Nigeria Stop TB Partnership

... working together for a TB-free Nigeria!

NIGERIA STOP TB PARTNERSHIP STRATEGIC PLAN 2013-2015

February 2013.

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ACKNOWLEDGEMENT

PREFACE

The fight against TB must be everybody's business: from the Ministry of Health to the smallest community-based organization in the rural area; from the Leadership of the country to the ordinary person in the village; from the renowned academician to the smallest child in nursery school, who is just a potential; from the people infected and affected by TB to the most healthy person on the street. Nigeria Stop TB Partnership was established to create a massive movement of organizations with individuals committed to the fight against TB in order to "work-our-talk" bolster action and leverage resources for TB elimination by 2050. Specifically, this Partnership is expected to advocate for the appropriate resources for TB elimination through individual and institutional commitments, development partners' engagement, coordination and harmonization, community mobilization for TB prevention, care and control, mobilization of resources and the engagement of partners in the development, dissemination and adoption of norms for TB control across all nooks and crannies of Nigeria.

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Acronyms

ACSM	-	Advocacy, Communication and Social Mobilization
AFB	-	Acid Fast Bacilli
AIDS	-	Acquired Immune Deficiency Syndrome
BCC	-	Behaviour Change Communication
CBO	-	Community Based Organization
CDR	-	Case Detection Rate
CIDA	-	Canadian International Development Agency
CPT	-	Co-trimoxazole Preventive Therapy
CSO	-	Civil Society Organization
CTBC	-	Community TB Care
DFID	-	UK Department for International Development
DHS	-	Demographic and Health Survey
DOT	-	Direct Observation of Treatment
DOTS	-	Directly Observed Therapy Short-course
DPT	-	Department of Public Health
DR-TB	-	Drug Resistant Tuberculosis
DST	-	Drug Susceptibility Testing
FCT	-	Federal Capital Territory
FMOH	-	Federal Ministry of Health
GDF	-	Global Drug Facility
GFTAM	-	Global Funds to fight AIDS, TB and Malaria
GLC	-	Green Light Committee
HBC	-	High Burden Countries
HSS	-	Health Systems Strengthening
HMIS	-	Health Management Information System
IEC	-	Information Education and Communication
ILEP	-	International Federation of anti leprosy associations
LACA	-	Local Action Committee on AIDS
MDG	-	Millennium Development Goal

MDR-TB	-	Multi Drug Resistant Tuberculosis
NACA	-	National Agency for the Control of AIDS
NARHS	-	National HIV/AIDS and Reproductive Health Survey
NASCP	-	National AIDS & STI Control Programme
NGO	-	Non-Governmental Organization
NPO	-	National Professional Officer
NSTBP	-	Nigeria Stop TB Partnership
NTBLCP	-	National Tuberculosis and Leprosy Control Programme
NTBLTC	-	National Tuberculosis and Leprosy Training Centre
NTS	-	Nigeria Thoracic Society
HIV	-	Human Immuno-deficiency Virus
LGA	-	Local Government Area
PATHS	-	Partnership for Transforming Health Systems
PEPFAR	-	Presidential Emergency Funds for AIDS Relief
PHC	-	Primary Health Care
PLHIV	-	People Living with HIV
PPM	-	Public Private Mix
PTB	-	Pulmonary Tuberculosis
SMOH	-	State Ministry of Health
STBLCP	-	State TB and Leprosy Control Programme
TA	-	Technical Assistance
TB	-	Tuberculosis
TBL	-	Tuberculosis and Leprosy
TWG	-	Technical Working Group
USAID	-	United States Agency for International Development
WDC	-	Ward Development Committee
WHO	-	World Health Organisation
XDR-TB	-	Drug Resistant TB

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1. OVERVIEW

Introduction & Background

Tuberculosis (TB) is an infectious airborne disease and a major global health problem. Globally each year, there are around nine million new cases of TB and close to two million deaths.[1] All countries are affected, but 85% of cases occur in Africa (30%) and Asia (55%), while India and China alone represent 35%. There are 22 so-called High Burden Countries (HBC) that account for 80% of the world's TB cases and which have been given particular attention in TB control since 2000. These 22 HBC (in alphabetical order) are: Afghanistan, Bangladesh, Brazil, Cambodia, China, the Democratic Republic of Congo, Ethiopia, India, Indonesia, Kenya, Mozambique, Myanmar, Nigeria, Pakistan, the Philippines, the Russian Federation, South Africa, Thailand, Uganda, Tanzania, Viet Nam and Zimbabwe. Globally, the absolute number of TB cases is increasing slowly due to HIV/AIDS among others. However, the number of per capital (expressed as the number of cases per 100, 000 population) is falling by 1% every year.[2]

TB is a major public health problem in Nigeria. It is among the ten leading causes of mortality among men and women of reproductive age (15 – 49 years) and hospital admissions across public and private health institutions in the country. Nigeria ranks tenth among the 22 HBC around the world and the fourth in Africa (after South Africa, Ethiopia and DR Congo). The exact burden of TB disease in Nigeria (measured as incidence, prevalence, socio-economic indices and mortality) has not been properly documented and disseminated. However, according to WHO estimates in 2011, the country has estimated 320,000 cases of all forms of TB with yearly prevalence of 199 cases per 100,000 population and 210,000 new cases representing an incidence rate of 133 per 100,000 population.

[1] *Global tuberculosis control 2010,* World Health Organization, Geneva 2010
[2] Lopez AD et al. *Global burden of diseases and risk factors.* New York. The Work Bank, 2006.

ESTIMATED TB BURDEN IN NIGERIA (2011 WHO GLOBAL TB REPORT)		
	ESTIMATES	**DENOMINATORS**
Estimated Prevalence rate	199 per 100,000 population	All cases
Estimated Incidence rate (all cases)	131 per 100,000 population	New cases
Registered TB cases (all forms)[3]	90,311	
i) All new cases	92%	Reported cases
ii) Re-treatment cases	8%	Reported cases
iii) New smear positive cases	50%	Reported cases
iv) Gender Distribution		Reported cases
Males	59.3%	
Females	40.7%	
Age Distribution of TB cases		New smear positives notified
i) 0 – 15 years	2.8%	
ii) 25 – 44 years	54%	
iii) 45 – 64 years	43%	
Treatment success rate	84%	

TB is closely related to HIV & AIDS. TB and HIV constitute lethal combination of diseases that have individually and collectively made impacts on public health systems, with each making the impact of the other worse. HIV is the most powerful known risk factor for reactivation of latent TB infection to active disease. The rise in TB cases among People Living with HIV (PLHIV) poses an increased risk of TB transmission to the wider community. TB is the leading cause of death among PLHIV.

Nigeria has a national HIV prevalence of 4.1% among pregnant women attending antenatal clinics.[4] The prevalence ranged from 1.0% in Kebbi State to 12.7% in Benue State. Overtime HIV prevalence in Nigeria has stabilized between 2005 and 2010. This ranged from 4.4% in 2005

[3] NTBLCP annual report. FMOH. Abuja. 2008.
[4] National HIV sero-prevalence sentinel survey among pregnant women . Technical report. FMOH.2010.

to 4.6% in 2008 and 4.1% in 2010. Based on this, it is estimated that 3.1 million people in Nigeria are living with HIV & AIDS as at 2010. Report from WHO in 2006 shows that one in every four HIV patient in Nigeria has TB and accounts for most of their deaths. At TB/HIV co-infection rate of 27%, it estimated that additional burden of 35,200 TB cases annually are added from PLHIV.[5] Yet TB is a curable disease. Using combinations of first-line drugs, around 90% of people with drug-susceptible TB can be cured in six months.

As essential component of TB control, the global strategy emphasized the need to empower communities and patients affected by TB. Several community Directly Observed Treatment (DOT) models have been implemented in Nigeria to compliment the facility-based DOT. WHO in 2000 thus recommended community-based TB care as an effective, acceptable, affordable and cost-effective way to deliver TB DOTS services.[6] Nigeria adopted Directly Observed Treatment Short course (DOTS) in 1993 and implemented across the thrity-six States and FCT in the country. Despite countrywide implementation of DOTS, accessibility to services still remains a huge challenge as most of the population live some distances from the DOTS centers. Quality of DOTS services need also to be improved. All these put together has constrained the attainment of the national target of TB case detection and treatment success rates. It is expected that increasing awareness of TB and its treatment in communities while making DOTS services more accessible and acceptable with PHC as the cornerstone of the health system, the attainment of national and global targets will be enhanced.

. Alongside HIV/AIDS is Multi-Drug Resistant-TB (MDR-TB). MDR-TB is yet another most important threat to TB control in Nigeria. According to the 2011 WHO global TB report, the Nigeria MDR-TB estimates among notified cases are 2.2% (among new cases) and 9.4% (among retreatment cases). . Some of the key challenges to MDR-TB treatment include high cost of second-line drugs which are at least 300 times more expensive than first-line drugs based on Green Light Committee (GLC) prices. Diagnosis of MDR-TB also requires extensive laboratory systems to conduct culture and drug susceptibility testing (DST); and most importantly are the adverse events associated with second-line drugs.

