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# THE NATIONAL STRATEGIC PLAN FOR TUBERCULOSIS AND LEPROSY CONTROL (2010-2015)


**Federal Republic of Nigeria**

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# THE NATIONAL STRATEGIC PLAN FOR TUBERCULOSIS AND LEPROSY CONTROL (2010-2015)

February 2011

This publication was produced for review by the United States Agency for International Development. It was prepared by (Add all authors names) for Health Systems 20/20 Project.

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# ACRONYMS

| | |
|---|---|
| **ACSM** | Advocacy, Communication, and Social Mobilization |
| **AFB** | Acid Fast Bacillus |
| **AIDS** | Acquired Immune Deficiency Syndrome |
| **ART** | Antiretroviral Therapy |
| **CBO** | Community-based organization |
| **CBR** | Community-based rehabilitation |
| **CDC** | Centers for Disease Control and Prevention |
| **CDR** | Case Detection Rate |
| **CIDA** | Canadian International Development Agency |
| **CPT** | Co-trimoxazole Preventative Therapy |
| **CSO** | Civil society organization |
| **CTBC** | Community TB Care |
| **CV/TS** | Community volunteer/Treatment supporter |
| **DOT** | Directly observed therapy |
| **DOTS** | DOT Short Course |
| **DST** | Drug Sensitivity Test |
| **EHF** | Eyes, Hands, Feet score; a measure of severity and disability |
| **FBO** | Faith-based Organizations |
| **FCT** | Federal Capital Territory |
| **FMOH** | Federal Ministry of Health |
| **GHCW** | General health care worker |
| **GOPD** | General Outpatient Department |
| **HCT** | HIV counselling and testing |
| **HCW** | Health Care Worker |
| **HDL** | Hospital DOTS Linkage |
| **HIMS** | Health information management system |
| **HIV** | Human Immunodeficiency Virus |
| **HR** | Human Resources |
| **HRD** | Human Resources Development |
| **IC** | Infection Control |
| **IEC** | Information, Education and Communication |
| **ILEP** | International Federation of Anti-Leprosy Associations |
| **IP** | Implementing Partner |
| **IPT** | Isoniazid Preventative Therapy |
| **ISTC** | Independent Sector Treatment Center |

| | |
|---|---|
| **IT** | Information Technology |
| **LEC** | Leprosy Elimination Campaign |
| **LGA** | Local Government Area |
| **LMIS** | Logistics Management Information System |
| **M&E** | Monitoring and evaluation |
| **MB** | Multibacillary (leprosy) |
| **MDGs** | Millennium Development Goals |
| **MDR-TB** | Multi-Drug Resistant Tuberculosis |
| **MDT** | Multi-Drug Therapy |
| **MO** | Medical Officer |
| **NGO** | Nongovernmental Organization |
| **NIMR** | Nigerian Institute for Medical Research |
| **NRL** | National Reference Laboratory |
| **NTBLCP** | National Tuberculosis and Leprosy Control Program |
| **NTBLTC** | National Tuberculosis and Leprosy Training Center |
| **PAL** | Person affected with leprosy |
| **PB** | Paucibacillary (leprosy) |
| **PHC** | Primary Health Care |
| **PLHIV** | People Living with HIV and AIDS |
| **POID** | Prevention of Impairment and Disability |
| **PPM** | Public-Private Mix |
| **PRS** | Preventive and rehabilitative surgery |
| **PSM** | Procurement and Supply Management |
| **QA** | Quality Assurance |
| **RR** | Recording and reporting |
| **SCC** | Short Course Chemotherapy |
| **SI** | Strategic Information |
| **SOP** | Standard Operating Procedures |
| **TA** | Technical Assistance |
| **TB** | Tuberculosis |
| **TBCAP** | Tuberculosis Control Assistance Program |
| **TBL** | Tuberculosis and Leprosy |
| **TWG** | Technical working group |
| **TOT** | Training of trainers |
| **USAID** | United States Agency for International Development |
| **WHO** | World Health Organization |
| **ZRL** | Zonal Reference Laboratories |

# FOREWORD

The worldwide tuberculosis (TB) epidemic is a major global health crisis. Nigeria, a country ranked fourth among the 22 countries with the highest TB burden in the world, and first among countries in Africa, has its fair share of the crisis. Similarly, despite Nigeria's attainment in December 1998 of the global leprosy elimination goal of less than one case per 10,000 population, the National Tuberculosis and Leprosy Control Program (NTBLCP) still reports about 5,000 registered leprosy cases annually, with more than one in every 10 new patients already having visible physical disabilities at diagnosis. This adds yearly to a growing pool of unfortunate Nigerians permanently disabled by leprosy.

There are many new challenges to the control and prevention of TB. These include the impact of HIV/AIDS and the emergence of multi-drug resistant tuberculosis (MDR-TB). The HIV/AIDS pandemic not only exacerbates the TB burden – HIV prevalence among TB cases in Nigeria is estimated at 27 percent (WHO 2009) – it also poses great challenges to TB diagnosis and management.

Achieving the Millennium Development Goals demands that the NTBLCP take a more proactive role and ownership in creating an enabling environment for implementation. Thus, this Strategic Plan for TB and Leprosy Control seeks to ensure the implementation of the TB control activities in Nigeria, in line with the Stop TB Strategy and the Global Plan to Stop TB 2006–2015.

In the implementation of this strategy, we will form strategic alliances and partnerships with all stakeholders including civil society organizations. We expect that all key stakeholders will use this document to guide their respective TB and leprosy work plans, in the spirit of the “three ones” – one coordination mechanism, one national strategic plan, and one monitoring and evaluation plan.

Linus Awute, mni

Permanent Secretary

Federal Ministry of Health

Federal Republic of Nigeria
June 2010

# ACKNOWLEDGEMENTS

The National Tuberculosis and Leprosy Strategic Plan 2010 – 2015 was developed based on the Stop Tb strategy, the Global Plan to stop TB 2006 – 2015 as well as the Millennium Development Goals. It was produced with the support of the United States Agency for International Development (USAID) through the Health Systems 20/20 project. Other organizations who contributed to this effort include World health Organization (WHO), Tuberculosis Control Assistance Programme (TBCAP), International Federation of anti-leprosy Organizations (ILEP), Family Health International (FHI-GHAIN), Institute of Human Virology Nigeria (IHVN), United States Centers for Disease Control and Prevention (CDC), and various Civil Society Organizations.

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# STAKEHOLDERS' DECLARATION

## DECLARATION OF STAKEHOLDER COMMITMENT TO THE NATIONAL STRATEGIC PLAN FOR TUBERCULOSIS AND LEPROSY CONTROL FOR THE DEVELOPMENT AND IMPLEMENTATION OF A COSTED TB AND LEPROSY PLAN AT ALL LEVELS

### 1. Context

We, the stakeholders involved in and supporting the provision of health services in Nigeria relating to tuberculosis and leprosy,

1.1 Recognizing that health is a basic human right, subscribe to the achievement of all the Millennium Development Goals (MDGs).

1.2 Acknowledge global and regional efforts to strengthen partnerships for health (such as International Health Partnership and Harmonization for Health in Africa).

1.3 Affirm our need to be responsive to the principles of the Paris Declaration on Aid Effectiveness in terms of:

- **Ownership:** the federal, state and LGAs exercise effective leadership over health development policies and coordinate health development plans and efforts.
- **Alignment:** health development partners base their overall development assistance on the National Strategic Plan for TB and Leprosy Control.
- **Harmonization:** implementing partners effectively coordinate within the program and harmonize activities in sequence.
- **Managing for Results:** National Tuberculosis and Leprosy Control Program (NTBLCP) and its partners work together to manage technical and financial resources towards achieving concrete results.
- **Mutual Accountability:** The federal, state, LGAs, technical and implementing partners, and other stakeholders hold each other accountable for results and outcomes.

1.4 Recognize that the Federal Ministry of Health (FMOH) has a broad mandate as the national coordinating authority on health.

1.5 Recognize the National Health Management Information System (NHMIS) as the single monitoring and evaluation framework, to track, monitor, and evaluate the NTBLCP.

### 2. Principles

We the undersigned, this 10th day of January 2011, declare our commitment to the following principles:

2.1 To strengthen capacity for active involvement of communities at all levels of service delivery for TB and leprosy control.

2.2 To work jointly, expanding utilization and delivery options and coordinating technical assistance.

2.3 To work in a result-focused and transparent manner, employing participatory approaches that involve representation of all stakeholders not only within the context of prevention, but beyond.

2.4 To ensure that partners are well coordinated to ensure the effectiveness of aid.

2.5 To support the FMOH through the NTBLCP in discharging its mandate as the coordinating authority for TB and leprosy control in Nigeria.

## 3. Undertakings

Bearing in mind that Nigeria is not on target toward meeting the health-related MDGs, we therefore resolve to take immediate and relevant actions in addressing the complexities and challenges presented by the burden of TB and leprosy through the National Strategic Plan (NSP) as listed below, and to build on these and other national and global commitments for future health investments:

3.1 Promote the use of the NSP for TB and leprosy for the development of health plans for each tier of government.

3.2 Ensure that appropriate and broad-based partnerships are built with the community and media to promote behavioral change towards improved health.

3.3 Engage all stakeholders under the leadership of the NTBLCP to update programs and projects to promote compatibility with the NSP.

3.4 Strive to synchronize planning and review cycles in line with the annual review and planning systems, in order to maximize the use of national capacities and competencies.

3.5 Promote data collection through harmonized reporting procedures and timelines within the national framework; strengthen information sharing and knowledge management mechanisms for better planning.

3.6 Create a conducive environment for the advancement of science and research in Nigeria while adhering to the highest ethical and scientific standards.

**IN WITNESS WHEREOF**, the undersigned, being duly authorized representatives of the parties hereto have signed this Declaration of Commitment on the day and year first above written.

**Signed:**

# EXECUTIVE SUMMARY

Tuberculosis (TB) is a serious public health challenge in Nigeria. The World Health Organization (WHO) estimates the incidence rate for all forms of TB at 311 per 100,000 population, incidence of smear positives annually at 131 per 100,000 population, and prevalence at 546 per 100,000 population (WHO 2009). These figures place Nigeria fourth among the 22 high-burden countries in the world.

At the end of 2004, Directly Observed Therapy, Short course (DOTS) was expanded to all 36 states and the Federal Capital Territory (FCT). The number of local government areas (LGAs) implementing DOTS varies from state to state: as of December 2008, 98.8 percent of the LGAs in the country (765 out of 774) had at least two to three health facilities implementing DOTS. There were also 969 TB microscopy centers in 494 LGAs (64 percent LGA coverage).

The review of the National Tuberculosis and Leprosy Control Program (NTBLCP) done in 2009 acknowledged that significant progress was made in the control of TB and leprosy. Nevertheless, significant challenges remain: the NTBLCP depends heavily on external funding; communication and coordination are weak; laboratory services, including diagnosis of multi-drug resistant TB (MDR-TB) are limited; access to quality DOTS remains low: stock-outs of drugs and reagents is common; and the monitoring and evaluation (M&E) system is weak.

The approach adopted in the current NTBLCP Strategic Plan 2010–2015 is based on both the Stop TB Strategy and the Global Plan to Stop TB. The plan seeks to strengthen leadership and management skills at all levels and to strengthen and expand DOTS as well as TB/HIV services in the public and private sectors. The plan will expand the laboratory network for culture, drug susceptibility testing, and microscopy, while establishing MDR-TB treatment services. All of these will be supported by a robust commodity management system. This comprehensive and sustained response also gives special attention to human resource development.

## GOAL:

The overall goal of the NTBLCP Strategic Plan 2010–2015 is to reduce significantly the burden, socio-economic impact, and transmission of TB and leprosy in Nigeria, in line with the targets set by the Millennium Development Goals and Stop TB Partnership.

## STRATEGIES:

1. Pursue high-quality DOTS expansion and enhancement.
2. Strengthen TB/HIV collaborative activities.
3. Establish MDR-TB services.

4. Engage all care providers, public and private, in a strategic alliance including academic, private, and other public practitioners.
5. Engage communities and patients in TB activities.
6. Strengthen advocacy, communication, and social mobilization.
7. Do early case detection for leprosy.
8. Ensure case holding (leprosy).
9. Prevent disability (leprosy).
10. Offer comprehensive rehabilitation services (leprosy).
11. Do research.
12. Strengthen human resource capacity.

