiscal Information"?)</p>	<p>Q1 Score: 1.0</p>	<p>OGAC-provided data sheet (follows tab E)</p> <p>Data derived from Open Budget Index (http://survey.internationalbudget.org/) and PEFA data (www.pefa.org)</p> <p>Nigeria received a score of 16 in the most recent OBI evaluation (2012)</p>
<p>Q2. National program report transparency: Does the host country government make an annual national HIV/AIDS program progress report and or results publically available?</p>	<p>Q2 Score: 6.0</p>	<p>1. NASA 2011/2012 http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/data-and-analysis/tools/nasa/20141017/nigeria_2011-2012_en.pdf</p> <p>2. Nigeria Global AIDS Response Country</p>
<p>Q3. No audit is conducted of the National HIV/AIDS program, or the audit report is not made available publically</p>	<p>Q3 Score: 0.0</p>	<p>No audit is conducted</p>

<p>Q3. Audit transparency: Does the host country government make an annual national HIV/AIDS program audit report publically available?</p>	<p><input type="radio"/> B. Yes, the national HIV/AIDS program audit report is made public. Check all that apply:</p> <p><input type="checkbox"/> On website</p> <p><input type="checkbox"/> Through any type of media</p> <p><input type="checkbox"/> Disseminate print report</p>			
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Public Access to Information Score: 7

<p>13. Oversight and Stewardship: Government institutions are held accountable for the use of HIV/AIDS funds and for the results of their actions by the electorate and by the legislature and judiciary. Public employees are required to account for administrative decisions, use of resources, and results obtained. There is timely and accurate accounting and fiscal reporting, including timely audit of public accounts and effective arrangements for follow-up. There are mechanisms for citizens and key stakeholders to review and provide feedback regarding public programs, services and fiscal management.</p>		<p>Source of data</p>	<p>Notes/Comments</p>	
<p>Q1. Availability of Information on Resources Received by Service Delivery Units. PEFA score on PI-23 was C or higher in most recent assessment.</p>	<p><input type="radio"/> A. PEFA assessment never conducted, or data unavailable</p> <p><input type="radio"/> B. PEFA was conducted and score was below C</p> <p><input checked="" type="radio"/> C. PEFA was conducted and score was C</p> <p><input type="radio"/> D. PEFA was conducted and score was B</p> <p><input type="radio"/> E. PEFA was conducted and score was A</p>	<p>Q1 Score: 1.0</p>	<p>Draft National Report - with National Score of C Data derived from Public Expenditure and Financial Accountability Framework (www.pefa.org)</p>	<p>At National level there only 1 draft report (with National Score of C). At subnational level - there are 26 final assessment reports and 1 publication</p>
<p>Q2. Quality and timeliness of annual financial statements. PEFA score for element PI-25 was C or higher in most recent assessment.</p> <p>Actual scores are ____</p>	<p>Check A or B; if B checked, select appropriate disaggregates:</p> <p><input type="radio"/> A. PEFA assessment never conducted, or data unavailable</p> <p><input checked="" type="radio"/> B. PEFA was conducted and score was C or higher for:</p> <p><input checked="" type="checkbox"/> (i) Completeness of the financial statements</p> <p><input checked="" type="checkbox"/> (ii) Timeliness of submission of the financial statements</p> <p><input checked="" type="checkbox"/> (iii) Accounting standards used</p>	<p>Q2 Score: 5.0</p>	<p>Actual Scores Data derived from Public Expenditure and Financial Accountability Framework (www.pefa.org)</p> <ul style="list-style-type: none"> • Completeness - B • Timeliness – A • Use of Accounting Standards - A 	<p>Same as above</p>
	<p>Check A, B, or C; if C checked, select appropriate disaggregates:</p>		<p>1. The Country Coordinating</p>	