[5] World Health Organization Global TB Report. 2009.
[6] Community TB care in Africa Project (1996 – 2000). WHO Report 2000

Governance System

The governance system in Nigeria is structured along the three tier system, each with some levels of autonomy - Federal, States, and LGAs. The Federal Government is headed by an elected President, with two National legislative assemblies – Senate and House of Representatives. Governors provide executive Leadership at State levels. There are thirty-six States spread across the Federation, including the Federal Capital Territory (FCT). Each State has a legislative House of Assembly. The third tier of governance is the Local Government Area (LGA) Council. Elected Chairmen provide overall Leadership at the area councils with support from Legislative Council. A total of 774 LGA Councils exits in the federating units of thirty-six States of the Federal Republic of Nigeria.

Nigeria is the most populous country in African with an estimated projected population of 160 million people.[7] The landmass of the country is 923,768 square km with about 350 ethnic groups, with diverse languages. The four main ethnic groups are the Hausa Fulani, Igbo and Yoruba. The two predominant religions are Islam and Christianity.

Health Systems Structure

The health system in Nigeria is based on the National health policy framework developed approved by Federal Ministry of Health (FMOH) in 1998 and revised in 2004. The overall goal of the policy is to achieve health levels that would enable Nigerians to achieve socially and economically productive lives with primary healthcare as its cornerstone. The policy provides for a health system based on primary, secondary and tertiary structures financed, supported and managed at LGAs, States and Federal levels respectively. LGA Councils are responsible for primary level of care, State government for secondary level of care and provision of technical guidance to the LGAs, and the Federal Government is responsible for the tertiary level of care in addition to policy formulation and technical guidance to the States.

[7] National Population Commission 2006

Health care services are provided through over 30,000 public and 20,000 private health care facilities spread across the country. All tertiary and most secondary health facilities have standard laboratories and the capacity to provide basic laboratory services including Acid Fast Bacilli (AFB) microscopy for identification of Pulmonary TB (PTB). The private sector (both for-profit and non-profit), non-governmental organizations, faith-based organizations, community-based organizations and local communities also provide considerable services at all the levels of health care including TB care. The private sector provides for more 50% of health care needs of the population in Nigeria.

National TB and Leprosy Control Program (NTBLCP)

NTBLCP is the responsible agency of the Federal Government that coordinates TB and Leprosy control activities in Nigeria. The agency operates as semi-autonomous unit under the Department of Public Health (DPH) of the Federal Ministry of Health (FMOH). NTBLCP is structured along the three tiers of government-Federal, State and LGAs. The overall goal of NTBLCP is to reduce significantly the burden, socio-economic impact, and transmission of TB and Leprosy in Nigeria.

NTBLCP (otherwise referred to as Central Unit) is responsible for facilitating policy design, development and implementation regarding TB control, support provision of tertiary care, mobilization of resources both locally and internationally, program evaluation and research, human resource development and technical support to State programs. The Leadership at NTBLCP is regarded as the National Coordinator of the entire TB Program in the country. The institution has retinue of supportive medical and paramedical staff.[8]

The National program has a human development and training center located at Zaria. The center often referred to as the National TB and Leprosy Training Centre (NTBLTC) for identifying various HR needs for program implementation and capacity development for various categories of health care staff to implement quality TBL services at Federal, State and LGA levels. The center also serves as a referral hospital with about 140 bed capacity for TB and leprosy care.

[8] National Strategic Plan for TB & Leprosy Control 2010 -2015. FMO 2009

In most States in Nigeria, TB control programs are under the Director within the Department of Disease Control. Other States have autonomous agencies saddled with the responsibilities for TB and HIV control activities. TB control, management, program implementation and supervision are carried out by the State TBL Control Officer(s) supported by the State TBL Supervisors. The State TBL programs coordinate TB activities in the respective states, provide secondary care as well as technical assistance to LGA councils.

The Local Government Area is the operational level of the program based on the Primary Health Care (PHC) principle. At the LGA Level, the TBL Control activities are the responsibility of the Local Government TBL Supervisors. At this level, PHC workers are involved in carrying out TBL activities in close collaboration with the respective communities and individual engaged in TB control efforts.

The National TB Program collaborates with several local and international partners in the planning, implementation and resource mobilization for TBL control. Key among these are - ILEP organizations, UK Partnership for Transforming Health Systems (PATHS), CIDA, USAID, CDC, PEPFAR partners , WHO and CSOs.

Successful TB control strategies rely on functioning health systems. The health system is faced with myriad of challenges such as shortages in health workforce, continuous low levels of public funding for health, weak government stewardship functions, weak data management system for evidence-based planning, weak infrastructural facilities, dysfunctional health service networks and improper coordination of TB control activities from National to LGA levels. It is widely recognized that DOTS expansion itself is one facet of health systems development. As such, to invest in DOTS means investing in improved health systems. However, DOTS expansion without strengthening of the general health services is not sustainable. The Nigeria Stop TB partnership must therefore recognize the need to join forces with other stakeholders in health systems development to find ways to strengthen human resources for health, increase equitable health financing and improve on general health systems management.

Global Targets

Recognizing the magnitude of the problem, targets for reduction of the burden of TB disease (measured as incidence, prevalence, mortality and socio-economic impact) have been set within two global frameworks. These are (1) Millennium Development Goals (MDG) and (2) Stop TB Partnership

Goal 6 of MDG addresses three public health diseases of global importance. This goal aims at combating HIV/AIDS, Malaria and other related disease which includes TB. In addition, MDG has specific target (6c) to measure global performance of TB control and two indicators (6.9 & 6.10) for this purpose. See Table 1 below.

The Stop TB Partnership has two additional targets for 2015. These targets are in shown (in red) in Table 1 below. The MDG target has been endorsed and adopted by the Stop TB Partnership as part of measurement controls towards the end-line of 2015.

Tuberculosis Control in MDG	
GOAL 6:	Combat HIV/AIDS, Malaria and other diseases
TARGET 6c:	Halt and begin to reverse the incidence of malaria and other major disease including TB
INDICATOR 6.9	Incidence, prevalence and death associated with TB reduced
INDICATOR 6.10	Proportion of TB cases detected and cured under DOTS
Stop TB Partnership Targets	
Target 1: By 2015	Reduce prevalence and death rates by 50%; compared with their levels in 1990
Target 2: By 2050	Eliminate TB as public health problem; defined as Global incidence of active TB of less than one case per 1 million population per year.

Global Stop TB Strategy

World Health Organization (WHO) in 2006 launched the Stop TB Strategy as the internationally-recommended approach to reducing the burden of TB across all countries and in line with global targets set for 2015. The overall goal of the strategy is defined as: "To dramatically reduce the global burden of TB by 2015 in line with the millennium Development Goals and the Stop TB Partnership targets." The Global strategy[9] has six major components:

1. Pursue high-quality DOTS expansion and enhancement

a. Political commitment with increased and sustained financing
b. Case detection through quality-assured bacteriology
c. Standardized treatment with supervision and patient support
d. An effective drug supply and management system
e. Monitoring and evaluation system, and impact measurement

2. Address TB/HIV, MDR-TB and other challenges

a. Implement collaborative TB/HIV activities
b. Prevent and control multidrug-resistant TB
c. Address prisoners, refugees and other high-risk groups and special situations

3. Contribute to health system strengthening

a. Actively participate in efforts to improve system-wide policy, human resources, financing, management, service delivery, and information systems
b. Share innovations that strengthen systems, including the Practical Approach to Lung Health (PAL)
c. Adapt innovations from other fields

4. Engage all care providers

a. Public-Public, and Public-Private Mix (PPM) approaches
b. International Standards for Tuberculosis Care (ISTC)

5. Empower people with TB and communities

a. Advocacy, communication and social mobilization
b. Community participation in TB care
c. Patients' Charter for Tuberculosis Care

6. Enable and promote research

a. Programme-based operational research
b. Research to develop new diagnostics, drugs and vaccines

[9] The Stop TB Strategy: building on and enhancing DOTS to meet the TB-related MDGs. WHO 2006.

2. NIGERIA STOP TB PARTNERSHIP STRUCTURE

Discussions to establish a national partnership began around 2005-2006 but the first formal meeting was held at the Union Conference in Cape Town in 2007. The partners who were involved at the beginning were the WHO (secretariat), USAID, International Federation of Anti Leprosy Organisations (ILEP), civil society, professional associations, National HIV/AIDS control, NTP, a member of the academia (Chair), a member of the private sector (vice chair) and the affected community. The approach to partnership was chosen keeping in mind the HIV/AIDS approach of involving multiple stakeholders but all on one common platform. The main goals of the partnership are to complement the work of the NTP, advocate for more funding for TB and to increase awareness and community mobilisation for TB.

The partners contribute to TB care and control based on their core competencies and interests. After determining the skills of each partner, responsibilities within the partnership were assigned depending on available resources and partners' capacities. The Ministry of Health, through the NTP provides guidelines and policies while the civil society supports the NTP and

mobilises communities. The private sector also partners with the partnership in many areas, depending on their skills. The members of the affected community play an active role in the partnership by giving support to TB patients, giving suggestions on quality assurance and information sharing to and from the community. An additional benefit of having engaged the affected communities is the identification of potential new partners. As a result of the suggestions of the affected communities, community-based organisations and support groups have joined the partnership and their roles and responsibilities have been integrated into the mapping of partners to coordinate activities in those communities. Greater coordination of activities of the many stakeholders already supporting the NTP has been the driving force of change.