The following table summarizes the 2010–2015 budget:

| 2010 - 2015 TUBERCLOSIS AND LEPROSY STRATEGIC PLAN SUMMARY | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | THEMATIC AREAS | YEAR 1 | YEAR 2 | YEAR 3 | YEAR 4 | YEAR 5 | TOTAL | *$ value* |
| 1 | LEPROSY | 347,605,900 | 346,196,235 | 363,506,047 | 381,681,349 | 400,765,417 | 1,839,754,947 | 13,141,107 |
| 2 | Community TB Care (CTBC) | 105,032,500 | 91,402,600 | 92,316,626 | 93,239,792 | 94,172,190 | 476,163,708 | 3,401,169 |
| 4 | Monitoring and Evaluation (M&E) | 1,075,067,900 | 796,247,842 | 823,526,730 | 812,252,424 | 840,079,617 | 4,347,174,513 | 31,051,247 |
| 5 | Human Resources Development (HRD) | 2,074,897,838 | 2,014,609,164 | 2,062,140,256 | 2,093,064,669 | 2,103,589,276 | 10,348,301,203 | 73,916,437 |
| 6 | Advocacy, Communication and Social Mobilization (ACSM) | 315,556,000 | 318,711,560 | 321,898,676 | 325,117,662 | 328,368,839 | 1,609,652,737 | 11,497,520 |
| 7 | Procurement Supply Management (PSM) | 1,710,260,323 | 1,727,362,927 | 1,744,636,556 | 1,762,082,922 | 1,779,703,751 | 8,724,046,479 | 62,314,618 |
| 8 | TB/HIV Collaborative | 107,117,100 | 108,188,271 | 109,270,154 | 110,362,855 | 111,466,484 | 546,404,864 | 3,902,892 |
| 9 | DOTS Expansion | 1,403,631,200 | 1,417,667,512 | 1,431,844,187 | 1,446,162,629 | 1,460,624,255 | 7,159,929,783 | 51,142,356 |
| 10 | Multi- Drugs Resistance Tuberclosis (MDR) | 1,767,327,000 | 1,785,000,270 | 1,802,850,273 | 1,820,878,775 | 1,839,087,563 | 9,015,143,881 | 64,393,885 |
| 11 | Laboratory | 1,476,506,960 | 1,488,109,417 | 1,502,990,511 | 1,518,020,416 | 1,533,200,620 | 7,518,827,923 | 53,705,914 |
| 12 | Research | 242,614,300 | 245,040,443 | 247,490,847 | 249,965,756 | 252,465,413 | 1,237,576,760 | 8,839,834 |
| | **TOTAL** | **10,625,617,022** | **10,731,873,192** | **247,490,847** | **249,965,756** | **252,465,413** | 22,107,412,231 | **377,306,977** |

# 1. INTRODUCTION

Tuberculosis (TB) is a serious public health problem in Nigeria. While the exact burden of TB in Nigeria is not known, the World Health Organization (WHO) estimates the incidence rate for all forms of TB at 311 per 100,000 population, incidence of smear-positive at 131 per 100,000 population, and prevalence at 546 per 100,000 population (WHO 2009). These figures place Nigeria fourth among the 22 high-burden countries in the world.

The WHO-recommended Directly Observed Treatment Short course (DOTS) policy strategy was adopted by the National Tuberculosis and Leprosy Control Program (NTBLCP) in 1993. By the end of 2002, only 21 of Nigeria's 36 states, as well as the Federal Capital Territory (FCT), were implementing the strategy. However, with assistance from the Canadian International Development Agency (CIDA) and United States Agency for International Development (USAID), DOTS was expanded to all states by the end of 2004. The number of local government areas (LGAs) implementing DOTS varies from state to state. As of December 2008, 765 of the 774 LGAs in the country had at least two or three health facilities implementing DOTS (98.8 percent LGA coverage). There are 969 TB microscopy centers in 670 LGAs (86.5 percent LGA coverage).

The total number of newly detected TB cases increased from 29,465 in 2001 to 83,263 by the end of 2008. There has been a remarkable increase in smear-positive case detection rate, from 15 percent in 2002 to 30.5 percent in 2008. The dual epidemic of TB and HIV further threatens the gains made in TB control in the past few years. HIV prevalence among TB patients has increased more than tenfold, from 2.2 percent in 1991 to 27 percent in 2008 (FMOH 1991 and 2008). The treatment success rate reported at the end of 2008 for those registered in 2007 was 82 percent.

In 1998 Nigeria achieved the WHO elimination target for leprosy of less than one case per 10,000 population. The implementation of multi-drug therapy (MDT) as the strategic intervention for leprosy elimination has resulted in a rapid decline of the number of registered leprosy cases, from nearly 500,000 in 1989 to 3,913 in 2010. Nevertheless, the country remains among those reporting relatively high numbers of registered leprosy cases. Of the 3,913 cases in 2010, 92 percent were multibacillary cases (MB). About 42 percent of cases were in females. Leprosy remains a leading cause of permanent physical disability: grade-2 disability among new cases in 2010 was 12 percent overall and 10 percent among children (NTBLCP 2010). Such disability results in stigmatization, isolation, and destitution of the patients, even after completing treatment with MDT.

The main support for DOTS implementation and leprosy control activities over the past years has come from the organizations of the International Federation of Anti-Leprosy Associations (ILEP), and more recently from bilateral and multilateral organizations such as CIDA, USAID, and WHO. Current DOTS implementation is mainly primary health care (PHC) based. Technical assistance, including supervision and monitoring and evaluation (M&E), is provided by WHO and the ILEP organizations.

Based on the findings and recommendations of the National TB Review conducted in 1999, the NTBLCP developed in 2000 the first DOTS expansion strategic plan (2001–2005) in collaboration with its development partners.

This document provides a strategic framework for improving TB and leprosy control in Nigeria from 2010 to 2015. It was developed in collaboration with development partners and is largely based on the experiences of implementing the 2005–2010 strategic plan, as well as findings and recommendations of the Joint International TB/HIV monitoring mission of 2008. It is hoped that it will contribute towards the achievement of the Millennium Development Goals (MDGs).

## 1.1 THE PURPOSE OF THE 2010–2015 STRATEGIC PLAN

The 2010-2015 strategic plan has five main objectives:

- To consolidate the gains of TB and leprosy control over the years.
- To serve as a medium-term plan for achieving the targets of the Global Plan to Stop TB and the MDGs, as well as the Enhanced Global Strategy for Leprosy Control.
- To provide the national framework on TB and leprosy activities for the operation of partners and other stakeholders.
- To contribute to strengthening the overall health system.
- To serve as an instrument for resource mobilization.

## 1.2 DEVELOPMENT PROCESS OF THE 2010–2015 NTBLCP STRATEGIC PLAN

The 2006–2010 National Strategic Plan for TB was an indispensable tool to guide the implementation of TB control activities across Nigeria. The overall goals of that plan were: to significantly reduce the TB burden in Nigeria to a level at which it was no longer a public health problem; to reduce the socioeconomic impact associated with TB; and to reduce the transmission of TB in Nigeria.

Based on recommendations drawn from the Midterm Review, the NTBLCP detailed a process for developing a new six-year strategic plan during October 2009. This new plan would be a comprehensive strategy, incorporating control measures against both TB and leprosy and designed to achieve the MDGs. Strategic planning workshops and overall NTBLCP Strategic Plan development were facilitated by technical advisors from Abt Associates Inc., using the Logical framework as the Program Planning Tool, with the support of USAID, /TBCAP/WHO, and other partners.

Both cross-cutting and thematic area-specific strengths, weaknesses, opportunities, and threats were noted. The SWOT analysis is included in Annex 4.

# 2. BACKGROUND

## 2.1 THE COUNTRY

With an estimated population of 148 million people (projected from the 2006 census), Nigeria is the most populous country in Africa. It has a landmass of 923,768 square km and is composed of about 350 ethnic groups, with diverse languages and religious faiths. The four main ethnic groups are the Hausa and Fulani (North), Igbo (Southeast), and Yoruba (Southwest). The official language is English.

## 2.2 GOVERNMENT STRUCTURE

Nigeria's government has three tiers: federal, state, and LGA. The country is composed of 36 states and the FCT. Each state has between eight and 44 LGAs, with a total of 774 LGAs in the country. The federal government is headed by an elected President, with a bicameral National Assembly (House of Representatives and Senate) as the legislative arm. The states are governed by elected governors and each has a State House of Assembly. The LGAs are governed by elected chairpersons and each has an LGA Legislative Council.

The federal structure as outlined in the Nigerian Constitution provides for some level of administrative as well as financial autonomy at the state and LGA level. The country's revenues are generated centrally and shared among the three tiers of government on a monthly basis. However, states and LGAs also generate local internal revenues. Each tier of government prepares its own annual plan and budget for execution based on need.

For socio-political reasons, the states are grouped into six geopolitical zones: North-East, North-West, North-Central, South-West, South-East, and South-South. These zones differ in terms of geographical size, ecologic characteristics, language and culture, settlement patterns, economic opportunities, and historical factors. However, the zones do not have any administrative function.

The responsibility for health care cuts across the three tiers of government.

## 2.3 ECONOMY

The country operates a mixed public and private sector economy. Petroleum plays a large role in the Nigerian economy, accounting for 40 percent of gross domestic product (GDP) and 80 percent of government revenue. Nigeria is the world's twelfth largest producer of petroleum and the eighth largest exporter, and has the tenth largest proven reserves. Other sources of revenue include agriculture, solid minerals, and trade.

## 2.4 DEMOGRAPHIC AND HEALTH INDICATORS

The 2006 population census put the population at 140 million, with an annual growth rate of 3.2 percent (National Population Commission 2006). In recent years there has been an increase in urban migration, resulting in an urban/ rural ratio of 40:60. This has led to overcrowding and an over-stretching of public services in the urban areas. The United Nations Development Program (UNDP) found key health and social indicators for 2005 as follows: life expectancy at birth of 46.5 years; infant mortality rate of 100/1,000 live births; under-five mortality rate of 195/1,000 live births; and adult literacy rate of 69.1 percent (UNDP 2008).

## 2.5 ORGANIZATION OF HEALTH SERVICES

Health care services in Nigeria are provided at three levels, primary, secondary, and tertiary. The local government level is responsible for primary care; state government is responsible for secondary 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 for the state level.

Health care services are provided through approximately 30,000 public and 20,000 private health care facilities. All tertiary and most secondary facilities have laboratories with the capacity to provide basic laboratory services, including Acid Fast Bacilli (AFB) microscopy for identification of pulmonary TB (PTB). The private sector, as well as nongovernmental organizations (NGOs) and local communities, also provide considerable services at all the levels of health care. The private sector accounts for about 50 percent of health care delivery in the country.

The general policy framework for health care is the National Health Policy, which has an overall goal to achieve a level of health that will enable all Nigerians to achieve socially and economically productive lives, with PHC as its cornerstone.

## 2.6 FEDERAL MINISTRY OF HEALTH (FMOH)

The objectives of the FMOH are: to reduce morbidity and mortality due to communicable diseases to the absolute minimum; to reverse the increasing prevalence of non-communicable diseases; to meet global targets on the elimination and eradication of diseases; and to significantly increase the life expectancy and quality of life of Nigerians.

Its mission statement is: To develop and implement policies and programs as well as undertake other necessary actions that will strengthen the national health system to be able to deliver effective, efficient, quality and affordable health services to all Nigerians.

## 2.7 THE NATIONAL HEALTH POLICY

The National Health Policy and strategy to achieve health for all Nigerians was promulgated in 1998 and revised in 2004, focusing on the national health system. Individual sections deal with: Management; National Health Care Resources; National Health Interventions and Service Delivery; National Health Information Systems; Partnership for Health Development; and Health Research and Health. The overall goal is to achieve a level of health that will enable all Nigerians to achieve socially and economically productive lives. The policy provides for the national health system to be based on PHC. A National Health Reforms Agenda is being implemented to carry forward the health strategies of the National Economic Empowerment and Development Strategy (NEEDS), New Partnership for Africa Development (NEPAD), and the MDGs.

## 2.8 HEALTH CARE FINANCING

The three levels of government have constitutional responsibilities for financing health care delivery. However, because the current constitutional provision places health care on the concurrent legislative list, their roles and responsibilities are ill defined. The federal government health budget is mainly for tertiary care, public health, and policy development. State governments fund provision of secondary care, while LGAs provide funding for PHC. The sources of health care funding in Nigeria are mainly the government budget, user fees, loans, and multilateral and bilateral development aid, including support from NGOs. The public sector budget for health currently accounts for about 5 percent of the national budget. The per capita budget for health care is about US$3. Recently the federal government launched the National Health Insurance Scheme (NHIS), which seeks to address sustainability of health care financing.

## 2.9 TUBERCULOSIS BURDEN IN NIGERIA

TB is a serious public health problem in Nigeria. At present, its exact burden is not known. Based on data collected in 2007, WHO has estimated the incidence rate for all forms of TB at 311 per 100,000 population, incidence of smear positives at 131 per 100,000 population, and prevalence at 546 per 100,000 population (WHO 2009). These figures place Nigeria fourth among the world's 22 high-burden countries.

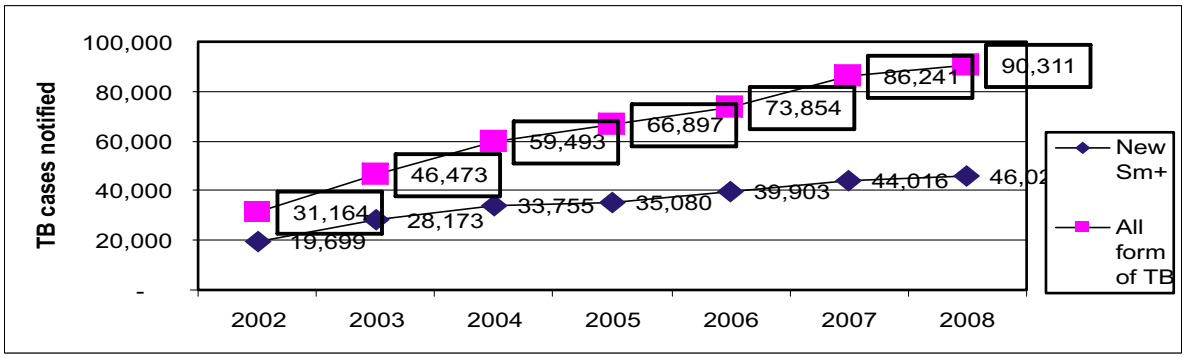
According to the NTBLCP 2008 Annual Report, a total of 90,311 of all forms of TB cases were registered, of which 83,263 (95 percent) were new cases and 8 percent were re-treatment cases. The infectious sputum (i.e., smear-positive) cases constituted 51 percent (46,026 cases) of new cases, including 18,734 (or 40.7 percent) females and 59.3 percent males. Children (male and female) younger than 15 years accounted for 1,324 (2.8 percent) of the

new smear-positive TB cases notified. The majority of smear-positive cases notified in 2008 (24,862, or 54 percent) were between 25 and 44 years of age, as shown in Figure 1. Thus, the major TB burden is on people of reproductive/workforce age.