<p>Q3. Government Channels and Opportunities for Civil Society Engagement: Does host country government have formal channels and opportunities for diverse civil society groups to engage and provide feedback on its HIV/AIDS policies, programs, and services?</p>	<p><input type="radio"/> A. No, there are no formal channels or opportunities</p> <p><input type="radio"/> B. No, there are no formal channels or opportunities but civil society is called upon in an ad hoc manner to provide inputs and feedback</p> <p><input checked="" type="radio"/> C. Yes, there are formal channels and opportunities for civil society engagement and feedback. Check all that apply:</p> <p><input checked="" type="checkbox"/> During strategic and annual planning</p> <p><input checked="" type="checkbox"/> In joint annual program reviews</p> <p><input checked="" type="checkbox"/> For policy development</p> <p><input checked="" type="checkbox"/> As members of technical working groups</p> <p><input checked="" type="checkbox"/> Involvement on evaluation teams</p> <p><input checked="" type="checkbox"/> Giving feedback through social media</p> <p><input checked="" type="checkbox"/> Involvement in surveys/studies</p> <p><input checked="" type="checkbox"/> Collecting and reporting on client feedback</p>	<p>Q3 Score: 6.0</p>	<p>Mechanism (CCM) 2014 Update http://www.ccmnigeria.org/?q=content/about-country-coordinating-mechanism-ccm 2. The Network of People Living with HIV/AIDS in Nigeria (NEPWHAN) – 2015 Updated Website Content http://nepwhan.net/programmes.php</p>	
<p>Q4. Civil society Enabling Environment: What score did your country receive on the 2013 Civicus Enabling Environment Index (EEI), which measure the socio-cultural, socio-economic and governance environments for civil society?</p> <p>If your country is not included in the EEI, are there any laws or policies that prevent a full range of civil society organizations from providing oversight into the government's HIV/AIDS response?</p>	<p><input checked="" type="radio"/> A. EEI score of 0-0.38; or if no EEI score, there are laws or policies that restrict civil society playing an oversight role</p> <p><input type="radio"/> B. EEI score of 0.39-0.50; or there are no laws that restrict civil society playing a role in providing oversight of the HIV/AIDS response but in practice, it is not accepted by government</p> <p><input type="radio"/> C. EEI score of 0.51 - 0.76; or there are no laws or policies that prevent civil society from playing a role in providing oversight of the HIV/AIDS response and civil society is very actively engaged in providing oversight</p>	<p>Q4 Score: 0.0</p>	<p>OGAC-provided data sheet (follows tab E)</p> <p>Data derived from Civicus Enabling Environment Index (civicus.org/eei/)</p>	<p>2013 Score was 0.38</p>
<p>Oversight and Stewardship Score:</p>			<p>12</p>	

THIS CONCLUDES THE SET OF QUESTIONS ON THE ACCOUNTABILITY AND TRANSPARENCY DOMAIN

Domain E. Enabling Environment

What Success Looks Like: Relevant government entities demonstrate transparent resolve and take actions to create an enabling policy and legal environment, and provide technical and political leadership to coordinate an effective national HIV/AIDS response.

14. Policies, Laws, and Regulations: Host country develops, implements, and oversees a wide range of policies, laws, and regulations that will achieve coverage of high impact interventions, ensure social and legal protection and equity for those accessing HIV/AIDS services, eliminate stigma and discrimination, and sustain epidemic control within the national HIV/AIDS response.