Conceptually, the partnership has been structured to have the following components subject to change due to the dynamism of the TB control work:

- Partners' forum
- Coordinating Board
- Working Groups
- The Partnership Secretariat

Partners Forum:

The Partners' forum is the general assembly of the Nigeria Stop TB Partnership (NSTBP) and consists of an inclusive, consultative meeting of representatives of all partners working directly or indirectly on TB or TB-related diseases. It also includes all those who have interest in TB control activities and would help to achieve the goals and aspirations of the Partnership. Some of the key functions of the forum are:

- To support and reinforce high level political commitment to the objectives of the Partnership and TB control activities in Nigeria.
- To create, support and implement opportunities for advocacy, information exchange, communication, networking and improved awareness of the Partnership aim.
- To review overall progress towards implementation of the National, States, LGA and Civil Society Organizations and Stop TB Partnership plans, review reports presented by the Board and make recommendations thereafter.

- To identify problems and new challenges to the Stop TB Partnership forum and serve as avenue for exchange information of ideas, new knowledge and initiatives.
- To serve as forum to formalize commitments to Global, National and Partnership targets and associated strategic plans.

Coordinating Board:

The Board provides leadership and direction, monitors the implementation of approved policies, plans and activities of the Partnership and ensures coordination among Stop TB Partnership components.

Some of the functions of the coordinating board include:

- Formulating priority actions by the partnership in line with National health policy, NTBLCP and technical advice from WHO and in line with recommendations of the partners forum.
- Support development partners (local and international) and CSOs according to agreed strategy.
- Approve the work plan and budget of the Nigeria Stop TB Partnership secretariat; provide leadership, direction and monitor plan implementation.
- Mobilize adequate resources (human, material, technical and financial) for the various activities of the Stop TB Partnership after identifying funding gaps with respect to work plans.
- Support, coordinate and promote advocacy and social mobilization in support of the Stop TB Partnership in appropriate fora.
- Review progress of work plan implementation of the Stop TB Partnership and maintain high quality information exchange including reports of meetings with all Partners and the public at large.
- Support the establishment of the Stop TB Partnership Trust Fund and provide oversight to ensure transparency and accountability in the use of the trust fund.
- Review annual financial statement and progress reports prepared by the Executive Secretary.
- Develop, adopt and review regularly operational and financial policy and guidelines of the Partnership to underpin accountability for resources entrusted to the Stop TB Partnership.

- Coordinate inputs, suggestions and submissions to better the Partnership processes and initiatives from constituencies within and outside the Board.
- Represent the Stop TB Partnership in local and international fora and events.
- Establish committees, working groups and task forces that would aid better performance as it may be necessary.
- Consider any other matter related to the Stop TB Partnership that might be referred to it by any of its members, Chair of the Board, Executive Secretary, NTBLCP, FMOH, SMOH, Corporate organizations, CSOs, Communities and individuals.

Selection of Board members: In order to represent effectively the interests of the Partnership, the Board must reflect the various constituencies which make up the Partnership. The criteria for Board members should be commitment to Stop TB, potential to contribute to the success of the Partnership program and relevant skills, knowledge, experience or access to resources. The process of selection should be open and accountable. In that perspective, the election, selection or nomination of members of the Board will be as follows:

- The constituencies of financial donors, foundations, NGOs / technical agencies and the corporate sector will organize and carry out, if necessary with the assistance of the Secretariat, an appropriate process of selection and will inform the Board of the process and criteria used.
- Representatives of States and LGAs, and of communities affected by TB and geo-political representatives will be selected by a consultative process managed by the Board.
- Any organization or IP represented on the Board will nominate their individual representative and inform the Board.
- The chairpersons of the Working Groups and of the WHO TB Technical Advisors in Nigeria will serve as Board members.
- Board members shall serve for a term of three years and may be re-appointed to a further final term of three years.
- At a moment of renewal of the Board, the Chair and the Executive Secretary shall ensure that the Board undertakes a review of the diversity of skill available on the Board and the expertise which will be needed in the proximate future. In this task, the Board may be

helped by a consultation (organized by the Secretariat via the website) among the partners at large to request suggestions on the profile and skills required for future Board members.

- The Board shall so arrange rotation of State membership such that no State has more than one geo-political representation at any one moment. At least each geo-political zone shall have representation on the Board at every term of not more than three years.

- The Board may co-opt other persons or invite other persons to attend Board meetings for specific, temporary purposes as and when the Board judges it necessary.

- The Executive Secretary will be responsible to the Board for the effective and timely fulfilment of the above procedures.

Composition of the Board The Board shall represent the component constituencies of Partnership. The Board shall be made up of XXX members in the following manner and shall be reviewed by the Board in the light of emerging situations based on evidence and evaluation of the Partnership:

- One representative from the Presidency of the Federal Republic of Nigeria
- Two representatives from the National legislative assemblies
- National Coordinator, NTBLCP
- One representative from the National Agency for the Control of AIDS (NACA)
- National Coordinator, NASCP
- Six representatives from State TB control programs spread across the geo-political zone.
- National Coordinator of NTBLTC Zaria
- One representative of tertiary academic research institution with excellence in public health research activities
- One representative each from WHO, GFATM, USAID, DFID, CIDA etc
- One representative each from international donor implementing agencies
- Chairpersons of working groups in DOTS Expansion, MDR-TB, TB-HIV, ACSM, PPM-DOT etc
- One representative of National TB Network
- Three representatives of local NGOs/CBO working extensively on TB
- Three representatives of community leaders of communities affected by TB

- Two representatives of people affected with TB
- Two representatives of private health providers of TB services
- One representative of the corporate business organizations

Chairperson of the Board: The Board shall elect from among its members a Chairman who shall serve for a term of three years. The Chairman shall be eligible for re-election, but shall not serve more than two consecutive terms. The Chairman shall preside over the Board sessions. The Board of Nigeria Stop TB Partnership shall elect from among its members a Vice-Chair, following the same procedures.

Secretariat of the Board: The Executive Secretary of Stop TB Partnership Secretariat will act as the Secretary of the Board. The Stop TB Partnership Secretariat shall prepare the agenda for each session of the Stop TB Coordinating Board, in collaboration with the Chairman and the Board members. A report, prepared by the Executive Secretary, with the assistance of appointed rapporteurs, shall be circulated as soon as possible after the conclusion of the session for the approval of the members.

Accountability/Inter-relationships: The Board responds to the partnership through reporting comprehensively to each meeting of the Forum. In between such meetings, the Board, through the Secretariat, will maintain a programme of frequent, high-quality information exchange, including reports on Board meetings, with all partners and the public at large. Decisions of the Board should, to the maximum extent possible, be based on consensus.

Transparency: The Board has a primary responsibility to display maximum transparency through regular, clear reporting on its work and activities both within and outside the Nigerian Partnership. At all time a balanced composition of the Board with National outlook would ensure and foster transparency and collective responsibilities.

Frequency of meeting: The Board should meet physically at least twice a year.

Technical Working Groups

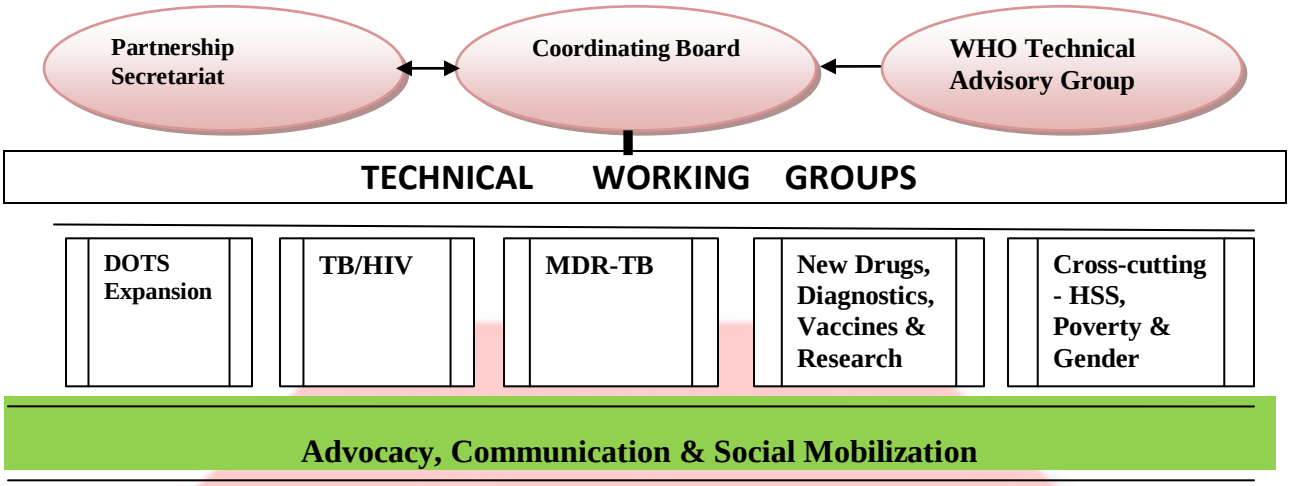
Technical Working Groups (TWG) are essential components of the Nigeria Stop TB Partnership that contribute significantly to the achievement of partnership aims and objectives. The working groups drive the implementation of key activities in a sustainable fashion within available resources. These TWGs include:

- DOTS Expansion
- TB-HIV
- MDR-TB
- ACSM
- PPM-DOTS
- CTBC

These TWG would serve to implement operational activities in pursuit of the group's specific area of interest and overall goal of the National partnership. In addition, collaborate with other elements of the partnership so as to create synergy and value added to actions taken in line with the Nigeria Stop TB partnership.

Membership is open to institutions and expert individuals involved in the specific areas focus of the TWG for better TB control and prevention outcome in Nigeria.

Figure .....