Progress has been made in both diagnosing and treating cases of TB. The case detection rate (CDR) nearly doubled, from 16.3 percent (2002) to 30.5 percent (2008). The treatment success rate of smear-positive TB cases increased in the past four years, from 73 percent in 2004 to 82 percent in 2008.

According to WHO, the CDR is calculated as the number of new smear-positive cases notified divided by the number of new smear-positive cases estimated for that year, expressed as a percentage (http://www.who.int/whosis/indicators/2007TBCasesDetectedDOTS/en/index.html).

**FIGURE 1. NATIONAL TREND OF TB CASES NOTIFIED,* 2002-2008**




* "Notified" cases have been first diagnosed, then reported to the national disease control center, and then reported to WHO.

## 2.10 TB/HIV CO-INFECTION

The HIV epidemic in the country has also impacted negatively on the burden of TB. HIV prevalence among TB patients increased more than tenfold, from 2.2 percent in 1991 to 27.4 percent in 2008, (FMOH 2001 and 2008). Currently, the co-infection rate is estimated at 27 percent (WHO 2009).

## 2.11 MDR-TB

Currently, there are no national baseline data on the prevalence of multi-drug resistant TB (MDR-TB); however, an ongoing TB drug resistance survey may be concluded by the end of first quarter 2011. WHO (2009) estimated an MDR-TB rate of 1.8 percent among new smear-positive cases and 9.4 percent among re-treatment cases. There are some limited institutional studies in the country that show MDR-TB to be an emerging public health problem. Access to diagnostic and clinical management of MDR-TB is still limited.

**TABLE 1. PREVALENCE OF MDR-TB**

| Reporting Institutions | Notified MDR TB Cases | | | | Total |
|---|---|---|---|---|---|
| | 2006 | 2007 | 2008 | 2009 | |
| Zankli Medical Center, Abuja | 10 | 16 | 9 | 11 | 46 |
| NIMR, Lagos | 0 | 0 | 9 | 13 | 22 |
| DFB | 0 | 29 | 5 | 4 | 38 |
| Total | 10 | 42 | 23 | 18 | 107 |

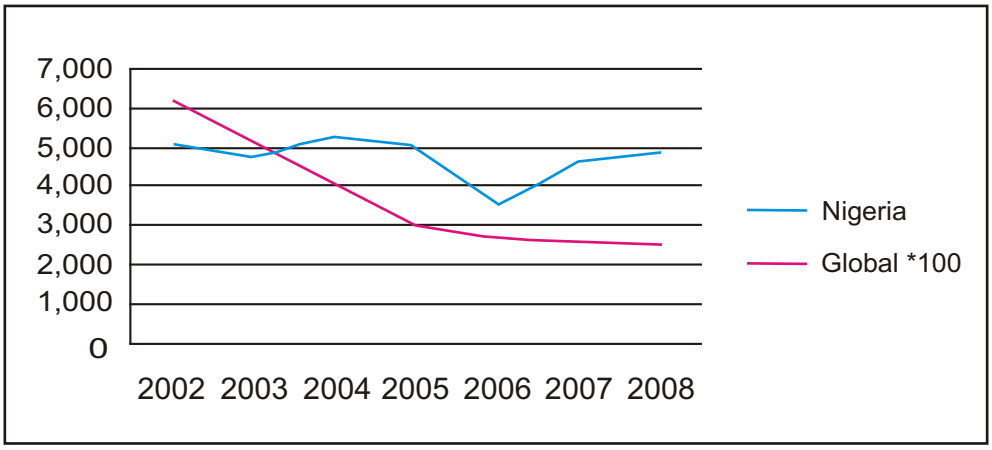
Note: NIMR=Nigerian Institute for Medical Research, DFB=Damien Foundation Belgium

## 2.12 LEPROSY BURDEN IN NIGERIA

Although in 1998 Nigeria achieved the WHO elimination target of less than one case per 10,000 population, the country remains among those reporting a relatively high number of registered leprosy cases. Leprosy remains a leading cause of permanent physical disability, which causes stigmatization, isolation, and destitution of patients even after completing treatment with MDT.

The implementation of MDT as the strategic intervention to eliminate leprosy has resulted in a rapid decline of the number of registered leprosy cases, from nearly 500,000 in 1989 to 3,913 in 2010 (Figure 2). Of these, 92 percent were MB. About 42 percent of cases were females. Grade-2 disability among new cases was 12 percent overall and 10 percent in children (NTBLCP 2010).

**FIGURE 2. NEW LEPROSY CASES IN NIGERIA AND WORLD, 2002-08**




Note: *100 : Global numbers shown are in multiples of 100.

# 3. THE NATIONAL TB AND LEPROSY CONTROL PROGRAM

## 3.1 ORGANIZATIONAL STRUCTURE

The NTBLCP is the responsible body that coordinates TB and leprosy control activities throughout Nigeria. The program operates under the FMOH Department of Public Health. The NTBLCP structure corresponds to the three levels of government: federal, state, and LGA. The national level (referred to as the NTBLCP Central Unit) is responsible for facilitating policy development on TB control, as well as tertiary care, resource mobilization, program evaluation, human resource development, and technical support to state programs. The NTBLCP is headed by a national coordinator, supported by medical and paramedical staff.

The program benefits from the National TB and Leprosy Training Center (NTBLTC) in Zaria, which is responsible for identifying the human resource needs for program implementation and for training various categories of health care staff to implement TB and leprosy activities. It also incorporates a referral hospital with a 140-bed capacity as well as the National TB Reference Laboratory.

At the state level, the NTBLCP is under the director of the Department of Disease Control; the day-to-day program implementation and supervision are carried out by the state TB and leprosy control officer(s), supported by the state TB and leprosy supervisors. The state TB and leprosy programs coordinate TB and leprosy activities in the respective states, and provide secondary care and technical assistance to the LGA level.

The LGA is the operational level of the NTBLCP. It is based on the PHC principle. At this level, TB and leprosy control activities are the responsibility of local government TB and leprosy supervisors. PHC workers carry out TB and leprosy activities in close collaboration with their respective communities. In fact, the LGA is the basic management unit of the NTBLCP at all health facilities where TB and leprosy activities are carried out and coordinated: public facilities (including secondary and tertiary health facilities), private facilities, faith-based organizations (FBOs), and military and para-military health facilities.

At the national level, the NTBLCP collaborates with several local and international partners in the planning, implementation, and resource mobilization for TB and leprosy control. Partners

include ILEP organizations, CIDA, USAID, President's Emergency Plan for AIDS Relief (PEPFAR) partners, WHO, and civil society organizations (CSOs).

## 3.2 GOAL, OBJECTIVES, AND STRATEGY

The goal of the NTBLCP is: To reduce significantly the burden, socio-economic impact, and transmission of TB and leprosy in Nigeria.

The overall objectives of the NTBLCP are:

1. To reduce TB prevalence to a level at which the disease no longer constitutes a public health problem in the country.
2. To prevent and reduce the impairments associated with leprosy, as well as provide appropriate rehabilitation for persons affected by leprosy.

### 3.2.1 TB CONTROL STRATEGY

NTBLCP's strategy to control TB in Nigeria is in line with the new Stop TB strategy recommended by WHO. It has the following elements:

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. Effective drug supply and management system
    e. M&E system and impact measurement
2. Address TB/HIV, MDR-TB, and the needs of poor and vulnerable populations
3. Contribute to health system strengthening
4. Involve all care providers
5. Engage people with TB and affected communities
6. Enable and promote research

### 3.2.2 LEPROSY CONTROL STRATEGY

NTBLCP's strategies to control leprosy are in line with WHO's Enhanced Global Strategy for Further Reducing Disease Burden Due to Leprosy 2010–2015 (WHO 2009):

- Expanding opportunities to reduce the disease burden further by means of timely case finding and treatment, BCG vaccination, and improved socioeconomic conditions.
- Closely monitoring progress of trend of new cases with grade-2 disabilities in the population.
- Strengthening leprosy control activities in areas where a high proportion of new cases with grade-2 disabilities are being detected.
- Promoting the use of community-based rehabilitation to improve the quality of life of persons and families affected by leprosy.
- Conscious efforts to integrate leprosy control into the general health care services.
- Increased surveillance for resistant strains of M. leprae.
- Applying cost-effective methods to improve community awareness, acceptance, and involvement, to combat stigma and discrimination against persons and families affected by leprosy.

# 4. STRATEGIC PLAN 2010-2015: GOALS, STRATEGIES, AND OBJECTIVES

The overall goal of the current strategic plan for 20102015 is to reduce significantly the burden, socio-economic impact, and transmission of TB and leprosy in Nigeria, in line with the MDG and Stop TB Partnership Targets.

## 4.1 STRATEGIES AND SPECIFIC OBJECTIVES

Table 3 presents the strategic interventions and specific objectives for each area of activity.

**TABLE 2. STRATEGIC INTERVENTIONS AND OBJECTIVES**

| Strategies | Specific Objectives |
|---|---|
| | **Tuberculosis** |
| Pursue high-quality DOTS expansion and enhancement | Increase TB case detection rate from 30.5% in 2008 to 70% by 2015, aligning with the WHO target. |
| | Increase treatment success rate from 82% in 2008 to at least 85% by 2015. |
| | Strengthen the existing PSM system in order to ensure uninterrupted drug and commodities supply in all TB and leprosy (TBL) facilities throughout the plan period. |
| | Strengthen the Supervision, M&E system at all levels to ensure that at least 95% of all planned activities are implemented effectively and efficiently. |
| TB/HIV collaborative activities | Increase and sustain the proportion of TB patients tested for HIV from 62% in 2008 to at least 85% by end of 2015. |
| | Ensure that at least 85% of TB/HIV co-infected patients receive CPT. |
| | Ensure that at least 85% of eligible TB/HIV co -infected patients receive antiretroviral therapy (ART). |
| | Establish infection control in all health care facilities providing both DOTS and ART services. |
| Establish MDR-TB services | Establish a routine drug resistance surveillance system by the end of 2011. |
| | Ensure that all Category 2 failures have access to lab diagnosis services for MDR by end of 2012 and all Category 1 failures by end of 2015. |
| | Provide second-line anti-TB drugs for at least 85% of d iagnosed MDR cases by end of 2015. |
| Engaging all care providers (PPM): Strategic alliance with academic, private and other public practitioners. | Scale up PPM services within the private, military, paramilitary, police, prisons, and customs health services such that it contributes to at least 15% of total TB cases detected (excluding those from tertiary health facilities) by the end of 2015. |
| | Expand Hospital DOTS Linkage (HDL) to all tertiary health institutions by 2015. |
| Engaging communities and patients in TB activities | Establish community TB care (CTBC) activities in at least 5 LGAs per state by end of 2015. |
| ACSM | Improve community awareness on TBL such that at least 60% of the public are aware of signs and symptoms of TBL and TBL service points by end 2015. |
| | Ensure budgetary allocation and release of annual funds for TBL activities at all levels. |

| | |
|---|---|
| **Leprosy** | |
| Early case detection | Reduce the rate of new cases with grade-2 disabilities by at least 35% by the end of 2015, compared to the base line at the end of 2010. |
| Ensuring case holding | Sustain MB and PB (Paucibacillary) treatment completion rate of at least 85% and 95% respectively throughout the plan period. |
| Prevention of disability | Ensure quality patient care such that the proportion of patients who deve lop new/additional disabilities at the end of treatment is not more than 5% annually. |
| Comprehensive rehabilitation services | Set up a systematic rehabilitation service aimed at empowering persons affected by leprosy, using community -based rehabilitation systems in all states by end of 2015. |
| **Research and HRD** | |
| Research | Develop and strengthen capacity for research on TB, TB/HIV, and leprosy at all levels. |
| HRD | Develop the management and leadership capacity of program managers at all levels by end 2015. |
| | Ensure that the human resource needs of TB and leprosy services at all levels are met (recruitment, retention and motivation). |
| | Develop and provide all program tools (guidelines, manuals and recording & reporting forms) for effective implementation of TB and Leprosy Control Program. |
| | Empower health care workers to provide comprehensive TL services through training in all components of Stop TB strategy and enhanced global strategy for leprosy. |
| | Establish and maintain health information management system for human resources for NTBLCP. |

## 4.2 OVERALL ASSUMPTIONS FOR IMPLEMENTATION OF THE STRATEGIC PLAN

Successful implementation of the Strategic Plan for 2010-2015 will depend on a number of positive factors and circumstances:

- Increased political commitment and budgetary release
- Absence of industrial action (strike)
- Willingness of private practitioners to abide to the terms of agreement with the National Program
- Strengthened and sustained functioning of PHC
- Uninterrupted Global Fund funding

# 5. STRATEGIC PLAN 2010-2015: CONTROL COMPONENTS AND THEMATIC AREAS

## 5.1 TUBERCULOSIS

TB services are offered in the following three types of health facility:

- Treatment center: Provides a standardized short-course treatment regimen for TB patients.
- Microscopy center: Performs sputum AFB microscopy.
- Comprehensive DOTS center: Provides both treatment and microscopy services.