	Source of data	Notes/Comments
<p>Q1. Structural obstacles: Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support?</p> <p> <input type="radio"/> A. No, there are no such laws or policies <input checked="" type="radio"/> B. Yes, there are such laws, regulations or policies. Check all that apply (each check box reduces score): </p> <ul style="list-style-type: none"> <input type="checkbox"/> Criminalization of HIV transmission <input type="checkbox"/> HIV testing disclosure policies or age requirements <input type="checkbox"/> Non-disclosure of HIV status laws <input checked="" type="checkbox"/> Anti-homosexuality laws <input checked="" type="checkbox"/> Anti-prostitution legislation <input checked="" type="checkbox"/> Laws that criminalize drug use, methadone use or needle exchange 	<p>Q1 Score: 3.0</p>	<p>The Nigeria Same-Sex Marriage (Prohibition) Act of 2014; http://www.ilo.org/aids/legislation/WCMS_329335/lang-en/index.htm</p> <p>http://www.huffingtonpost.com/news/nigeria-anti-gay-bill/ - also Prostitution is criminalized in many states and in the Nigeria Criminal Code Act - Chapter 77.</p>
<p>Q2. Access protection: Is there a National HIV/AIDS Policy or set of policies and laws that creates a legal and policy environment that ensures non-discriminatory and safe access to HIV/AIDS services, providing social and legal protection where those rights are violated?</p> <p>(note: full score of six points possible without checking all boxes)</p> <p> <input type="radio"/> A. No, there are no such policies or laws <input checked="" type="radio"/> B. Yes, there are such policies and laws. Check all that apply: </p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> For people living with HIV <input type="checkbox"/> For men who have sex with men <input type="checkbox"/> For transgendered persons <input type="checkbox"/> For sex workers <input type="checkbox"/> For people who inject drugs <input checked="" type="checkbox"/> For children orphaned or affected by HIV/AIDS 	<p>Q2 Score: 4.0</p>	<ol style="list-style-type: none"> 1. The Nigeria HIV and AIDS Anti-Discrimination Act (2014). http://nepwhan.net/assets/Anti_Discrimination_Bill.pdf 2. National HIV/AIDS Policy (2009) http://nigeria.unfpa.org/pdf/ntpol.pdf 3. The Revised National Workplace Policy and National Action Plan (2014) 4. The Child's Rights Act of 2003 5. National Human Rights Commission (Amendment) Act of 16 December 2010 http://www.ilo.org/aids/legislation/WCMS_186089/lang-en/index.htm 6. Federal Ministry of Women Affairs and Social Development/NACA, National Plan of Action: Addressing Gender-based Violence and HIV/AIDS (GBV/HIV/AIDS) Intersections 2015-2017, December 2014, 56 pp. <p>Though these policies are in place, the implementation remains a challenge</p>

	<input checked="" type="checkbox"/> For young girls and women vulnerable to HIV <input checked="" type="checkbox"/> For survivors of gender-based violence			
Q3. Civil society sustainability: Does the legislative and regulatory framework make special provisions for the needs of Civil Society Organizations (CSOs) or give not-for-profit organizations special advantages?	<input type="radio"/> A. No, there are no special provisions or advantages for CSOs <input checked="" type="radio"/> B. Yes, there are special provisions and advantages for CSOs. Check all that apply: <input checked="" type="checkbox"/> Significant tax deductions for business or individual contributions to not-for-profit CSOs <input checked="" type="checkbox"/> Significant tax exemptions for not-for-profit CSOs <input checked="" type="checkbox"/> Open competition among CSOs to provide government-funded services <input checked="" type="checkbox"/> Freedom for CSOs to advocate for policy, legal and programmatic change	Q3 Score: 4.0	In country source, name of legislation: The 2012 CSO Sustainability Index for Sub-Saharan Africa pg. 109 - http://www.usaid.gov/sites/default/files/documents/1860/CSOSI_AFR_2012.pdf	Individual contributions are not tax-deductable
Q4. Enabling legislation: Are there policies or legislation that govern HIV/AIDS service delivery?	<input type="radio"/> A. No <input checked="" type="radio"/> B. Yes, there are. Check all below that are included: <input checked="" type="checkbox"/> A national public health services act that includes the control of HIV <input checked="" type="checkbox"/> A task-shifting policy that allows mid-level providers to provide key HIV/AIDS services	Q4 Score: 4.0	National Policy on HIV/AIDS 2009 http://nigeria.unfpa.org/pdf/ntpol.pdf ; National Task-shifting Policy 2014 (available in soft copies); http://gatesinstitute.org/news/nigerian-national-council-health-approves-new-task-shifting-policy ;	
Policies, Laws, and Regulations Score:		15		



15. Planning and Coordination: Senior policy makers prioritize health and the HIV/AIDS response. Host country develops, implements, and oversees a multiyear national strategy and serves as the preeminent architect and convener of a coordinated HIV/AIDS response in the country across all levels of government and key stakeholders, civil society and the private sector. National plans are aligned to national priorities to achieve planned targets and results, with full costing estimates and plans incorporated.		Source of data	Notes/Comments
Q1. National Strategy: Does the country have a	<input type="radio"/> A. No, there is no national strategy for HIV/AIDS <input checked="" type="radio"/> B. Yes, there is a national strategy. Check all that apply: <input checked="" type="checkbox"/> It is multiyear	Q1 Score: 4.0	1. National HIV/AIDS Strategic Plan 2010-2015 http://www.ilo.org/aids/legislation/WCMS_146389/lang-en/index.htm 2. National HIV/AIDS