PARTNERSHIP SECRETARIAT

The Nigeria Stop TB Partnership secretariat is housed at WHO country office, Abuja, Nigeria . The role of the secretariat is to serve and support the partnership in terms of administration, operational implementation of activities, coordination of civil societies working in TB care and control efforts, resources management and generation for TB care and control and strategic innovations in pursuit of the achievements of partnership goals and objectives. The secretariat plans to further entrench governance and management practices along business models to enable Stop TB Partnership remain dynamic and responsive to the needs of policy makers, government, civil societies, communities, corporate entities and individuals. Some of the key objectives of the secretariat include:

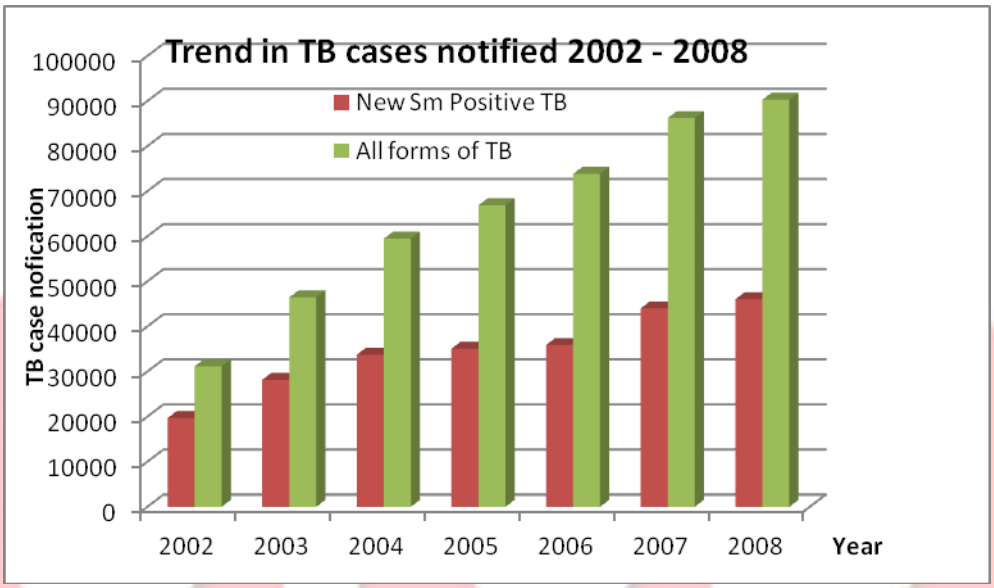
- To place TB care and control on the development agenda of Federal, States and LGAs; while at the same time mainstreaming pro-poor approaches to TB activities in areas of poverty reduction, gender and health systems strengthening.
- To facilitate and move TB control beyond the existing reach and scope of traditional disease control efforts at National and State levels. Begin to catalyse new opportunities and promoting the aspiration of the National Strategic Plan for TB Control (2010 -2015).
- To stimulate and mobilize additional resources to enable effective implementation of the National TB Control Plan (2010 -2015).
- To promote accountability, flexibility and coordination in the management of partnership resources.

- To facilitate relationships between and with existing development partners, CSO, donor agencies, implementing partners, public-private partnerships and communities in order to strengthen our coalition by reaching out to new or potential partners.
- To build skills, resources and capacities at national and State levels to enable successful partnerships are development across board.
- To monitor and evaluate the impact of the secretariat and partnerships in the delivery and attainment of the National and State TB Control Strategic Plans (2010 – 2015) overall goals, targets and objectives.

3. SITUATION ANALYSIS OF TB IN NIGERIA

Tuberculosis is a major public health problem in the country, being one of the ten leading causes of hospital admissions and a leading cause of death in adults, especially among the economically productive age group. Nigeria now ranks tenth in global list of 22 High Burden Countries (HBCs) that account for about 80% of the estimated global TB burden.

According to the 2011 WHO Global TB report, Nigeria has an incidence rate of 133 per 100,000 populations per year (210,000 cases). The estimated prevalence for Nigeria in the same report for all forms of TB is 199 per 100,000 populations per year (320,000 cases) and mortality rate for all forms of TB is 21/100,000 population (33,000 deaths per year).



A rapid increase in trend of TB cases notified was observed from 2002 when the country received the USAID and CIDA grants through WHO to support DOTS expansion in the 17 non DOTS states at that time. Consequently, the number of TB cases notified increased from 31,164 in 2002 to 90,447 in 2010. Kano and Lagos, the two most highly populated states in Nigeria account for 18% of the cases notified in 2008 (NTBLCP Annual report, 2008).

The TB burden is also driven by the high National HIV prevalence of 4.1%. The HIV prevalence varies from states to states, Benue state with the highest HIV prevalence of 12.7% and Kebbi state with 1%. (National HIV sentinels survey, 2010). Similarly, 79% of the notified TB cases in 2010 were tested for HIV out of which 25% were found to be co-infected (NACA 2010).

The treatment success rate for new smear positive cases increased from 73% in 2004 to 83% in 2010 while that of re-treatment cases also increased from 73% in 2004 to 81% in 2010 (WHO Global report 2011).

Multi-Drug Resistant TB (MDR-TB) and Extensive Drug-Resistant TB (XDR-TB) are major threats to TB control efforts in Nigeria. MDR-TB is defined as resistance in vitro to Rifampicin and Isoniazid whereas XDR-TB is defined as MDR-TB plus resistance to a fluoroquinolone plus one or more of the injectable agents. This implies that the standard six/eight months treatment with first-line anti-TB drugs is no longer effective for people with MDR-TB and XDR-TB. Instead they are treated with drugs that are less efficacious, more toxic and much more costly over a timeframe of up to two years. The burden of DR-TB in Nigeria based on WHO estimates is 1.8% among new cases and 9.4% among re-treatment cases in Nigeria[10].

Despite the successes recorded in the control of TB in Nigeria, considerable challenges exist that must be addressed through collective efforts in order to achieve targets set within the National Strategic Plan for TB control (2010 – 2015). Some of these challenges include:

- Inadequate funding and budgetary provisions for TB care and control services at National, State and LGA levels.
- Poor coordination and lack of synergy of efforts among different players in TB control. This is not limited to Government control efforts in HIV/AIDS, TB and TB/HIV collaboration alone but integrated coordination among all players including donor agencies, implementing partners, civil society organizations, community-based NGOs, corporate organizations, Philanthropists, Academia, private health practitioners and individuals.
- Coverage of community TB care programs have limited successes. This aspect of TB control is very important in addressing the social link between TB and poverty, TB and gender as well as TB and community health system structures.
- The participation of private health institutions in TB control services has been very minimal.
- The use of evidence-based data to inform better TB control planning, design, implementation, monitoring and supervision is also very weak. Most of the empirical data currently being utilized to access the burden of the disease are based on estimates.
- The coverage of 98% of LGAs in the country with DOTS services has not translated to reaching targeted population. Consistently between 2004 and 2008, the number new smear

[10] WHO Global TB Report 2009

positive cases have remained on steady increase. Rather efforts should be made at disaggregating coverage to the lowest household, communities and wards within LGAs for better targeted results.

- Even where DOTS are implemented in health facilities, defaulter tracing and retrieval systems have been on the lower side.
- There is also insufficiency in TB Laboratory infrastructures and capacities to address the burden of TB disease in Nigeria. Specifically rapid and quality-assured diagnostic test kits for tropical environments such as Nigeria.
- The procurement, supply chain management and distribution of high quality anti-TB drugs and Laboratory supplies have been donor driven and needs improvements. Government support and intervention in this direction will ensure provision of total care to individuals and communities affected by TB and reduce the twin burden of poverty.
- Poor dissemination and implementation of National policies, guidelines and standard protocols for TB treatment and control among public and private health practitioners has exacerbated increased number of MDR-TB and XDR-TB in communities.
- So far, there has been less emphasis on emerging trends in TB research and development in areas of new diagnostics, new drugs and new vaccines for the prevention, control and treatment of TB.

4.NIGERIA STOP TB PARTNERSHIP STRATEGY

Vision:

A Nigerian society free of Tuberculosis and associated socio-economic consequences.

Mission:

To create a massive movement of individuals and organizations committed to the fight against TB and its attendant consequences; ensure that every TB patient has access to high quality diagnosis, treatment and cure; recognizing effective service delivery to the needs of the poor and vulnerable in our communities; through partnership engagement and harmonization of efforts in TB care and control; remove barriers in accessing TB services and harness fully, resources for the elimination of TB in Nigeria and monitor progress towards attainment of the set targets within the context of the Millennium Development Goals (MDG) 6 and Stop TB Partnership.

Goal, Targets & Indicators

Goal: To contribute to the dramatic reduction of National and Global burden of Tuberculosis by 2015, in line with Millennium Development Goals and the Stop TB Partnership targets.

Targets:

- To halt and begin to reverse the incidence TB by 2015.
- To halve TB prevalence and death rates by 2015, compared to the 1990 levels
- To eliminate TB as a public health problem, defined as global incidence of active TB of less than one case per 1 million population per year by 2050. .