### 5.1.1 CASE DETECTION

Case detection is done through screening of TB symptoms, along with sputum microscopy for AFB. Two positive smears out of three define positivity for TB. For sputum smear-negative cases, diagnosis is made after three negatives, along with X-ray and confirmation by a medical officer. Extra-pulmonary TB and cases in children are diagnosed by medical officers using clinical examination, X-ray, and/or any other investigation deemed necessary to establish a diagnosis.

### 5.1.2 CHEMOTHERAPY AND CASE HOLDING

In line with recommendations of the WHO and the International Union Against Tuberculosis and Lung Disease (IUATLD), all detected TB cases in Nigeria are treated with eight months of Short Course Chemotherapy (SCC) under directly observed therapy (DOT). The program plans to switch to the six-month DOTS (DOT Short course) regimen by the end of 2011. Defaulter prevention and/or retrieval activities are part of the treatment delivery system.

All TB patients are monitored during the course of treatment in order to ascertain clinical improvement as well as progress toward a bacteriological cure. Treatment monitoring is based on serial sputum follow-up examinations at the second, fifth, and seventh months. Clinical monitoring — ensuring regular drug intake, weight gain, and so forth — is done for every TB patient.

### 5.1.3 ANTI-TB DRUG SUPPLY AND DISTRIBUTION (PROCUREMENT AND SUPPLY MANAGEMENT)

The supply of first line anti-TB drugs has been through grants from the Global Drug Facility (GDF); those grants ended in 2009. Currently, funds from the Round 5 Phase 2 Global Fund to Fight AIDS, Tuberculosis and Malaria grant (GFATM) are used to procure anti-TB drugs through 2012, after which the federal government will assume this responsibility. The drug distribution system is through an established infrastructure, from the Central Medical Store to the six zonal stores. States receive their supplies from zonal stores in their area. A logistics management information system governs overall drug procurement and distribution; a procurement and supply management plan has been developed.

The national program has adopted the use of patient kits for the treatment of TB. This will be phased in and then scaled up in all states by the end of 2012. The federal government is expected to play a greater role in ensuring sound logistic arrangements for drug procurement, including the provision of duty exemption and port clearance.

### 5.1.4 LABORATORY SERVICES

The proposed NTBLCP laboratory network is organized in pyramidal fashion. A large number of peripheral laboratories will provide AFB services readily accessible to TB suspects and patients, with one laboratory for each state (including the FCT). The NTBLCP will ensure that these 37 state-level laboratories are in place. In addition, the plan includes six designated zonal reference laboratories located in tertiary health facilities in each of the zones, as well as two national reference laboratories (NRLs): one at the Nigerian Institute of Medical Research (NIMR) will serve the southern part of the country; the other, at the NTBLTC, Zaria, will serve the northern part of the country. The NRLs will be linked to a Supra-National Laboratory for technical support and external quality assurance (QA).

To ensure reliability of AFB bacteriology results, laboratory services are subjected to constant evaluation through an external and internal QA system.

### 5.1.5 SUPERVISION AND MONITORING AND EVALUATION

The NTBLCP has a well-organized supervision and M&E system that operates at all levels. Supervision is carried out at the national, zonal, state, and LGA levels. Supervision by national and zonal officers aims to provide technical assistance to state program teams, while state-level supervision provides support to LGAs and facilities. The LGA supervisors ensure delivery of DOT by health facility staff according to guidelines; they also generate primary data for TB control monitoring.

The NTBLCP has a well-established reporting system and national M&E plan (currently being revised). Quarterly reports are generated from the facility level, collated at the local government level, and sent to the state and zonal level, and then forwarded to the federal level for collation. Routine quarterly meetings are held at state and zonal levels for the purpose of data collation and analysis and discussions of program challenges and actions.

### 5.1.6 ADVOCACY, COMMUNICATION, AND SOCIAL MOBILIZATION

Advocacy, communication, and social mobilization (ACSM) have been identified as key elements of TB and leprosy control in Nigeria and will be given priority. The aim is to improve political commitment at all tiers of government, in order to increase resources for case detection and rehabilitation of persons affected by both diseases. Communities and persons affected with leprosy will be mobilized through organizations such as IDEA, to enhance case finding, case holding, rehabilitation, and stigma reduction.

### 5.1.7 TB/HIV COLLABORATION

TB and HIV are among the leading causes of death in Nigeria and indeed Africa. It is the policy of the national program to offer HIV counseling and testing to all TB suspects and patients, to provide Co-trimoxazole Preventative Therapy (CPT) to all TB-HIV co-infected patients, to provide access to ARV therapy to eligible TB patients, and to provide Isoniazid Preventative Therapy (IPT) to all HIV patients who do not have active TB.

Implementation of the "three I's" — IPT, Intensified case finding and Infection control — will be strengthened at the facility level.

### 5.1.8 PUBLIC-PRIVATE MIX FOR DOTS

To enhance case finding and treatment outcomes, existing partnerships with public and private sector/institutions will be strengthened. Tertiary, military, para-military, and private health institutions will be engaged. The Hospital DOTS Linkage (HDL) initiative will guide collaboration with tertiary and larger secondary health facilities.

### 5.1.9 COMMUNITY TB CARE

The objectives of Community TB care include:

1. Demand creation— greater awareness of the disease and of service points
2. Opportunities for involvement of treatment supporters to improve adherence

The program intends to use civil society organizations (CSOs) and community-based organizations (CBOs) at the community level.

### 5.1.10 NTBLCP MANAGEMENT AND LEADERSHIP

The program is managed at different levels by program managers, and the successful implementation of TBL control activities depends on the competence of the key players. Technical, leadership, and management skills of program managers at all levels shall be developed and enhanced, both locally and internationally, through the support of NTBLCP and the NTBLTC, Zaria.

### 5.1.11 MDR-TB

The NTBLCP will establish a cross-country network of laboratories for the diagnosis and surveillance of MDR-TB. Treatment centers will be established in each zone, with adequate human resources and logistics.

## 5.2 LEPROSY

### 5.2.1 LEPROSY CASE-FINDING

Early case-finding with effective chemotherapy remains the most important strategy to control leprosy. The case-finding method will largely remain passive: that is, people suspected to

have leprosy are encouraged to report voluntarily for screening. In special circumstances, surveys or intensified case-finding can be conducted in the form of mini-leprosy elimination campaigns (mini-LEC), in areas (LGAs or communities) where leprosy cases are suspected to be in high, or in hard-to-reach areas where the health infrastructure is inadequate. Leprosy diagnosis will still be done mainly through clinical examination and eliciting cardinal signs of the disease; however, certain facilities will have the capacity for slit skin smear testing. Leprosy services will be strategically integrated so that all health facilities will be empowered to suspect leprosy and refer to a designated center in the LGA for diagnosis and management. The existing referral system will be strengthened to ensure that patients with complications continue to have access to appropriate care. Contacts of newly diagnosed MB leprosy patients should be examined at least once.

### 5.2.2 CHEMOTHERAPY

Any person diagnosed as having active leprosy will be treated with MDT, according to the WHO regimen. Patients on treatment will be monitored monthly at health facilities for drug adherence and for early onset of complications. However, flexibility of providing more than a one-month supply of drugs can be accommodated in special circumstances (for nomads, migrants and the like).

### 5.2.3 PATIENT CARE AND DISABILITY PREVENTION

Prevention of disability will be promoted at three levels: in the home, at the clinic, and at referral centers for more complex interventions. More emphasis will be placed on self-care, including the promotion of self-care groups. Six zonal leprosy referral centers will be identified for highly specialized services such as reconstructive surgery and prosthetics. Collection, recording, and reporting of disability data will be routinely carried out at all levels of intervention; the use of EHF scores will be promoted.[2]

Where possible, reactions will be managed in the field; the program will ensure the regular and uninterrupted supply of quality anti-reaction drugs. The program will liaise with other disability services to provide wheelchairs, eye surgery, and other aids to improve accessibility for people affected by leprosy. Finally, the use of suitable, commercially available footwear and gloves will be encouraged.

### 5.2.4 REHABILITATION

A comprehensive approach to rehabilitation will be adopted to maximize the benefit for the individual, the family, and society at large. Community-based rehabilitation (CBR) is the strategy of choice. The program will liaise with existing rehabilitation services and disabled people's organizations to give people affected by leprosy equal access. Rehabilitation will be rights-based and linked to MDGs and poverty alleviation strategies.

2 The EHF (Eyes, Hands, Feet) score is a measure of severity and disability.

## 5.3 HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

The NTBLTC, located in Zaria, is the NTBLCP's Human Resource Development (HRD) unit, serving the following functions: (1) developing HRD policies, guidelines, and modules; (2) identifying the human resource (HR) needs for program implementation; and (3) training various categories of health care staff to implement TBL activities. As much as possible, staff training will be combined for the two diseases.

The program will use all categories of general health care workers (including dermatologists) in the implementation of leprosy control activities at the health facility level. At the same time, expertise will be maintained at the federal, state, and LGA level for program planning, supervision, and M&E. Capacity of the NTBLTC Zaria will be enhanced to meet this increasing demand. Collaboration will be promoted with other health institutions, to ensure pre-service training of health workers in both diseases.

The HRD vision is that “every individual in Nigeria has access to a motivated, supported and competent health worker who is skilled in tuberculosis and leprosy control at all levels of care in Nigeria.” The goal is to “ensure that all staff involved in providing TB, leprosy as well as TB/HIV services are competent and have the necessary tools and support for effective implementation of TBL and TB/HIV activities.”
HRD strategies include the following:

1. Engage pre-service institution and professional bodies in TBL and TB/HIV training activities.
2. Use standardized/harmonized training modules, guidelines and protocols.
3. Use competent TBL and TB/HIV trainers at all levels.
4. Conduct trainings at all levels.
5. Provide necessary resources/tools for effective performance at all levels.
6. Establish a functional system for supervision and M&E of all trainings.

## 5.4 RESEARCH

The NTBLCP will promote operational research through its training institute in Zaria. A national research agenda will be developed to provide guidance on priority issues for research, to be funded by annual budgetary provisions. Relevant research findings will guide program policy and practice, in keeping with the GRIPP concept (Getting Research into Policy and Practice). Publication of research results in relevant journals will also be promoted.

## 5.5 GOVERNMENT COMMITMENT AND PARTNERSHIP

Government is committed to the successful implementation of the strategic plan by providing effective coordination and mobilization of resources. NTBLCP will continue to leverage the technical and financial assistance of the partners to complement its efforts to control TB and leprosy. Some of the major partners are listed in Table 2.

## TABLE 3. MAJOR TECHNICAL AND FINANCIAL PARTNERS OF NTBLCP

| Stakeholder | Area of Work |
|---|---|
| USAID | Support for the establishment and expansion of TB DOTS services in 17 sta tes, and TB/HIV collaborative activities nationwide. USAID has been actively involved in 17 states in the northern part of the country, including Lagos and the FCT. USAID is also supporting the MDR-TB survey and implementation of MDR -TB activities, includi ng strengthening the zonal and national reference laboratories. USAID is also supporting the national TB logistic systems, community TB care, Public -Private Mix (PPM) -DOTS, and ACSM, and is strengthening the health system through renovation of facilities, human capacity building, and supply of microscopes and laboratory commodities. USAID has supported the development of a costing tool for provision of TB services, NTP strategic plan, and HRD plan 2010 –2015 and is strengthening supportive supervision through the use of personal digital assistants (PDAs). |
| WHO | Technical support in policy formulation, strategic planning, supervision, monitoring, and program evaluation at national and state levels. Resource mobilization and supply of anti - leprosy drugs. |
| Centers for Disease Control and Prevention (CDC) | Supporting IPs to provide TB/HIV collaborative activities in all the states of the federation and FCT. Support for the National MDR -TB survey and for diagnosis and management of MDR-TB, including culture, drug sen sitivity test (DST) and polymerase chain reaction for line probe assay. QA system. |
| Damien Foundation Belgium (DFB) | Supporting TB and leprosy control in two states of S/W Nigeria (Oyo and Osun): provision of anti-TB drugs, lab reagents/consumables, trainin g of health staff, and supervision. Supporting the MDR -TB Treatment Center at UCH -Ibadan (culture and DST, training, cost of patient management) |
| German Leprosy and TB Relief Association (GLRA) | Supporting TB and leprosy control in 14 states in S/E, S/W, an d S/S Nigeria (Abia, Akwa Ibom, Anambra, Bayelsa, Cross River, Delta, Ebonyi, Edo, Ekiti, Enugu, Imo, Ondo, Ogun, and Rivers): Provision of anti -TB drugs, microscopes, project vehicles, and general logistics (to 2006); lab reagents/consumables, training of health staff, and supervision. TB/HIV project in Lagos: co - |
| | ordinates ILEP support to leprosy control in Lagos state; piloted PPM in Anambra and Abia; operational research in TB, TB/HIV and leprosy; pilot project in Buruli Ulcer control in Cross River State. |
| Netherlands Leprosy Relief (NLR) | Supported TB control in four states in N/C and N/E Nigeria (Bauchi, Gombe, Kaduna, and Plateau): provision of anti -TB drugs, lab reagents/consumables, training of health staff and supervision (to 2006). Supporting 13 st ates in leprosy control (Adamawa, Bauchi, Benue, Borno, Gombe, Jigawa, Kaduna, Kano, Katsina, Nasarawa, Plateau, Taraba, and Yobe): provision of logistics (vehicles and motorcycles) for TB control in combination with leprosy. |
| The Leprosy Mission Nigeria | Supporting leprosy control in seven states of N/C and N/W Nigeria (FCT, Kebbi, Kogi, Kwara, Niger, Sokoto, and Zamfara). Partly supporting TB in those states with respect to training of state and LGA TBL supervisors and technical support in field supervision. |
| Private Health Care Providers | Provide service for profit (mainly clinical care). Current piloting to determine public -private sector mix in TB control. |
| Abt Associates Inc. | *Partnership for Transforming Health Systems 2 (PATHS2):* Designed to facilitate efficient use of Nigeria's resources to attain the MDGs through improving the planning, financing, and delivery of sustainable and replicable pro -poor health services for common health problems in specific locations (Enugu, Jigawa, Kaduna, Kano, and two o thers to be determined).<br>*Health Systems 20/20*:<br>In collaboration with the Ministry of Health, piloting supportive supervision using PDAs<br>National TB Services Improvement via Human Capital Development: Costed Plan<br>Continued Improvement and Application of the Nigeria TB Direct Costing Tool<br>Improved diagnostics for TB, in collaboration with Tulane University: will provide technical assistance to Zaria TB Institute to improve TB diagnostics (e.g., for under -diagnosed pediatric |

| | |
|---|---|
| | TB), with the new Microscopic Obs ervation-Drug Susceptibility (MODS) technique for culturing Mycobacterium tuberculosis.<br>Strengthening TB laboratory capacity, in collaboration with the South African Medical Research Council (SMRC): will support Zaria to enhance laboratories' diagnostic a nd management systems by updating manuals/guides; creating a new overall framework for managing TB laboratory networks; helping to train laboratory personnel in new guidelines and frameworks; and introducing modern methods for TB detection and treatment, s uch as LED microscopy.<br>Establishing systems for systematizing and harmonizing laboratory quality assurance |
| JSI Deliver (USAID \| DELIVER PROJECT) | Providing technical assistance and capacity building in logistics management of TBLCP commodities. Main focus is on central -level capacity building, with support to Logistics Unit and NTBLTC in system development and implementation of capacity building for health care workers HCWs.<br>Provision of technical support for implementation of Procurement and Supply managem ent functions with the NTBLCP, including national -level quantification, supply planning, and inventory management. |