<p>multi-year, costed national strategy to respond to HIV?</p>	<p><input checked="" type="checkbox"/> It is costed</p> <p><input checked="" type="checkbox"/> Its development was led by the host country government</p> <p><input checked="" type="checkbox"/> Civil society actively participated in the development of the strategy</p>		<p>2. National HIV/AIDS Strategic Framework (NSF) 2010-2015 http://www.ilo.org/aids/legislation/WCMS_146388/lang-en/index.htm</p>	
<p>Q2. Data driven prioritization: Did the host country government develop the strategy using a data-driven prioritization approach, which coordinates the investment of multiple sources of funding, i.e. Investment Case?</p>	<p><input type="radio"/> A. No data-driven prioritization approach was used</p> <p><input type="radio"/> B. Yes, a data-driven prioritization approach was used but it did not coordinate the investment of multiple funding sources</p> <p><input checked="" type="radio"/> C. Yes, a data-driven prioritization approach was used that coordinated the investments of multiple funding sources</p>	<p>Q2 Score: 4</p>	<p>1. The President's Comprehensive Response Plan 2013-2015 2. National Operational Plan for the Elimination of Mother to Child Transmission (eMTCT) of HIV in Nigeria 2015-2016 http://www.emtct-iatt.org/wp-content/uploads/2014/11/National-Operational-Plan-for-EMTCT-Nigeria-Nov-2014.pdf 3. The National HIV Prevention Plan 2014-2015 http://shrcrwh.naca.gov.ng/sites/default</p>	<p>The current operational plans (referenced) focus the National Response on 12+1 states which account for more than 70% of the National HIV burden (out of 36 States).</p>
<p>Q3. CCM criteria: Has the country met the minimum criteria that all CCMs must meet in order to be eligible for funding by the Global Fund?</p>	<p><input type="radio"/> A. No or there is no CCM</p> <p><input type="radio"/> B. Yes, with conditions</p> <p><input checked="" type="radio"/> C. Yes</p>	<p>Q3 Score: 2</p>	<p>Global Fund Eligibility List 2014 yes, Country has a functional CCM with representatives from all relevant bodies.</p>	
<p>Q4. Coordination of national response: Does the host country government coordinate (track and map) all HIV/AIDS activities in the country, including those funded or implemented by CSOs, private sector, and donor implementing partners, to avoid duplication and gaps?</p>	<p><input type="radio"/> A. No, it does not track or map all HIV/AIDS activities</p> <p><input checked="" type="radio"/> B. the host country government coordinates all HIV/AIDS activities. Check all that apply:</p> <p><input checked="" type="checkbox"/> Of Civil Society Organizations</p> <p><input checked="" type="checkbox"/> Of private sector</p> <p><input checked="" type="checkbox"/> Of donor implementing partners</p> <p><input checked="" type="checkbox"/> Activities are tracked or mapped</p> <p><input checked="" type="checkbox"/> Duplications and gaps are addressed</p> <p><input checked="" type="checkbox"/> Joint operational plans are developed that include key activities of all implementing agencies</p>	<p>Q4 Score: 6.0</p>	<p>In country source for each checked: Structured National Coordination Meetings like the Expanded Theme Group led by NACA, the DPG on HIV/AIDs and the State Management Teams at State Levels</p>	

<p>Q5. Civil society engagement: Is there active engagement of diverse non-governmental organizations in HIV/AIDS advocacy, decision-making and service delivery in the national HIV/AIDS response?</p>	<p><input type="radio"/> A. No</p> <p><input checked="" type="radio"/> B. Yes, civil society (such as community-based organizations, non-governmental organizations and faith-based organizations, local leaders, and/or networks representing affected populations) are actively engaged. Check all that apply:</p> <p><input checked="" type="checkbox"/> In advocacy</p> <p><input checked="" type="checkbox"/> In programmatic decision-making</p> <p><input checked="" type="checkbox"/> In technical decision-making</p> <p><input checked="" type="checkbox"/> In service delivery</p>	<p>Q5 Score: 4.0</p>	<p>In country source for each checked: CSOs have representation in all the National TWGs and involved in all programme planning, implementation and monitoring activities.</p>	
<p>Planning and Coordination Score:</p>		<p>20</p>		

THIS CONCLUDES THE SET OF QUESTIONS ON THE ENABLING ENVIRONMENT DOMAIN