Key Indicators: Recognizing the magnitude of the challenges posed by TB, a number of few indicators were agreed at the global level to guide performance measurement. However, these key indicators do not preclude indicators for major component areas for TB control such as DOTS Expansion, TB/HIV, MDR-TB etc. The major key indicators are:

- TB incidence rate
- TB prevalence rate
- Mortalities associated with TB
- Knowledge, Attitude and Behaviour about TB

Guiding Principles:

Nigeria Stop TB Partnership will work to ensure that the under listed guiding principles are respected in all its activities. These values are:

Partnership: All efforts would be made to reach out systematically to engage with all partners and stakeholders in the fight against TB. This is aimed at maximizing the benefits accrued from proactive rather than passive involvement of all partners and coordinate better with Government, working groups, non-traditional partners, NGO, CBO, communities and individuals to strengthen the constituency of patient-TB cure relationship.

Equity: Emphasis will be on ensuring equal access to quality TB care and prevention. TB control will be viewed beyond traditional disease control and feature in wider health and socio-economic development agenda

Integration: All efforts would be made to ensure harmonization at various levels of the health system including the private sector; in a coherent manner that is responsive to the overall mission of the Nigeria Stop TB Partnership.

Rights-based Approach: The rights and privileges of every individual, group or organization will be respected and upheld at all time during the design, planning, implementation of the partnership agenda for TB control.

Multi-sectoral Collaboration: Considering TB as developmental issue, achieving positive health outcomes requires contributions from all sectors.

Transparency & Accountability: The management of financial, human, material and technical resources shall be undertaken to build confidence of accountability and reputation for the partnership.

Shared Responsibility & Inclusiveness: Everybody has a stake in ensuring set targets are achieved whether as short, medium or long term.

Strategic Approach:

Based on analysis of current situation of TB in Nigeria and in line internationally-recommended standards, six strategic approaches have been adopted by Nigeria Stop TB Partnership aimed at reducing the burden of TB. Each strategic approach has sub-components that contribute to the priority intervention area. These are:

Strategic Approach 1: To pursue high quality DOTS expansion and enhancement through:

a) Improved political commitment measured by sustained financial allocation, approval and release for TB care and control.
b) Ensuring early case detection and diagnosis through quality assured bacteriology.
c) Provision of standardized TB treatment and prevention regimen with supervision and patient support.
d) Ensuring an effective drug logistics and supply management
e) Effective monitoring and evaluation system based on performance and impact assessment.

Strategic Approach 2: Address TB/HIV, MDR-TB and the needs of poor and vulnerable populations

a) Scale-up collaborative TB/HIV activities
b) Scale-up prevention and management of MDR-TB
c) Address the needs of TB contacts, and of poor and vulnerable population

Strategic Approach 3: Contribute to health systems strengthening based on primary health care

a) Support improvement in National/State health policies and plan, human resource development, health financing and supplies, service delivery and information.
b) Strengthen infection control in health facilities, congregate settings and households.
c) Increase and upgrade number of laboratories and their networks proving investigative TB services.
d) Adopt and adapt successful innovative approaches from other fields, program areas or sector, to foster better action on the social determinants of health.

Strategic Approach 4: Engage all stakeholders and care providers

a) Involve all public, voluntary, corporate, communities, private providers and individuals through Public-Private Mix (PPM) approaches.
b) Promote use of international standards for TB care

Strategic Approach 5: Empower people with TB, and communities through partnership

a) Continuously pursue advocacy, communication and social mobilization activities
b) Foster community participation in TB care, prevention and health promotion

Strategic approach 6: Enable and promote research

a) Support the conduct of program-based operations research
b) Advocate for , participate in and use evidence-based researches developed in new TB diagnostics, anti-TB drugs and vaccines.

To scale-up these interventions, the strategic requirements are:

- Strong and persistent advocacy to promote, implement, scale-up and allocate resources in order to achieve internationally agreed goals and targets by 2015.
- Strengthen the health systems by building the capacity of critical mass at all levels of health sector and reducing the bottlenecks for access, availability, continued utilization of high quality TB services to achieve total coverage.
- Empower household and communities especially the poor and vulnerable groups to provide TB care and control services.
- Promoting strong operational partnerships to take promising interventions to scale with Government at all levels, NGOs, private health providers, donor agencies, implementing

partners, corporate organizations, communities and individuals in joint programming, co-funding and providing technical support services.

5. PRIORITY AREAS & STRATEGIC OBJECTIVES

This framework has been developed to serve as a guide to the Stop TB Partnership and implementing partners at National, State, LGA, Private sector and Communities in the selection of evidence-based priority interventions that would contribute to the attainment of set targets for the MDG and Stop TB Partnership. It is expected that institutions within the partnership will use this framework in the design, development and implementation strategic activities using participatory approaches to reflect their context and prevailing situations.

What is presented within the context of the Nigeria Stop TB Partnership are six evidence-based priority areas based on the global Stop TB Plan 2011 – 2015 while situating them appropriately within TB disease pattern in the local environment. The six identified priority areas that would improve TB performance in a holistic manner are:

1. DOTS Expansion
2. MDR – TB
3. TB/HIV
4. ACSM
5. New Diagnostics, Drugs, Vaccines and Research
6. Health Systems Strengthening, Poverty and Gender issues

These six critical priority intervention areas serves as collective roadmap and aligns with National TB and Leprosy Control Strategic Plan (2010 -2015) and goal to reducing significant the burden, socio-economic impact and transmission of TB in Nigeria[11].

[11] Draft National Strategic Plan for TB & Leprosy Control 2009.

Each priority area has clearly defined strategic objective(s) with focused interventions and detailed activities that would contribute to the attaining stated objectives. It is our hope and aspiration that the Nigeria Stop TB Partnership Strategic Plan 2013 – 2015 will form the basis of situating TB eradication within the National development agenda government of Vision 202:2020, National development plan and sectoral national health plan 2010 -2015.

DOTS EXPANSION

Nigeria is one of the 22 HBC that account for 80% of Global TB cases. It is estimated that XXX number of new cases of TB occur each in the country. In order to achieve set targets of beginning to reverse the trend of TB prevalence by 2015 and total elimination by 2050, it has become imperative to scale up DOTS expansion activities and models of enhancing TB case detection and cure rates in Nigeria. DOTS expansion assume strategic importance because TB can be treated and cured within eight months of chemotherapy using 'first-line drugs'. The involvement of all partners is essential to reach patients currently treated outside DOTS programmes, traditional healers, households and even clients in whom TB is not diagnosed at treated at all. Two strategic objectives have been identified under DOTS Expansion. These are:

MDR-TB

Multi-Drug Resistant TB (MDR-TB) and Extensive Drug Resistant TB (XDR-TB) are major threats to TB control efforts in Nigeria. The primary focus at the moment in the country is mostly on DOTS coverage. There is elevated risk of MDR-TB if success treatment rates are not sustained at very proportions and most laboratories lack of capacity to monitor drug resistance.. The non-availability of second line drugs is a major barrier to MDR-TB.

The new shift is to develop the capacities of care providers and integrate drug resistance surveillance and MDR-TB as part of the routine component of TB control providing easy access to diagnosis and treatment. To this effect, DOTS expansion will be implemented in collaboration with MDR-TB management measures.

TB-HIV

In Nigeria, it estimated that rate of TB infection among People Living with HIV is 27%. However, the rates of TB-HIV co-infection vary from State to State. States with high prevalence of HIV are more likely to carry higher burden of TB cases. TB is the major cause of mortality among HIV-positives accounting for one-in-three death among PLHIV. Over 35,200 new cases are added annually to the burden of TB from HIV infected people.

Currently, a TB-HIV working group exist in the country to facilitate collaborative activities between NTBLCP and National AIDS Control Agency (NACA). Currently, Isoniazid are provided for PLHIV when active TB are excluded, just as co-trimoxazole preventive therapy is given to PLHIV in DOTS centers. The National HIV program also provides ART to HIV-positive TB patients. With the Nigeria Stop Partnership, it is anticipated that all these services would be provided as part of integrated package of care.

ACSM

Advocacy, communication and social mobilization (ACSM) is an important means of engaging policy makers at Federal, State and Local Government levels, public and private health professional of diverse fields, traditional and religious leaders, community leaders, private and public health institutions, corporate organizations, civil societies, CBO and NGOs, patients and families to bring about sustainable behavioural and social changes that would contribute to reducing the burden of TB. It is critical to note that advocacy efforts put pressure on policy makers to increase the supply side of TB services while communication and social mobilization efforts generate demand for services.

In 2009, NTBLCP adopted a national ACSM guideline which focused on four key areas of mobilizing political commitment and resources for TB control, improving case detection and treatment adherence, empowering communities affected by TB and combating stigma and discrimination associated with TB. The major challenge has always remained with implementation and monitoring ACSM activities as outlined in the national guideline document.

Strategic Objective: To mobilize political commitment and ensure improved budgetary allocation and release of funds for TB control activities at all levels.

Key Interventions Areas:

- Advocacy for political and community support for TB services and information

- Foster participatory events of Nigeria Stop TB Partnership at National, State, LGA and communities.
- Build alliances to raise awareness about TB control and strengthening community participation for sustainability and ownership of Nigeria Stop TB Partnership.

Strategic Objective: By end of 2015, ensure that at least 60% of the population are empowered with knowledge of sign and symptoms of TB and service delivery areas using culturally acceptable ACSM mechanisms; from health care settings through communities to households.

Key Interventions Areas:

- Support the development, implementation and dissemination of key behavioural and social changes in knowledge, attitude and practices for TB control.
- Support improvements in TB case detection and treatment adherence
- Combating TB associated stigma and discrimination
- Mass media and behaviour change communications to inform and empower.