# ANNEX A. LOGFRAME FOR TBL STRATEGIC PLAN 2010-2015

The following table shows the objectives and activities for each thematic area, along with the objectively verifiable indicators (OVI) and means of verification (MOV) for each objective and activity.

| Objectives and Activities | OVI | MOV |
|---|---|---|
| **Pursue high-quality DOTS and enhancement** | | |
| **Objective 1** | | |
| **1.1 Increase TB case detection rate from 30.5% in 2008 to 70% by 2015.** | **Case detection rate of new smear positive cases** | **Quarterly and annual report on TB case finding at LGA, state, zonal and national levels** |
| **1.2 Increase treatment success from 82% in 2008 to 85% by 2015.** | **Treatment success rate** | |
| **Main activities:** | **Outputs:** | |
| 1.1 Establish 2,346 additional DOTS treatment centers | 1.1. 2,346 additional DOTS treatment centers established | |
| 1.2 Support renovation of both old and new DOTS treatment centers (5,088) | 1.2 5,088 DOTS treatment centers for DOTs renovated | |
| 1.3 Establish 1,247 addition AFB microscopy centers | 1.3 1,247 new AFB microscopy centers established | |
| 1.4 Support renovation of both new and old AFB microscopy centers (2,216) | 1.4 2, 216AFB microscopy centers renovated | |
| 1.5 Upgrade and maintain the reference laboratories (2 national and 6 zonal laboratories) | 1.5 2 national and 6 zonal reference laboratories functional | |
| 1.6 Establish TB/HIV services in at least 70% of eligible PPM facilities by 2015 | 1.6 (a) TB/HIV services available in 70% PPM sites (b) Proportion of cases detected attributable to PPM | |
| 1.7 Scale up HDL plan in all tertiary health facilities by 2015 | 1.7 All tertiary health facilities have HDL | |
| 1.8 Establish DOTS services in at least 85% of Nigerian prisons | 1.8 85% of Nigerian prisons providing TB services | |
| 1.9 Provide first-line anti TB drugs, reagents, etc. (see section on PSM) | | |
| 1.10 Support contact investigations of symptomatic contacts and children less than 6 yrs within treatment facilities in 36 states and FCT | | |
| 1.11 Develop and distribute cough signage for all DOTS Treatment centers | | |
| 1.12 Training activities (refer to section on HRD) | | |
| **Strengthen PSM** | | |
| **Objective 2**<br>**Strengthen the existing PSM system in order to ensure uninterrupted drugs and commodities supply in all TBL facilities throughout the plan period.** | **Proportion of health facilities reporting 'no stock-out' of all anti-TBL drugs and other commodities** | **Quarterly and annual reports and logistic assessment tools** |

| Objectives and activities | OVI | MOV |
|---|---|---|
| **Main activities:** | **Outputs:** | |
| 2.1 Renovation and annual maintenance of national, 6 zonal and 37 states stores | 2.1 Functional stores at all levels | Annual reports at all levels |
| 2.2 Procurement of both 1st and 2nd anti-TB drugs for estimated number of patients | 2.2 1st and 2nd line anti-TB drugs procured | |
| 2.3 Support commodities clearance and transport to different levels | 2.3 Drugs available at appropriate levels in adequate quantities | |
| 2.4. Procurement of laboratory reagents and consumables for 2, 216 AFB microscopy centers (old & new centers) | 2.4 Reagents and other consumables procured | |
| 2.5 Procurement of reagents and other consumables for culture, DST and line probe assay for the 2 national and 6 zonal reference laboratories. | 2.5 Reagents and consumables for NRL and ZRL procured | |
| 2.6 Procurement and installation of equipments for the 2 national and 6 zonal laboratories. | 2.6 Equipments for NRL and ZRL installed and functional | |
| 2.7 Procurement of microscopes (light, LED and FM) for the additional laboratories as appropriate (1,247) | 2.7 Microscopes for 1,247 AFB micros copy centers procured | |
| 2.8 Procurement of Isoniazid for prophylaxis among children and PLHIV (4,000 clients). | 2.8 Isoniazid procured for 4,000 clients per year | |
| 2.9 Procurement, installation and maintenance of X-ray machines (at least one per state) for diagnosis of TB in children and EPTB | 2.9 X-ray machines installed and maintained in each state | |
| 2.10 Procurement of Rifabutin for TB/HIV co-infected patients on 2nd line ARVs (estimate 2-5% of total TB/HIV co-infected cases) | 2.10 Rifabutin procured for –1,341 patients annually | |
| 2.11 Procurement of Cotrimoxazole for CPT among TB/HIV co-infected patients at DOTS centers (27-40% co-infection rate) | 2.11 Cotrim for CPT procured for 26,822 patients annually | |
| 2.12 Procure and support maintenance of TB infection control equipment (N95 respirator, vaneometer, surgical mask, etc.) | 2.12 IC materials and equipment available in all health facilities with DOTS services | |
| 2.13 Replacement and maintenance of project vehicles and motorcycles at various levels. | 2.13 8 vehicles and 155 motor-cycles replaced and maintained annually | |
| 2.14 Procurement of MDT and other drugs/ POID materials for leprosy patients (using an average of 5,000 patients annually). | 2.14 MDT drugs, POID materials procured. | |
| 2.15 Organize quarterly meeting of TBL logistics technical working group (TWG) | 2.15 Quarterly meetings for logistics TWG conducted | |
| 2.16 Conduct annual stock-taking for TBL Drugs and other commodities by national and zonal logistics officers. | 2.16 # of laptops procured and distributed | |
| 2.17 Procure laptops for state M&E officers and LGA supervisors | | |

| Objectives and activities | OVI | MOV |
|---|---|---|
| **Objective 3.1** | | |
| **Strengthen the M&E system at all levels in order to ensure that over 95% of planned activities are implemented, monitored and evaluated in line with the National Strategic Plan 2010–2015.** | **Percentage of planned activities implemented at national, state, and LGA level** | |
| **Strengthen M&E** | | |
| **Main activities:** | **Outputs:** | |
| 3.1.1 Organize and conduct situation analysis to establish baseline data for some of the program indicators. | 3.1.1 Supervisory visits conducted | |
| 3.1.2 Develop, produ ce, and disseminate an indicator reference book for the NTBLCP | 3.1.2 Quarterly supervision to states conducted and reported | |
| 3.1.3 Conduct annual data audit on key indicators | 3.1.3 Quarterly supervision to LGAs conducted and reported | |
| 3.1.4 Conduct a stakeholders meeting for harmonization of work plans at national level. | 3.1.4 Fortnightly supervision to health facilities conducted and reported | |
| 3.1.5 Develop annual work plans with a costed budget at national level | 3.1.5 Bi-annual supervision to national and zonal reference labs conducted and reported | |
| 3.1.6 Plan and conduct quarterly Program Review Meeting at the 37 states | 3.1.6 Quarterly meetings conducted at zonal levels | |
| 3.1.7 Support conduct of quarterly zonal review meeting | 3.1.7 Quarterly meetings conducted at state levels | |
| 3.1.8 Plan and conduct quarterly planning cell/coordination meeting at national level | 3.1.8. Quarterly planning cell meetings conducted | |
| 3.1.9 Plan and conduct annual program review meeting with state program officers and partners | 3.1.9 Annual control officers meeting held | |
| 3.1.10 Plan and conduct mid-term and end term evaluation of the TBL strategic plan | 3.1.10 Mid- and end-term evaluation conducted | |
| 3.1.11 Conduct biennial Program monitoring and periodic evaluation (Joint International Monitoring Mission) | 3.1.11 Annual program monitoring mission conducted | |
| 3.1.12 Plan and conduct program-integrated supervision to all TBL health facilities monthly by LGA TBLS | 3.1.12 # of health facilities supervised monthly by TBLS | |
| 3.1.13 Plan and conduct program-integrated supervision to all LGAs quarterly by State TB and Leprosy Control Officer (STBLCO) | 3.1.13 # of LGAs supervised by State TBLCO | |
| 3.1.14 Organize supervision from national/zonal officers to state TBL Control Programs at least 12 states per quarter | 3.1.14 # of supervisory visits conducted by NTBLCP | |
| 3.1.15 Plan and conduct program-integrated supervision to all states bi-annually by National Program Officers | 3.1.15 # of supervisory visits conducted to states by NPOs | |
| 3.1.16 Support central unit zonal coordinators to provide technical assistance through supportive supervisory visits to 3 states per quarter | 3.1.16 # of supervisory visits conducted by central unit zonal coordinators | |
| 3.1.17 Organize a monthly coordination meeting of all units at the national levels | 3.1.17 Monthly review meetings conducted | |

| Objectives and activities | OVI | MOV |
|---|---|---|
| **Objective 3.2** | | |
| **Institute and strengthen electronic data management system at all levels (facilities, LGAs, states, and national).** | **#/proportion of management units with electronic data ace management system in pl** | **Program reports** |
| **Activities:** | **Outputs:** | |
| 3.2.1 Identify and engage a technical assistant (TA) for the development of a database for NTBLCP | 3.2.1 Database for NTBLCP developed | |
| 3.2.2 Conduct situation analysis, inventory and IT assessment at the national, states and LGA level for M&E | 3.2.2 IT situation analysis conducted | |
| 3.2.3 Develop IT specification for IT requirements at all levels | 3.2.3 IT specificatio ns developed for various levels | |
| 3.2.4 Develop a suitable software for data management at all levels | 3.2.4 Software for data manage-ment developed at all levels | |
| 3.2.5 Procure and distribute IT infrastructure to all the points of need at all levels (including laptops) | 3.2.5 # of IT materials procured and distributed | |
| 3.2.6 Support maintenance of the IT supportive structures/ national website | 3.2.6 IT supportive structure/web site maintained | |
| 3.2.7 Provision of regular feedback on completeness and quality of data transmitted at all levels | | |
| | | |
| **Objective 3.3** | | |
| **Build capacities in M&E, strategic information (SI), and data management for the program at all levels (health facilities, LGAs, states, and national) by 2015.** | **#/proportion of health workers trained on M&E, SI, and data management system** | |
| **Activities:** | **Outputs:** | |
| 3.3.1 Review the National M&E training curriculum/module | 3.3.1 M&E training curriculum reviewed | |
| 3.3.2 Organize a training of trainers (TOT) for the M&E course | 3.3.2 # of persons trained on TOT for M&E | |
| 3.3.3 Train all the LGA TBLS on M&E and Health Facilities | 3.3.3 # of LGTBLS and facility staff trained on M&E | |
| 3.3.4 Develop SOP and checklists for data quality review at all levels (LGA, state, national) | 3.3.4 SOPs for data quality review developed | |
| 3.3.5 Develop SOP to address data quality challenges (such as missing data, inconsistencies, updates on already submitted data) | 3.3.5 SOPs for addressing data quality challenges developed | |
| 3.3.6 Training of all management units on the use of the data management software | 3.3.6 # of program managers trained on data management soft ware. | |
| 3.3.7 Provide facility registers for all DOTS facilities | 3.3.7 # of health facilities provided with facility register | |

| Objectives and activities | OVI | MOV |
|---|---|---|
| **Objective 3.4** | | |
| **Develop a system and process for data dissemination at all levels by 2015.** | **Data dissemination system and processes in place** | **Program progress report** |
| **Activities:** | **Output:** | |
| 3.4 .1 NTBCLP stakeholders meeting, with the heads of ILEP partners, WHO, U.S. Government, and CDC Ips, to discuss policy on data dissemination | 3.4.1 Stakeholders meeting held | |
| 3.4.2 Develop policy document on data dissemination | 3.4.2 Policy document on data dissemination developed | |
| 3.4 3 Printin g and distribution of the policy document on data dissemination to all in country partners | 3.4.3 # of copies of policy document printed and distributed | |
| 3.3.5 Monitor compliance of all in - country partners with the policy on data dissemination, through tracking reports and communication products (e.g., newsletters and journals) | 3.4.5 # of TBL newsletters printed quarterly | |
| 3.3.6 Produce quarterly TB newsletter | | |
| **Strengthen TB/HIV collaborative activities** | | |
| **Objective 4** | | |
| 4.1 Increase and sustain the proportion of TB patients tested for HIV from 62% in 2008 to at least 85% by end of 2015. | 4.1 Proportion of TB patients tested for HIV | Quarterly and annual case finding reports |
| 4.2 Ensure that at least 85% of TB/HIV co - infected patients receive CPT by 2015. | 4.2 Proportion of TB/HIV co - infected patients on CPT | |
| 4.3 Ensure that at least 85% eligible TB/HIV co-infected patients receive ARVs by 2015. | 4.3 Proportion of TB/HIV co - infected on ARVs | |
| 4.4 Establish infection control (IC) in all health care facilities providing both DOTS and ART services by 2015. | 4.4 Number of health facilities with IC plans | |
| **Main activities:** | **Outputs:** | |
| 4.1 Expand TB/HIV TWG to the remaining 14 states of Nigeria | 4.1 14 Additional states TB/HIV TWG inaugurated | |
| 4.2 Support quarterly meetings of TB/HIV working groups (WGs) at national level | 4.2 A. Quarterly meetings held at national level | |
| 4.2B. Support quarterly meetings of TB/HIV WGs at state level | 4.2 B. Quarterly meeting held at state level | |
| 4.3 Provide HCT in all DOTS treatment centers. | 4.3 HIV testing provided in all DOTS treatment centers | |
| 4.4 Provide Cotrim for CPT to TB/HIV co infected personin all DOTS treatment centers | 4.4 Cotrim for CPT provided to TB/HIV co-infected patients in all DOTS treatment centers | |
| 4.5 Procurement of HIV- test kits, IPT, CPT, ARVs, etc. (see PSM section) | | |
| 4.6 Support facilities with both DOTS and ART services to develop an IC plan | 4.6 IC plan available and implemented in all facilities with both DOTS and ART services | |
| 4.7 Strengthen referral system between DOTS and HIV sites | 4.7 Referral linkages and instructions established between DOTS and HIV service delivery sites | |
| 4.8 Other related activities: see PSM, HRD, and M&E sections | | |

| Objectives and activities | OVI | MOV |
|---|---|---|
| **MDR-TB** | | |
| **Objective 5** | | |
| **5.1 Establish a routine drug resistance surveillance (DRS) system by end of 2011** | **5.1 Number of MDR-TB patients reported on through routine surveillance system** | **DRS report, monthly, quarterly, annual report.** |
| **5.2 Ensure that all CAT 2 failures have access to lab diagnostic services for MDR by end of 2012 and all CAT 1 failures by end of 2015** | **5.2 Proportion of CAT 2 and CAT 1 failures evaluated for MDR-TB** | |
| **5.3 Provide 2nd line anti-TB drugs for at least 85% of diagnosed MDR cases by end of 2015** | **5.3 Proportion of diagnosed MDR-TB patients placed on 2nd line drugs** | |
| **Main activities:** | **Outputs:** | |
| 5.1. Support quarterly meeting of national MDR committee | 5.1 MDR-TB quarterly meetings held | |
| 5.2. A. Establish and support referral network and transport logistics between peripheral health facilities/laboratories and the reference laboratories | 5.2 A. Proportion of MDR suspects whose sputum samples were transported to reference labs | |
| 5.2. B. Support referral/linkage of diagnosed or confirmed MDR patients to treatment centers for management with 2nd-line drugs | 5.2 B. Proportion of diagnosed MDR-TB patients placed on treatment | |
| 5.3 Support cost for ancillary investigations for all MDR-TB patients on treatment | 5.3 Proportion of MDR-TB patients supported for ancillary investigations | |
| 5.4 Provide support and incentives/enablers to all TB patients on treatment (e.g., bed fees, food packages, and transport cost and sustenance allowance). | 5.4 Incentives/enablers provided to MDR-TB patients | |
| 5.5 Support the renovation of 2 treatment center perzone for MDR treatment | 5.5 12 MDR-TB treatment centers renovated | |
| 5.6 2nd line drugs and other commodities (see section on PSM) | 5.6 See section on PSM | |
| 5.7 Facilitate linkage to Supra-NRL and support for annual external QA | 5.7 Report of DRS available | |
| 5.8 Review QA guideline to include external QA by Supra-National Reference Laboratories (see lab) | 5.8 See appropriate section | |
| 5.9 Conduct quarterly supervision to MDR treatment centers | | |
| 5.10 Conduct periodic DRS (by 2014) | | |
| 5.11 Support weekly review meetings at MDR-TB treatment facilities | | |
| 5.12 Provide TA for MDR-TB implementation (TA for Green Light Committee /drug management, lab and programmatic/ clinical mgt) | | |
| 5.13 Issues on HRD, community involvement, PSM: see appropriate section | | |

| Objectives and activities | OVI | MOV |
|---|---|---|
| **Engaging communities and patients in TB activities** | | |
| **Objective 6** | | |
| **Establish CTBC activities in at least 5 LGAs per state by end of 2015.** | **Number of states with CTBC activities in 5 LGAs.**<br>**Number and proportion of TB suspects referred to DOTs facilities by Community Volunteers/Treatment Supporters (CV/TS)**<br>**Proportion of TB patients receiving treatment from CV/TS** | **Annual report**<br>**Quarterly case finding report** |
| **Main activities:** | **Outputs:** | |
| 6.1. Mapping of CSOs and CBOs in 36 states and FCT (using existing supervisory system) | 6.1 List of CSOs and CBOs available | |
| 6.2 Organize and conduct a consensus meeting with CSOs and CBOs on CTBC activities | 6.2 Consensus meeting with CSOs and CBOs held | |
| 6.3 Conduct situation analysis and advocacy visits to identified communities within the 5 selected LGAs | 6.3 Situation analysis and advocacy conducted for 5 LGAs | |
| 6.4 Establish appropriate linkage between CTBC and the state programs using appropriate RR forms | 6.4 RR for CTBC available | |
| 6.5 Identify and support 1 umbrella CSO/CBO per state for implementation of CTBC activities at community level. | 6.5 36 umbrella CSO/CBOs identified and involved in CTBC | |
| 6.6 Provide incentives and enablers for TS and CVs | 6.6 Appropriate incentives provided to CVs/TS | |
| 6.7 For RR formats, guidelines and trainings, see appropriate section | | |
| 6.6 Adoption and printing of community based patient charter by CBOs and CSOs | | |
| **Advocacy, Communication and Social Mobilization** | | |
| **Objective 7** | | **Annual report** |
| **7.1 Ensure budgetary allocation and release of annual funds for TB and leprosy activities at all levels.** | **7.1 Proportion of annually planned budget released at national, state, and LGA levels** | |
| **7.2 Improve community awareness of TB and leprosy such that at least 60% of the public are aware of signs and symptoms of TB and leprosy and TBL service points by end 2015.** | **7.2 Percentage of community members with basic knowledge of signs and symptoms of TB and leprosy** | |

| Objectives and activities | OVI | MOV |
|---|---|---|
| **Main activities:** | **Outputs:** | |
| 7.1 Develop and print a comprehensive ACSM framework | 7.1 ACSM framework available | |
| 7.2A Support quarterly meeting of ACSM committees at national Level<br>7.2B Support quarterly meeting of ACSM committees at state levels | 7.2 All states have ACSM committees | |
| 7.3 Organize annual advocacy visit to national and state assembly | 7.3 ACSM quarterly meetings held | |
| 7.4 Support STOP TB Partnership, to carry advocacy and conduct quarterly executive committee meetings | 7.4 Annual advocacy visits held | |
| 7.5 Develop and produce appropriate context-specific advocacy kits and IEC materials for TB and leprosy control | 7.5 Stop TB partners supported | |
| 7.6 Organize national TB and leprosy conference biennially | 7.6 Appropriate IEC materials available | |
| 7.7 Organize World TB and Leprosy Day annually | 7.7 TBL conference held bi-annually | |
| 7.8 Organize public awareness campaigns on TB and leprosy using appropriate channels quarterly at all levels (print, TV, and radio) | 7.8 TB & leprosydays celebrated | |
| | 7.9 Regular public awareness campaigns held | |
| **Strategic alliances with academic, private, and other public practitioners** | | |
| **Objective 8** | | |
| **8.1 Scale up PPM services within the private, military, paramilitary, police, prisons, and custom health services, to contribute to at least 15% of total TB cases detected (excluding those from tertiary health institution) by the end of 2015** | **8.1 Proportion of detected TB cases attributable to private, military, and paramilitary institutions.** | **Quarterly report, Annual report** |
| **8.2 Expand Hospital DOTS Linkage (HDL) to all tertiary health institutions by 2015** | **8.2 Number and proportion of tertiary health institutions implementing HDL** | |
| 8.1 Conduct a situation analysis and facility assessment of military and paramilitary health services in 36 states and FCT | 8.1 Situation analysis conducted and facility assessment done | |
| 8.2 Expand TB and TB/HIV services to additional military, paramilitary, prisons and custom health services, in providing DOTS (see DOTS expansion to additional facilities) | 8.2 Additional military and paramilitary health services engaged in providing DOTS | |
| 8.3 Renovate old (63) and newly identified military and paramilitary facilities see DOTS | 8.3 Renovation of both old and new military and paramilitary health facilities including customs and prison facilities | |

| Objectives and activities | OVI | MOV |
|---|---|---|
| **Main Activities:** | **Outputs:** | |
| 8.4 Support quarterly national PPM steering committee meetings | 8.4 Quarterly national PPM meeting conducted | |
| 8.5 Support quarterly state PPM steering committee meetings | 8.5 Quarterly statePPM meeting conducted | |
| 8.6 Support monthly review meetings of DOTS unit within HDL facilities | 8.6 Monthly review meetings of DOTS unit within HDL facilities conducted | |
| 8.7 Support biannual meetings of the hospital DOTS committee in the HDL facilities | 8.7 Bi-annual meetings of hospital DOTS committee conducted | |
| 8.8 Support mapping of professional associations and define roles in PPM See other HR, PSM, and DOTs expansion related activities in appropriate section | 8.8 Mapping of professional associations done | |
| **Objective 9.1** | | |
| **Reduce the rate of new cases with grade-2 disabilities/100,000 population by at least 35% by the end of 2015, compared to the baseline at the end of 2010.** | **Leprosy Grade-2 disability rate /100,000 population** | **Annual case finding report** |
| **Main activities:** | **Outputs:** | |
| 9.1.1 Incorporate and integrate leprosy activities into General Outpatient Department (GOPD) /Skin/dermatology clinics through integration of leprosy into secondary and tertiary health facilities (stakeholders) | 9.1.1 GOPDs/Skin/Dermatology clinic in all LGA providing leprosy services | |
| 9.1.2 Conduct contact examination among all new cases of leprosy | 9.1.2 Contact examination conducted among all index cases (MB) | |
| 9.1.3 Identify and involve CVs and ex-leprosy patients in a ppropriate leprosy activities in the community in high priority states and LGAs (150 LGAs in six states) | 9.1.3 Leprosy community activities in 150 high endemic LGAs | |
| 9.1.4 Engage private practitioners and traditional healers in leprosy control services | 9.1.4 Number of private practitioners involved in leprosy service | |
| 9.1.5 Organize special case finding activities in difficult to reach areas (37 sites) | 9.1.5 Mini- LEC in 6 high prevalence states | |
| 9.1.6 Community awareness, IEC, training and ACSM (see appropriate section) | | |
| Objective 9.2 | | |
| Sustain MB and PB treatment completion rate of at least 85% and 95% respectively th roughout the plan period. | Treatment completion rate for MB and PB | Quarterly and Annual reports |
| Main activities: | Outputs: | |
| 9.2.1 Provision of MDT and other related drugs (PSM) | 9.2.1 Number of patients provided with MDT | |
| 9.2.2 Introduce adherence and counseling on MDT in leprosy program | 9.2.2 Adherence and counseling session provided to all leprosy patients | |

| Objectives and activities | OVI | MOV |
|---|---|---|
| 9.2.3 Strengthen defaulter retrieval system<br>9.2.4 Provide patient support and enablers for referral | | |
| 9.2.5 Training, curriculum review and supervision ( see HRD, M&E) | | |
| Objective 9.3 | | |
| Ensure quality patient care such that proportion of patients who develop new/additional disabilities at the end of treatment is not more than 5% annually. | Proportion of new patients with new disabilities | |
| Main Activities: | Outputs: | |
| 9.3.1 Provide appropriate POID materials for leprosy patients (e.g., Vaseline, shoes, eye glasses, crutches) | 9.3.1 Proportion of leprosy patients provided with POID materials. | |
| 9.3.2 Provide adequate health education and counseling to all leprosy patients | 9.3.4 Number of leprosy patients enrolled in self-care groups | |
| 9.3.3. Strengthen leprosy reaction management in the field | | |
| 9.3.4 Expand and strengthen self-care groups in all leprosy settlements | | |
| Objective 9.4 | | |
| Set up a systematic rehabilitation service aimed at empowering leprosy patients using CBR system in all states by end of 2015. | Number of states implementing community rehabilitation services (CBR) | Annual report |
| Main Activities: | Outputs: | |
| 9.4.1 Engage the services of a CBR expert | 9.4.1 CBR expert engaged | |
| 9.4.2 Develop a comprehensive rehabilitation services for leprosy patient based on CBR | 9.4.2 Comprehensive rehabilitation plan available in all states | |
| 9.4.3 Link all PALs with umbrella organization of people living with disabilities in Nigeria | 9.4.3 PALS links to umbrella organization of people living with disabilities | |
| 9.4.4 Support the activity of IDEA annually based on needs | 9.4.4 IDEA's activity supported annually | |
| 9.4.5 Identify and equip 2 facilities for preventive and rehabilitative surgery (PRS) (1 in South, 1 in North) | 9.4.5 Two facilities equipped to carry out PRS | |
| **Research** | | |
| **Objective 10** | | |
| **Develop capacity and environment for research on TB, HIV and leprosy among program managers at all levels.** | **Number of operational researches conducted and disseminated** | |
| **Main activities**: | **Outputs:** | |
| 10.1. TBL training institute to ally with academic institutions and other implementing partners to set up research committee | 10.1 Research team constituted | |
| 10.2. Support bi-annual meeting of research committee | 10.2 Research committee meetings held | |