It is important to note that the ACSM working group at National, States and LGA levels will implement activities in close collaboration with other working groups within Nigeria Stop TB Partnership. Particular supporting behaviour change communication activities in DOTS Expansion, MDR-TB, TB-HIV, Research and Development. ACSM should be mainstreamed into sectoral plans of these working groups. In addition support NTBLCP, STBLCPs, academic institutions, civil society groups, other health sector agencies and local Leaderships at grass root levels, with the aim of expanding access to effective treatment for the poor, vulnerable and hard-to-reach population.

New Diagnostics, Drugs, Vaccines & Research

The use of AFB microscopy for the diagnosis of TB was the initial focus of DOTS strategy which emphasized the detection and treatment of sputum smear positive cases of pulmonary TB. AFB microscopy will not only identify people who are smear-negative, it cannot be used to detect drug-

resistant forms of TB which is common among PLHIV. To diagnose such cases, culture laboratories need to be established across Nigeria. A vigorous campaign to make accurate TB diagnosis available to all people who need it will require investments in new diagnostic competencies and coordinated technical assistance.

The NTBLTC Zaria has been identified as centre of excellence in building capacities of laboratory staff in TB diagnostics. Yet the numbers of such centres are insufficient to serve the multitude of Nigeria population of over 160 million. The NTBLCP set a target of establishing 1,500 AFB centres across primary health centers by end of 2010[12]. In addition, there is need to increase the number of microscopic centers across LGAs and establish systemic quality assurance structures across the six geo-political zones.

The development of new anti-TB drugs and vaccines is an inherently low and uncertain process in Nigeria. There have not been much coordinated efforts to invest on TB research. Efforts in the next three years will focus on communicating to medical research institutions in-country on broad research areas that will benefit from closer collaboration among disciplines including basic research, pharmaceutical product development, clinical research and epidemiology that are likely to yield significant advances in TB control by 2015 and beyond.

Health Systems Strengthening, Poverty and Gender

The achievement of most health related targets in Nigeria to a large extent depends on functional health systems that provide uninterrupted access, equity and quality care services including TB control. TB control programs at National, State and LGAs levels need further strengthening because of inadequacies in staffing and management of resources which vary widely across different States of the federation. So far innovative concepts through public-private partnerships and community organizations have improved capacities of staff in TB control through implementation of PPM DOT. The issue of human resource for health is one of the greatest challenges in TB control in Nigeria. This requires concrete actions across all levels of the health systems, all programs, donor funded projects, civil societies, the Nigeria Stop TB Partnership and all relevant stakeholders. Shortage of competent and motivated staff is one of the most important

[12] TB policy in Nigeria 2007

barriers to achieving the National TB control targets. Human resource issues for effective TB control are centred on three fundamental areas of insufficient quantity, quality and distribution of staff.

TB and Poverty:

The association between poverty and TB is well established. TB epidemics are more pronounced in rural Nigerian communities were poverty is endemic in term of overcrowding, inadequate ventilation, malnutrition and acceptance of routine immunization services. One of the long term measures include improvements in socio-economic conditions of the people. Improvements in some of the key socio-economic conditions will lead to reduction of TB incidence. Growing population explosion, combined with poor uptake of reproductive health services and lack of resources for infrastructural development have resulted in sprawling slum settlements in many urban and rural areas of Nigeria.

TB and Gender:

Estimates of TB burden in Nigeria show many more men (60%) than women have TB. This is total paradigm shift from where HIV infection rates is higher in women than men. The predominance of men among TB clients is more likely due to epidemiological differences between sexes than differential access to health. As such addressing gender-specific barriers to effective TB care can contribute to achieving National targets.

6. STRATEGIC IMPLEMENTATION PLAN 2013 – 2015

		Main Activities	Year 1				Year 2				Year 3				Means of Verification	Stakeholder Responsible
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4		
OVERALL GOAL: To contribute to the reduction of National and Global burden of Tuberculosis by 2015, in line with the Millennium Development Goals (MDG) and the Stop TB Partnership targets.																
1.0	To mobilize political commitment and ensure improved budgetary allocation and release of funds for TB control activities at all levels.															
	1.1	Advocacy for political and community support for TB control services and information														
	i.	Advocate to political leaders, policy makers, traditional and religious institutions on essence of TB control													Report and commitment to TB control	NSTBP
	ii.	Engage legislative assemblies at National and State levels to support implementation of Stop TB Partnership plan													Improved annual budgetary allocation to TB control activities	NSTBP, WHO, CSO networks on TB control, TB patients, IP agencies in TB control
	iii.	Facilitate formation National and States TWG on ACSM as well as LGA and community coordinating entities.													Terms of reference document	NSTBP
	iv.	Capacity building for implementation of ACSM activities at all levels													Training report	NSTBP, NTBLCP
	v.	Regular quarterly and annual ACSM TWG meeting													Report of TWG meeting	NSTBP
	vi.	Establish linkage with The Global Funds and other bilateral and multilateral agencies for financial support on ACSM activities with proposals													Approve from proposal and funding from these partnerships	NSTBP, NTBLCP, WHO, ILEP Partners
	vii.	Advocate to relevant government and non-governmental institutions, academia, policy makers, CSOs and philanthropist to generate political and financial commitment to effective TB control													Improved funding support	NSTBP, NTBLCP, WHO, ILEP Partners
	viii.	Support identification and promotion of TB champions both within Government sector (Ministries of Health, NACA,													List of active TB “champions”	NSTBP, NTBLCP, WHO, ILEP Partners

		Main Activities	Year 1				Year 2				Year 3				Means of Verification	Stakeholder Responsible
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4		
OVERALL GOAL: To contribute to the reduction of National and Global burden of Tuberculosis by 2015, in line with the Millennium Development Goals (MDG) and the Stop TB Partnership targets.																
		Finance, National Ass.), Non-Governmental (Private sector, CSO, Traditional & Religious Leaders) and Philanthropists.														
	ix.	Advocacy visits to organized private sector under the auspices of Pharmaceutical Group of Manufacturers Association of Nigeria (PGMAN) and other corporate organizations such as Banks, Chemical & Allied Ind., Food & Beverages etc													Letter of commitment and funding	NSTBP, NTBLCP, WHO, ILEP Partners
	1.2	Foster participatory events of Stop TB Partnership at National, State, LGA and communities.														
	i.	Support establishment of ACSM TWG at National and States levels composed of broad coalitions of stakeholders with Desk officers.													Terms of reference; Meeting report	NSTBP, NTBLCP, WHO, ILEP Partners
	ii.	Support celebration World TB Day and other international days of public health importance such as HIV/AIDS, Leprosy, Health weeks, etc													Published communiqué	FMOH, NACA, NSTBP, NTBLCP, WHO, ILEP Partners, CSO, States, TB Champions, Ind. etc
	iii.	Production of IEC and promotional materials in the form of pamphlets, posters, banners, customized bags, T-shirts and caps for World TB day celebration													Stock receipt vouchers of IEC materials	NSTBP, NTBLCP, WHO, ILEP Partners
	iv.	Support knowledge exchange visits and technical assistance from bilateral and multilateral organizations													Reports of TA	WHO, NSTBP,
	v.	Advocacy to private health providers for participation in NSTBP implementation													--	NSTBP, NTBLCP, WHO, ILEP Partners
	1.3	Build alliances to raise awareness about TB control for sustainability and ownership of Nigeria Stop TB Partnership.														

		Main Activities	Year 1				Year 2				Year 3				Means of Verification	Stakeholder Responsible
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4		
OVERALL GOAL: To contribute to the reduction of National and Global burden of Tuberculosis by 2015, in line with the Millennium Development Goals (MDG) and the Stop TB Partnership targets.																
	i.	Establish interactive multi-sectoral NSTBP website													Interactive web page	NSTBP
	ii.	Engage actively on TB control activities with professional bodies and associations such as Nigerian Thoracic Society (NTS)													Memorandum of understanding (MoU)	NSTBP, NTBLCP, WHO, ILEP Partners
	iii.	Support collaborative workshops on TB & HIV interventions through technical assistance and support services from NACA, NASCP and other donor funded HIV/AIDS programs													Workshop reports	NSTBP, NTBLCP, NACA, FMOH, SMOH, SACA
	iv.	Support regular quarterly coordination meeting of network of CSOs working in various facets of TB control activities including academia.													Report of quarterly meeting	NSTBP, CSO networks on TB control
	v.	Conduct biennial National TB conference													Communiqué from the conference	NSTBP, CSO, ACSM TWG, Bilateral and multilateral organizations.
	vi.	Support printing of 1000 copies and dissemination workshop of adopted NSTBP strategic plan 2013 - 2015													Copies of NSTBP Strategic Plan	NSTBP
	vii.	In collaboration NTBLCP, build capacities of national, states, LGA and CSOs focal persons in ACSM strategies for TB control													Training reports	NTBLCP, NSTBP, WHO, CSO Networks on TB control.
2.0	By end of 2015, ensure that at least 60% of the population are empowered with knowledge of sign and symptoms of TB and service delivery areas using culturally acceptable ACSM mechanisms; from health care settings through communities to households.															
	2.1	Mass media and behaviour change communications to inform and empower.														
	i.	Media roundtables with TB champions, clients, service providers, experts and advocates													Reports; Editorial features on TB	NTBLCP, NSTBP, WHO, CSO Networks on TB control.