| Objectives and activities | OVI | MOV |
|---|---|---|
| 10.3. Organize and conduct research training workshops for program managers at different levels | 10.3 Six Health Service Research (HSR) teams training conducted annually | |
| 10.4. Conduct situation analysis and develop research agenda for TBL annually | 10.4 Research agenda developed | |
| 10.5. Organize scholarship for presentations of research findings at international conferences | 10.5 Attendance at international conference with paper presentation | |
| 10.6. Support at least 6 researches annually based on priorities and needs | 10.6 Research activities conducted by different group annually | |
| 10.7. Subscribe to international journals for all program managers | 10.7 Subscription and publications of research findings | |
| 10.8. Support the dissemination of research findings in appropriate journals and newsletters | | |
| **HRD** | | |
| **Objective 11.1** | | |
| **Develop the management and leadership capacity of program managers at all levels by end of 2015.** | **# of program managers who had training on leadership and management** | **Program annual report** |
| **Main activities:** | **Outputs:** | |
| 11.1.1 Train at least 15 LG TB and leprosy supervisors annually | 11.1.1 # of TBLS trained annually | |
| 11.1.2 Train at least 15 program managers on TBL program management (including new initiatives) annually | 11.1.2 # of program managers trained annually | |
| 11.1.3 Provide and maintain office space and equipment including internet facility for national, state, and local government control offices | 11.1.3 # of equipment supplied | |
| 11.1.4 Organize a training workshop for all program officers on WHO costing tool (20 participants per year) | 11.1.4 # of program managers trained on WHO costing tool | |
| 11.1.5 Support 12 participants for international courses annually (Union, Sondalo, Bangkok, or other relevant courses) | 11.1.5 # of participants who attended Sondalo course | |
| 11.1.6 Support at least 12 program officers to attend annual international conference on TB and leprosy | 11.1.6 # of program managers who attend international course annually | |
| **Objective 11.2** | | **Program annual report** |
| **Ensure that the human resource needs of TB and leprosy at all levels are met (recruitment, retention, motivation, and tools).** | **# (%) of health facilities with at least one health worker trained on TB**<br>**# (%) of posts filled according to HRD plan** | |
| **Activities**: | **Outputs**: | |
| 11.2.1 Recruit and redeploy 10 medical officers, 48 Nurses, 6 laboratory scientists, 2 pharmacists, 1 physiotherapist, and 10 medical lab technicians | 11.2.1 # of staff recruited for NTBLTC Zaria by carder | |

| Objectives and activities | OVI | MOV |
|---|---|---|
| 11.2.2 Recruit and train 2 maintenance officers for both NRLs and ZRLs | 11.2.2 2 Maintenance officers recruited and trained | |
| 11.2.3 Conduct leadership and management course for at least 15 program officers twice yearly | 11.2.3 # of program managers trained on leadership and management course per year | |
| 11.2.4 Train 4 national M&E officers and 2 state M&E officers per states on harmonized formats, data management and use of software (3 days training) | 11.2.4 # of M&E officers trained | |
| 11.2.5 Provide monetary incentives to program management staff at all levels | | |
| **Objective 11.3** | | |
| **Develop and provide all program tools (guidelines, manuals and RR forms) for effective implementation of TB and Leprosy Control Program.** | | |
| **Activities:** | **Outputs:** | |
| *Tools* | | |
| 11.3.1 Review, print, and disseminate the NTBLCP Workers Manual (print 1000 annually) | 11.3.1 # of manuals printed annually<br>11.3.2 Training materials | |
| 11.3.2 Review and harmonize all training materials (inclusion of TB/HIV, infection control, ISTC) | reviewed and harmonized | |
| 11.3.3 Print 8,000 copies of the TB training module (1,600) copies annually | 11.3.3 # of TB training modules printed annually | |
| 11.3.4 Review and harmonize all laboratory guidelines and training modules to include HIV rapid testing | 11.3.4 Laboratory guidelines reviewed and harmonized | |
| 11.3.5 Print 4,000 copies of laboratory training module (800 copies annually) | 11.3.5 # of laboratory manuals printed | |
| 11.3.6 Develop a training module for physicians/pediatricians on TB and leprosy | 11.3.6 Training module for physicians/ pediatricians developed | |
| 11.3.7 Print 2,500 copies of MO training module (500 copies annually) | 11.3.7 # of MOs manual printed | |
| 11.3.8 Develop M&E training module | 11.3.8 M&E training module developed | |
| 11.3.9 Print 2,5 00 copies of M&E training module (500 copies annually) | 11.3.9 # of M&E training modules printed | |
| 11.3.10 Develop training materials for PLHIV support groups and community home-based care providers for TB/HIV | 11.3.10 Training materials for PLWHIV support group developed | |
| 11.3.11 Review and finalize MDR-TB management guideline (5-day workshop for 15 participants) | 11.3.11 MDR-TB management guideline developed | |
| 11.3.12 Print and distribute 1,000 copies of MDR-TB guidelines | 11.3.12 # of MDR - TB guidelines printed | |
| 11.3.13 Develop guidelines/protocol for routine MDR- TB surveillance and finalization of RR for MDR-TB (12 participants) | 11.3.13 Guideline and protocol for MDR-TB survey developed | |

| Objectives and activities | OVI | MOV |
|---|---|---|
| 11.3.14 Develop MDR-TB training module (5-day workshop for 15 participants) | 3.14 MDR-TB training module developed | |
| 11.3.15 Develop and finalize SOPs for BSL3, LED microscopy, Hain assay, and DST (15 participants) | 3.15 SOPs for BSL3, LED and Hain developed | |
| 11.3.16 16 Print and distribute 500 copies of MDR-TB training module | 3.16 # of SOPs developed | |
| 11.3.17 Develop policy on TB patient support | | |
| 11.3.18 Review and update leprosy training modules (suspect/refer and leprosy management module) | 3.18 Leprosy training module reviewed | |
| 11.3.19 Print and distribute 5,000 copies of leprosy training modules (1,000 copies annually) | 11.3.19 # of leprosy training modules printed | |
| 11.3.20 Review and harmonize all recording and reporting formats | 11.3.20 RR forms of program reviewed | |
| 11.3.21 Printing and distribution of ALL program recording and reporting formats, including IEC materials for TB and leprosy | 11.3.21 IEC materials printed and distributed | |
| 11.3.22 Review of ALL program policy documents and guidelines | 11.3.22 All program policy documents reviewed | |
| 11.3.23 Develop a web-based software for data management at all levels | 11.3.23 Web -based software developed | |
| 11.3.24 Develop a national M&E country plan | 11.3.24 M&E country plan developed | |
| 11.3.25 Develop a procurement plan for TBL commodities | 11.3.25 PSM plan developed | |
| 11.3.26 Review and print LMIS recording and reporting formats | 11.3.26 LMIS RR forms reviewed | |
| 11.3.27 TOT workshops on the training tools for each of the above stated tools; 30 participants each for DOTS, Microscopy, MDT TB, and leprosy training (30 *4) | 11.3.27 # of personnel trained for TOT | |
| **Objective 11.4** | | |
| **Empower health care workers to provide comprehensive TB and leprosy services, through training in all components of Stop TB strategy and enhance global strategy for leprosy.** | | |
| ***General and TB*** | | |
| 11.4.1 Conduct a 5-day training for lab staff on AFB microscopy and QA (2 per lab for 1,247 additional labs) | 11.4.1 # of lab staff trained on AFB and QA | |
| 11.4.2 Organize a refresher course for lab staff (2/lab for 969 existing labs) | 11.4.2 # of lab staff who had refresher course | |
| 11.4.3 Organize and conduct 4-day training workshop for 3 GHCW per facility on DOTS for 2,346 additional DOTS centers (3 *2,346 = 7,038); each training session with a maximum of 25 participants and 3 facilitators. | 11.4.3 # of GHCWs trained on DOTS | |

| Objectives and activities | OVI | MOV |
|---|---|---|
| 11.4.4 Organize a 3-day refresher training for national and state QA officers (15 participants annually)<br>Organize a 2-day training for physicians and pediatricians on TB management (6 participants per tertiary institution for 45 tertiary centers)<br>Organize 3-day training for national and state logistic officers (4 national and 2 per state) | 11.4.4 # of QA officers trained | |
| 11.4.5 Organize a 3-day TOT workshop among selected private practitioners (10 participants per zone) | 11.4.5 # of private practitioners who attended TOT | |
| 11.4.6 Train 5 health care workers from each selected prison health facility on TB DOTS (85% of prison health facilities) | 11.4.6 # of HCW in prison trained on DOTS | |
| 11.4.7 Organize a 2-day meeting annually to develop a QA panel test kit | 11.4.7 # of meetings organized on QA panel testing annually | |
| ***PSM*** | | |
| 11.4.8 Train and retrain health workers at all levels on the LMIS tools | 11.4.8 # of GHCWs trained on LMIS | |
| 11.4.9 Train state teams on the use of patients kits for treatment of TB | 11.4.9 # of state TBL teams trained on patient kits | |
| 11.4.10 Train zonal pharmacists/store officers on PSM and store management | 11.4.10 # of zonal pharmacist/ store officers trained on PSM | |
| 11.4.11 Collaborate with JSI Deliver (USAID) to institutionalize PSM training at NTBLTC | | |
| ***TB/HIV*** | | |
| 11.4.12 Organize 5 -day training of GHW on counseling and testing (3 GHWs per DOTS site for 2,742 sites) | 11.4.12 # of GHWs trained on HCT | |
| 11.4.13 One-day trainings of PLHIV and TB patients on adherence (2 participants per site for 100 sites implementing TB/ HIV collaborative activities annually). | 11.4.13 # of support group members trained on adherence | |
| 11.4.14Organize 5- day training on "3 Is" (infection prevention and control, Intensify case finding and IPT) for health facilities providing TB and TB/HIV collaborative activities (5 participants per site for at least 5 sites per state) | 11.4.14 # of health workers trained on 3 Is | |
| 11.4.15 Organize 5-day training for PLHIV support groups and community home-based care providers for TB/HIV (4 participants per support group from 5 communities per LGA) | 11.4.15 # of support group members trained on home based care | |
| ***MDR-TB*** | | |
| 11.4.16 Conduct 5 -day training for all program managers on programmatic management of MDR-TB (including PSM personnel); 20 participants per course annually (20*5) | 11.4.16 # of program managers trained on MDR-TB | |

| Objectives and Activities | OVI | MOV |
|---|---|---|
| 11.4.17 Organize 5 -day training on MDR-TB for physicians and nurses for MDR-TB management (2 MO, 6 nurses, 2 lab staff and 1 pharmacist, 2 social workers per center for 12 treatment centers) | 11.4.17 # of physician trained on MDR-TB care | |
| 11.4.18 Organize 2 weeks training for 4 -6 staff of the 2 NRL and 6 ZRLs on culture and DST | 11.4.18 # of lab staff of NRL & ZRL trained on culture and DST | |
| 11.4.19 Support study tour to countries with functioning MDR-TB program for key program staff at national, state, and facility level (a team of 10 annually) | 11.4.19 # of participants who had study tour | |
| 11.4.20 Organize training for CBOs and CSOs on MDR- TB (support adherence for patients on treatment)<br>11.4.21 Support 2 TAs annually on MDR-TB management | 11.4.20 # of CBO,s & CSO,s trained | |
| ***CTBC*** | | |
| 11.4.22 Organize a one-day sensitization training for at least 4 participants per CSO for 2 CSO per state | 11.4.22 # of participants who attended sensitization workshop | |
| 11.4.23 Organize 2-day training for 4 Cvs per community for 5 communities per state (2*4*5* 37) | 11.4.23 # of CVs trained | |
| ***ACSM*** | | |
| 11.4.24 Organize 5-day training for all program managers on advocacy and lobby skills (25 participants per course for 2 courses) | 11.4.24 # of program managers trained on ACSM | |
| 11.4.25 Train selected journalists and CSO stakeholders involved in TBL services on ACSM (20 participants per state for 37 states) | 11.4.25 # of journalist trained on TB ACSM | |
| ***Leprosy*** | | |
| 11.4.26 Organize a 1-day training on leprosy suspect and referral for 3 GHWs per facility for 2 health facilities per LGA (3*2*774) for the period of 5 years | 11.4.26 # of GHWs trained on leprosy suspect and referral | |
| 11.4.27 Organize a 3-day training on leprosy diagnosis and treatment for 3 Physicians/ dermatologists for one secondary/ tertiary health facility for 774 LGA (3*774) | 11.4.27 # of GHWs trained on leprosy diagnosis and management | |
| 11.4.28 Organize 3-day training on leprosy for 3 GHWs per PHC for 2 PHC facilities in 150 high endemic LGAs (3*2*150) | 11.4.28 # of GHWs trained on leprosy | |