		Main Activities	Year 1				Year 2				Year 3				Means of Verification	Stakeholder Responsible
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4		
OVERALL GOAL: To contribute to the reduction of National and Global burden of Tuberculosis by 2015, in line with the Millennium Development Goals (MDG) and the Stop TB Partnership targets.																
	ii.	Develop behaviour change communication materials such as IEC, fact sheets, policy briefs, information brochure on TB control efforts in Nigeria													Sample IEC materials and other BCC materials developed	NTBLCP, NSTBP, WHO, CSO Networks on TB control.
	iii.	Empower and link communities and people affected by TB with poverty reduction agencies through transport subsidy and knowledge on nearest TB treatment and control centers.													Report of TB clients accessing poverty reduction funds	NTBLCP, NSTBP, WHO, CSO Networks on TB control.
	iv.	Build capacities of media organizations and Journalists from Television, Radio, Newspaper outfits on TB control activities and reportage													Training report	NTBLCP, NSTBP, WHO, CSO Networks on TB control.
	v.	Compliment and sustain media campaigns with local dramas, road shows and interpersonal communication in communities													Report on number of communities reached	NTBLCP, NSTBP, WHO, CSO Networks on TB control.
	2.2	Support the development, implementation and dissemination of key behavioural and social changes in knowledge, attitude and practices for TB control.														
	i.	Develop and disseminate culturally sensitive media messages on TB prevention and control in electronic, print and traditional media													E-copies of media messages	NTBLCP, NSTBP, WHO, ILEP Partners, CBO, States, CSO Networks on TB control etc
	ii.	Promote educational sermons in mosques, churches, workplaces, schools etc to reduce stigma associated TB and enhance positive health seeking behaviour.													Copies of sermons delivered	NTBLCP, NSTBP, WHO, CSO Networks on TB control.
	iii.	Develop IEC material across technical areas of DOTS, MDR-TB and TB/HIV services													Samples of materials and other BCC materials	NTBLCP, NSTBP, WHO, CSO Networks on TB control.

		Main Activities	Year 1				Year 2				Year 3				Means of Verification	Stakeholder Responsible
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4		
OVERALL GOAL: To contribute to the reduction of National and Global burden of Tuberculosis by 2015, in line with the Millennium Development Goals (MDG) and the Stop TB Partnership targets.																
															developed	
	iv.	Ensure regular supply of condoms, family planning services, IEC materials at DOTS centers													Sample products and stock delivery sheets	NSTBP, NACA, NASCP, SACA, LACA, WHO, CSO Networks on TB control.
	v.	Support TB control events and health promotion activities with development and dissemination policy briefs and fact sheets.													Reports of health promotion events	NTBLCP, NSTBP, WHO, CSO Networks on TB control.
		Conduct impact assessment of media messages on TB control in Nigeria													Report of assessment findings	NSTBP, WHO, CSO Networks on TB control.
	2.3	Support improvements in community TB case detection and treatment adherence														
	i.	Develop and implement effective communication strategic approach to TB control at National, State, LGA and communities using various participatory approaches													Copy of communication strategy document	NSTBP, NACA, NASCP, SACA, LACA, WHO, CSO Networks on TB control.
	ii.	Sensitize traditional and religious leaders as intervention channels in community TB.													Report	NSTBP, WHO, CSO Networks on TB control.
	iii.	Involvement of TB patients and PLHIV as advocates of TB control													Membership list	NSTBP, WHO, CSO Networks on TB control.
	iv.	Domesticate and use appropriate channel of communications to community gatekeepers													----	NSTBP, WHO, CSO Networks on TB control.
	v.	Build capacities of community leaders and volunteer on TB suspects and prompt referral.													Training report	NSTBP, WHO, CSO Networks on TB control.
	vi.	Engage community leaders in monitoring ACSM activities to measure outputs and audience satisfaction													Monitoring report	NSTBP, WHO, States, LGAs, Community Leaders,

		Main Activities	Year 1				Year 2				Year 3				Means of Verification	Stakeholder Responsible
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4		
OVERALL GOAL: To contribute to the reduction of National and Global burden of Tuberculosis by 2015, in line with the Millennium Development Goals (MDG) and the Stop TB Partnership targets.																
																CBO, CSO Networks on TB control.
	i.	Develop and build capacities of community TB volunteers and supporters as educators, social mobilizers, adherence counsellors and monitors													Training report; Attendance list	NSTBP, WHO, States, LGA, CBO, CSO Networks on TB control.
	i.	Develop National guideline on community TB volunteer workers													Copy of guideline document	NSTBP, WHO, ILP Partners, CSO Networks on TB control etc
	ii.	Involve TB patients and affected communities to participate effectively in Community TB program planning, design, implementation at State, LGA and communities.													Consolidated community TB implementation plan	NSTBP, WHO, CSO Networks on TB control.
	iii.	Establish linkages with ward development committees (WDCs) for community TB control													Membership list; Reports of meetings	SSTBP, WHO, CSO Networks on TB control.
	iv.	ACSM targeted training for traditional and religious community leaders													Report and attendance list	NSTBP, SSTBP, WHO, CSO Networks on TB control.
	v.	Support the selection, training and kitting of community TB volunteers. The kits will include 2 uniforms, 2 pair of shoes, 1 pair of gumboots and 1 bicycle every two years.													Sample kits procured	NSTBP, WHO, CSO Networks on TB control.
	vi.	Build capacities of community structures including women groups on TB control measures, treatment adherence and support													Training report	NSTBP, SSTBP, WHO, CSO Networks on TB control, CBO and Individuals.
	vii.	Build capacities of private health													Training report	NSTBP, SSTBP,

		Main Activities	Year 1				Year 2				Year 3				Means of Verification	Stakeholder Responsible
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4		
OVERALL GOAL: To contribute to the reduction of National and Global burden of Tuberculosis by 2015, in line with the Millennium Development Goals (MDG) and the Stop TB Partnership targets.																
		providers including corporate health clinics in community TB care														WHO, CSO Networks on TB control, CBO and Individuals.
	viii.	Regular supervision, monitoring and evaluation of community TB services with regular feedback to communities													Supervision checklist and reports therein	NSTBP, SSTBP, WHO, CSO Networks on TB control, CBO and Individuals.
	2.4	Combating TB associated stigma and discrimination														
	i.	Engage TB patients in DOTS facilities and outreach services; as supporters and adherence counsellors													Number of TB clients successfully reached	NSTBP, SSTBP, WHO, CSO Networks on TB control, CBO and Individuals.
	ii.	Address stigma and discrimination associated with TB and HIV to promote dual access using TB and HIV champions.														NSTBP, WHO, CSO Networks on TB control.
	iii.	Documentation, exchange visits and sharing of best practices in TB control and related diseases													Reports	
	iv.	Review and update existing draft HIV stigma and discrimination bill to include TB associated stigma reduction approaches.													Revised and approved Stigma bill	NSTBP, WHO, CSO Networks on TB control.
	v.	Support establishment of TB support groups in high and low risk communities and LGAs													Minutes of meeting; Attendance	NSTBP, WHO, CSO Networks on TB control.
	vi.	Promotion of peer education among communities and TB patients in high risk communities and LGAs.													Report of peer visits	NSTBP, WHO, CSO Networks on TB control.

7. FINANCIAL RESOURCE REQUIREMENT

This section considers the current trends in health expenditure in Nigeria to estimate financial resources needed for achieving the goals and target set within the Nigeria Stop TB strategic plan 2013 – 2015. The interplay of funding sources and financing agents that support the Nigerian health system is critical in ensuring adequate and timely resourcing of the strategic plan. Some of these additional financing agencies include bilateral and multilateral international agencies as well as Global public-private partnership institutions such as Global Funds to fight AIDS, Tuberculosis and Malaria (GFTAM).

The process of developing this plan has identified key intervention areas for investment required for achieving the Nigeria Stop TB Partnership, National and MDG targets in line with the overall development plan of the country as stipulated in Nigeria's Vision 20:2020 blueprint. The financial resource requirement was therefore developed and based on careful review of current estimated cost of similar activities, available and potential sources of additional resources, financial strategies relevant to the Nigerian context and fund allocations at Federal, State and LGA for achieving measureable results.

Critical analysis of health funding trends in Nigeria indicates the role of government contribution to promote equitable access to essential health services, particularly for the poor and vulnerable such as women and children who are also mostly affected by TB.[13] With limited external aid, the onus lies on government at all levels to provide at least 60% of the resources required for the implementation of the three year strategic plan.

Determinants of NSTB Plan Budget

Some of the key determinants of resource allocation for implementing Nigeria Stop TB Partnership Plan 2013 – 2015 include:

- Current level of Tb transmission, burden and associated stigma
- Current level of HIV transmission and associated stigma
- MDR – TB and associated issues

[13] Nigeria Health Accounts 2010 - 2015

- Accessibility and efficiency of Nigeria decentralized health systems to provide DOTS services particular at primary health care level.
- Cultural sensitivity and diversity of the Nigerian population
- Understanding of the factors that influence treatment seeking behaviour including gender consideration
- Socio-economic status of the affected population
- Demographic distribution
- Consideration of different types and channels of communication and community structures

An incremental approach is adopted over the three year plan period (2013 -2015). Experience has shown that absorptive capacity might be initially low due to health systems consideration (human resources, infrastructure, service provider capacity, ACSM capacity etc). Overtime, expenditure target for TB control and prevention, begin to peak when stigma is reduced, gender inequality is low, improved treatment seeking behaviours, sustained behaviour change communications, and positive attitude of health workers.

Table XXX

Estimated Cost of Nigeria Stop TB Strategic Plan 2013 – 2015 (US$ millions)

Classification	2013	2014	2015	All Years (2013 – 2015)	% Total
Advocacy	0.28	0.35	0.52	1.14	2.49
Communication, Media engagement activities	2.87	3.59	5.39	11.85	25.91
Social mobilization	2.74	3.43	5.14	11.32	24.73
Capacity building	1.76	2.20	3.32	7.27	15.89
Technical assistance	1.25	1.57	2.35	5.17	11.30
Technical working group and sub-groups coordination meetings	1.89	1.48	2.23	4.90	10.71
Policy planning and implementation	0.28	0.35	0.51	1.12	2.45

Service improvement support	0.68	0.85	1.27	2.79	6.10
Monitoring and Evaluation including assessments	0.05	0.08	0.10	0.18	0.39
TOTAL AMOUNT (US$ millions)	**11.09**	**13.86**	**20.79**	**45.75**	

The total estimated cost of the Nigeria Stop TB Partnership Strategic Plan 2013 – 2015 for the three year period is USD 45,748,310 million which is equivalent to =N=6,862,246,500. This estimated cost of the different strategic ACSM interventions if properly implemented would improve the access to available quality TB services and information.

The costing took cognisance of implementation at Federal, State and LGA as well as community directed interventions especially in areas of differential communication strategies that would be adopted based on culture and attitude of the targeted population. However, geo-political zonal communication, media and social mobilization strategies would be best adopted as cost saving mechanism.

Majority of technical assistance (TA) support would come mostly from bilateral, multilaterals and development partners through organizational development assistance support to TB control and prevention in Nigeria. It suffices to mention that this plan excludes investment in health facilities improvement / renovations, procurement logistics, provision of anti-TB drugs, laboratory consumables and commodities and advances in research efforts and dissemination in areas of new diagnostics, anti-TB and vaccines.

8. MONITORING & EVALUATION FRAMEWORK

The Nigeria Stop TB Partnership recognizes that stakeholder engagement and harmonization of efforts in TB care and control, and the harnessing of resources for the elimination of TB in Nigeria is very critical to achieve set targets within the context of the National TB control program and Millennium Development Goals (MDG). This can only be achieved with regular monitoring of performance indicators to assess progress as stated in the Stop TB plan 2013 - 2015.

The main objective the proposed Monitoring and Evaluation (M & E) framework therefore is to provide accurate, reliable and timely data and information on progress made towards the end-line of the Nigeria Stop TB Plan and provide regular reporting of performance to all stakeholders.

RESULT MATRIX

The result matrix set out below contains set of indicators on outcome, outputs, processes and inputs. Some of these indicators would require population based data while others might require facility-based information collected by surveys, quantifiable supervision checklists, Health Management Information System (HMIS), routine programme reports and data from published reports, trend monitoring and records. All the indicators included in this matrix are clearly defined and baselines provided where available. Performance target for each of the these indicators have been established on year basis from 2013 – 2015 through consultative process with key stakeholders.

Monitoring & Evaluation Result Matrix

Outcome Objective	Indicator	Source of Data	Frequency	Baseline (Value; Year)	Target Year		
					2013	2014	2015
Increased political and financial commitment to TB control activities at National, State and LGA levels.	Percentage increase in National and States annual budgets spent on TB control activities.	Approved annual budget report	Yearly	NA	--	--	--
	Percentage of National and States annual TB budgets spent on ACSM	Approved sectoral annual budget	Yearly	NA	--	--	--
	Percentage of States and/or LGAs with designated social mobilization and communication staff with appropriate experience[14]	Interview with State / LGA TB Managers	--	--	--	--	--
	Proportion of States and/or LGAs that have developed and implemented operational plans for TB control social mobilization activities.	Interview with State / LGA TB Managers	--	--	--	--	--
By end of 2015, at least 60% of the population are empowered with knowledge of TB and service delivery points; using culturally acceptable ACSM	Number of TV, radio and print programmes produced and disseminated on TB control activities and aired as public service	Monitoring charts	Monthly	--	10%	30%	60%

[14] Appropriate experience refers to set criteria such as tertiary education training, field experience in mass communication etc.
NA – Not Applicable

Outcome Objective	Indicator	Source of Data	Frequency	Baseline (Value; Year)	Target Year		
					2013	2014	2015
mechanisms; from health care settings through communities to households.	announcements						
	Number of traditional rulers, religious leaders, service providers and media personnel trained in TB ACSM and interpersonal communication skills	Training report	--	--	NA	NA	NA
	Number of civil society organizations (including CBOs) reached and active in TB communication and social mobilization activities	NSTBP records	Quarterly	--	--	--	--
	Number of TB and TB/HIV support groups formed and active	Membership list	Quarterly	--	--	--	--
	Number of people reached with promotional materials during World TB Day celebration.			--	NA	NA	NA
	Proportion of States/LGAs that have active pro-poor incentive schemes for TB-patients on DOTS	Financial records	Yearly		20%	30%	50%
	Percentage of the population who are aware that chronic cough (at least for 3 weeks) could be sign of TB	Nigeria DHS report 2008 NARHS 2007	Every five years	72%; NARHS 2007	80%	90%	95%
	Percentage of the	Nigeria DHS		64%; NARHS	70%	75%	80%

Outcome Objective	Indicator	Source of Data	Frequency	Baseline (Value; Year)	Target Year		
					2013	2014	2015
	population who know the location of their nearest sputum-testing facility	report 2008 NARHS 2007		2007			
	Percentage of the population who know TB is curable	Nigeria DHS report 2008 NARHS 2007		80%; NARHS 2007	90%	90%	95%
	Percentage of the population who know that TB treatment through DOTS is free	Nigeria DHS report 2008 NARHS 2008		NA	--	--	--

9. RISK & ASSUMPTIONS

7.1 Deteriorating Health Systems

Successful TB control strategies rely heavily on functioning general health systems. TB programs at Federal, State and LGA levels operate within the context of the Nigeria health systems. Today, the health system struggle to implement high quality services in the face severe health work force crises; low levels of public funding for health care, weak government stewardship functions and disintegrated health service networks between primary, secondary and tertiary level of care.

TB prevention control in Nigeria is one of the public health challenges that need urgent attention because the country ranks among the twenty-two high TB burden nations in the world and fourth highest in Africa with over 280,000 estimated cases of all forms of Tuberculosis annually. As such this make TB control itself one of the facet of the health system development. To invest more in TB means investing more in improved health system. This is the more reason why the Nigeria Stop TB Partnership needs to join forces with other stakeholders in public health diseases, health system development, overseas development assistance etc to find ways to strengthen all the facets of functional health system such as – human resource for health, health financing, stewardship, service delivery, infrastructural upgrade, health research and functional partnership building.

7.2 Weak Private Participation

TB control efforts in Nigeria have suffered too long, due to weak private sector participation and low recognition for clearly defined roles and responsibilities within the health sector reform of government. New approaches to further strengthen implementation of private sector partners through PPM DOTS and community DOTS provides additional opportunities in harnessing available resources for improve TB control. The risk that the role of government sector as the albatross of TB control in Nigeria is overblown and needs to be addressed, with substantial efforts to bring in private sector providers and civil society organizations. Capacity needs of private and civil society groups in stewardship functions, supervision, quality data, programme management, granting and contracting, policy inclusion, enforcement of regulations etc should

be strengthened. Nigeria Stop TB partnership needs to strongly advocate for increased resources to strengthen private sector participation in TB prevention and control activities.

7.3 Cycle of Poverty and TB

It is clear now that there is causal relationship between poverty and TB. Under long term conditions, Nigeria's socio-economic development to some extent is linked to TB control measures in place. This has been clearly demonstrated in high income countries where TB incidence is on the decline due to improve socio-economic status of the population. Nigeria Stop TB Partnership should pay more attention and reduce the risk of impact of poverty and socio-economic development on TB epidemic.

7.4 Donor Dependency

Health reform in Nigeria is on the concurrent list with each level of governance giving priority to the health needs of its population. At the Federal level, Nigeria TB & Leprosy Control programme provides leadership and policy direction for TB control activities to all States and LGAs. However, even at the National level, there is tendency towards more donor dependent activities to support TB control efforts. Available funding for the National TB programme to achieve its set targets are most often inadequate or not provided on time. Nigeria Stop TB Partnership needs to work with all stakeholders to leverage additional resources from public , private and corporate institutions to support TB control.

7.5 HIV Epidemic & Control

Currently, HIV epidemic and control in Nigeria is stagnating at 4.4% with some States worst hit than others. HIV is also the major driver of increasing TB cases across the country. These two disease are controlled by two different agencies of government that need to work more collaboratively than ever before. Therefore it will be impossible to reach the 2015 targets and 2050 goal of eliminating TB as public health problem if HIV epidemic remains unchecked. Nigeria Stop TB Partnership must continue to advocate for impact mitigation of HIV/AIDS epidemic and promote HIV prevention and treatment as a vital component of TB control strategy.

7.6 Low TB Technical Assistance Mechanism

With the high burden of TB in Nigeria, there is low technical assistance support to Nigeria TB control programme and institutions to develop and adapt to new development approaches in new drugs, vaccines, diagnostics and research agenda on TB control as well as build sustainable national and local capacities. These new evolutions can only be tapped by availing the Nigeria Stop TB Partnership the opportunity to work close with the worldwide network of TB experts dedicated to providing technical assistance. This would help uptake of new innovative approaches and tools to improve TB control while integrating into these activities within the National TB and Leprosy Control Programme.