| Objectives and Activities | OVI | MOV |
|---|---|---|
| 11.4.29 Organize 5-day training on community dermatology for one site per state (4 participants per site: 4*37) | 11.4.29 # of staff trained on community dermatology | |
| 11.4.30 Organize 5-day training workshop for all program officers and partners on rehabilitation based on CBR (30 participants per course for 2 course) | 11.4.30 # of program officers trained on CBR | |
| 11.4.31 Train 2 selected surgeons and a physiotherapist on preventive rehabilitative surgery for 2 zones (North/South); 2-3 months training at ALERT | 11.4.31 # of surgeon trained on leprosy surgery | |
| 11.4.32 Train CVs and ex-leprosy patients on leprosy control activities in selected high endemic LGA (150 LGAs ); 2 days training for 4 participants per LGA | 11.4.32 # of ex-leprosy patients trained on leprosy activities | |
| ***Research*** | | |
| 11.4.33 Recruit a focal person for research for NTBLTC Zaria | 11.4.33 Research focal person appointed | |
| 11.4.34 Organize HSR training workshop for 6 teams (4-6 participants per team) annually, based on research agenda of the TBL program | 11.4.34 # of participants trained on HSR | |
| ***Engagement with stakeholders*** | | |
| 11.4.35 Organize a stakeholders meeting with professional bodies and heads of pre-service institutions on TBL control | 11.4.35 Stakeholders meeting organized | |
| 11.4.36 Support the integration of TBL control activities into existing curriculum of pre-service training school | 11.4.36 TBL activities integrated into pre-service curriculum | |
| 11.4.37 Develop a pool of facilitators within academia and the private sector (organize TOT for 15 participants per zone) | 11.4.37 # of staff in the academia trained on TBL | |
| **Objective 11.5**<br>**Establish and maintain a health information management system (HIMS) for human resources for NTBLCP.** | | |
| **Activities:** | | |
| 11.5.1 Organize a stakeholders meeting among all partners on HIMS for HR | 11.5.1 Stakeholders meeting held | |
| 11.5.2 Develop and print HIMS for HR | 11.5.2 HIMS for HR developed | |
| 11.5.3 Disseminates HIMS for HR for NTBLCP to all stakeholders and at the control officers meeting. | 11.5.3 HIMS for HR discussed at various meetings | |

# ANNEX B: SUMMARY BUDGET

| 2010 - 2015 TUBERCLOSIS AND LEPROSY STRATEGIC PLAN | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| SUMMARY | | | | | | | | |
| | THEMATIC AREAS | YEAR 1 | YEAR 2 | YEAR 3 | YEAR 4 | YEAR 5 | TOTAL | *$ value* |
| 1 | LEPROSY | 347,605,900 | 346,196,235 | 363,506,047 | 381,681,349 | 400,765,417 | 1,839,754,947 | 13,141,107 |
| 2 | Community TB Care (CTBC) | 105,032,500 | 91,402,600 | 92,316,626 | 93,239,792 | 94,172,190 | 476,163,708 | 3,401,169 |
| 4 | Monitoring and Evaluation (M&E) | 1,075,067,900 | 796,247,842 | 823,526,730 | 812,252,424 | 840,079,617 | 4,347,174,513 | 31,051,247 |
| 5 | Human Resources Development (HRD) | 2,074,897,838 | 2,014,609,164 | 2,062,140,256 | 2,093,064,669 | 2,103,589,276 | 10,348,301,203 | 73,916,437 |
| 6 | Advocacy, Communication and Social Mobilization (ACSM) | 315,556,000 | 318,711,560 | 321,898,676 | 325,117,662 | 328,368,839 | 1,609,652,737 | 11,497,520 |
| 7 | Procurement Supply Management (PSM) | 1,710,260,323 | 1,727,362,927 | 1,744,636,556 | 1,762,082,922 | 1,779,703,751 | 8,724,046,479 | 62,314,618 |
| 8 | TB/HIV Collaborative | 107,117,100 | 108,188,271 | 109,270,154 | 110,362,855 | 111,466,484 | 546,404,864 | 3,902,892 |
| 9 | DOTS Expansion | 1,403,631,200 | 1,417,667,512 | 1,431,844,187 | 1,446,162,629 | 1,460,624,255 | 7,159,929,783 | 51,142,356 |
| 10 | Multi- Drugs Resistance Tuberclosis (MDR) | 1,767,327,000 | 1,785,000,270 | 1,802,850,273 | 1,820,878,775 | 1,839,087,563 | 9,015,143,881 | 64,393,885 |
| 11 | Laboratory | 1,476,506,960 | 1,488,109,417 | 1,502,990,511 | 1,518,020,416 | 1,533,200,620 | 7,518,827,923 | 53,705,914 |
| 12 | Research | 242,614,300 | 245,040,443 | 247,490,847 | 249,965,756 | 252,465,413 | 1,237,576,760 | 8,839,834 |
| | TOTAL | **10,625,617,022** | **10,731,873,192** | **247,490,847** | **249,965,756** | **252,465,413** | 22,107,412,231 | **377,306,977** |

# ANNEX C: DETAILED BUDGET FOR EACH THEMATIC AREA

| 2010 - 2015 TUBERCLOSIS AND LEPROSY STRATEGIC PLAN | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Leprosy section** | | | | | | | |
| | | | **Year 1** | **Year 2** | **Year 3** | **Year 4** | **Year 5** |
| **Objective** | | **Activities** | **Amount** | | | | |
| To reduce the rate of new case with grade 2 disabilities/ 100,000m population by at least 35% by the end of 2015, compared to the base line at the end of 2009 | 8.1 | B Incorporate and integrate Leprosy activities into GOPD/Skin/dermatology (clinics ( integration of leprosy into secondary and tertiary health facilities (organise a stakeholders meeting) | 3,988,600 | 4,188,030 | 4,397,432 | 4,617,303 | 4,848,168 |
| | 8.2. | Conduct contact examination among all new cases of Leprosy | 0 | 0 | 0 | 0 | 0 |
| | 8.3. | Identify and involve CVs and ex-leprosy patients in appropr-iate leprosy activities in the community in high priority states/LGAs (150 LGAs in 6 states) see HRD section | 0 | 0 | 0 | 0 | 0 |
| | 8.4. | Engage private practi-tioners and traditional healers in Leprosy control services | 3,988,600 | 0 | 0 | 0 | 0 |
| | 8.5. | Plan special case finding activities in difficult to reach areas (37 sites) | 41,585,000 | 43,664,250 | 45,847,463 | 48,139,836 | 50,546,827 |
| | 8.6. | Community awareness, IEC, training and ACSM (see appropriate section) | 0 | 0 | 0 | 0 | 0 |
| **Sub Total** | | | **49,562,200** | **47,852,280** | **50,244,894** | **52,757,139** | **55,394,996** |
| To sustain MB and PB treatment comple-tion rate of at least 85% & 95% respec-tively throughout the plan period | 9.1. | Provision of MDT and other related drugs (PSM) | 0 | 0 | 0 | 0 | 0 |
| | 9.2. | Introduce adherence and counseling on MDT in Leprosy program | 0 | 0 | 0 | 0 | 0 |
| | 9.4. | Provide patient support and enablers for referral | 611,000 | 641,550 | 673,628 | 707,309 | 742,674 |
| To ensure quality patient care such that proportion of patients who develop new/additional disa-bilities at the end treatment is not more than 5% annually. | 10.1. | Provide appropriate POD materials for Leprosy patients (e.g Vaseline, shoes, eye glasses, crutches) | 3,082,500 | 3,236,625 | 3,398,456 | 3,568,379 | 3,746,798 |
| | 10.2. | Provide adequate health education and counseling to all Leprosy patients | 0 | 0 | 0 | 0 | 0 |
| | 10.3. | Strengthen Leprosy reaction management in the field | 0 | 0 | 0 | 0 | 0 |
| | 10.4. | Expand & strengthen self care groups in all leprosy settlements | | | | | |
| **Sub total** | | | **16,650,000** | **17,482,500** | **18,356,625** | **19,274,456** | **20,238,179** |

| 2010 - 2015 TUBERCLOSIS AND LEPROSY STRATEGIC PLAN | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Leprosy section** | | | | | | | |
| | | | **Year 1** | **Year 2** | **Year 3** | **Year 4** | **Year 5** |
| **Objective** | | **Activities** | **Amount** | | | | |
| To set up a systematic rehabilitation service aim at empowering leprosy patients using community based rehabilitation system in all states by end of 2015 | 11.1. | Engage the services of a CBR expert | 9,785,000 | 10,274,250 | 10,787,963 | 11,327,361 | 11,893,729 |
| | 11.2. | Develop a comprehensive rehabilitation services for Leprosy patient based on the concept of CBR | 4,959,000 | 0 | 0 | 0 | 0 |
| | 11.3. | Link all PALs with umbrella organization of people living with disabilities in Nigeria | 0 | 0 | 0 | 0 | 0 |
| | 11.4. | Support the activity of IDEA annually based on needs | 1,000,000 | 1,050,000 | 1,102,500 | 1,157,625 | 1,215,506 |
| | 11.5. | Identify and equip 2 facilities for preventive and rehabilitative surgery (1 in South, 1 in North) | 90,000,000 | 94,500,000 | 99,225,000 | 104,186,250 | 109,395,563 |
| **Sub total** | | | **105,744,000** | **105,824,250** | **111,115,463** | **116,671,236** | **122,504,797** |
| **Overall Total** | | | **347,605,900** | **346,196,235** | **363,506,047** | **381,681,349** | **400,765,417** |

| 2010 - 2015 TUBERCLOSIS AND LEPROSY STRATEGIC PLAN | | | | | | | |
|---|---|---|---|---|---|---|---|
| DOTS expansion | | | | | | | |
| | | | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| Objective | | Activities | Amount | | | | |
| 1.A To increase TB case detection rate from 30.5% in 2008 to 70% by 2015 | 1.1 | Establish 2, 346 additional DOTS treatment centers | | | | | |
| | 1.2 | Support renovation of both old and new DOTS sites (i.e 5,088) | 612,595,200 | 618,721,152 | 624,908,364 | 631,157,447 | 637,469,022 |
| | 1.3 | Establish 1,247 additional AFB microscopy centers | 523,740,000 | 528,977,400 | 534,267,174 | 539,609,846 | 545,005,944 |
| | 1.4 | Support renovation of both new and old labs (i.e 2,216) | 217,168,000 | 219,339,680 | 221,533,077 | 223,748,408 | 225,985,892 |
| | 1.5 | Completion of the reference laboratories (2 National and 6 Zonal laboratories) | 44,800,000 | 45,248,000 | 45,700,480 | 46,157,485 | 46,619,060 |
| | 1.6 | Establish TB/HIV services in at least 70% of eligible PPM facilities by 2015 | 0 | 0 | | | |
| | 1.7 | Scale up HDL plan in all tertiary health facilities by 2015 (quarterly committee meetings) | 5,328,000 | 5,381,280 | 5,435,093 | 5,489,444 | 5,544,338 |
| | 1.8 | Establish DOTS services in at least 85% of Nigerian prisons | 0 | 0 | 0 | 0 | 0 |
| | 1.9 | Provide first line anti TB drugs, reagents etc (see obj 2 on PSM) | 0 | 0 | 0 | 0 | 0 |
| | 1.10 | Training activities (refer to section on HRD) | 0 | 0 | 0 | 0 | 0 |
| **Total** | | | **1,403,631,200** | **1,417,667,512** | **1,431,844,187** | **1,446,162,629** | **1,460,624,255** |

| 2010 - 2015 TUBERCLOSIS AND LEPROSY STRATEGIC PLAN | | | | | | | |
|---|---|---|---|---|---|---|---|
| **TB/HIV** | | | | | | | |
| | | | **Year 1** | **Year 2** | **Year 3** | **Year 4** | **Year 5** |
| **Objective** | | **Activities** | **Amount** | | | | |
| 4. A To increase and sustain the proportion of TB patients tested for HIV from 62% in 2008 to at least 85% by end of 2015 | 4.1 | Expand TB/HIV TWG to the remaining 14 states of Nigeria | 411,500 | 415,615 | 419,771 | 423,969 | 428,209 |
| 4.B To ensure that at least 85% of TB/HIV co-infected patients received CPT by 2015 | 4.2 | A. Support quarterly meetings of TB/HIV Wgs at National level | 2,040,000 | 2,060,400 | 2,081,004 | 2,101,814 | 2,122,832 |
| 4.C To ensure that at least 85% eligible TB/HIV co-infected patients received ARVs by 2015 | 4.3 | Provide HIV (HCT) in all DOTS sites. | 784,000 | 791,840 | 799,758 | 807,756 | 815,834 |
| | 4.4 | Provide CPT to TB/HIV co-infected person in all DOTS sites | 0 | 0 | 0 | 0 | 0 |
| | 4.5 | Procurement of HIV-test kits, IPT, CPT, ARVs etc See PSM section | 0 | 0 | 0 | 0 | 0 |
| | 4.6 | Support facilities to develop an IC plan | 103,881,600 | 104,920,416 | 105,969,620 | 107,029,316 | 108,099,610 |
| | 4.7 | Strengthen referral system between DOTS and HIV sites | 0 | 0 | 0 | 0 | 0 |
| | 4.8 | Other related activities see PSM, HRD and M&E sections | 0 | 0 | 0 | 0 | 0 |
| **Total** | | | **107,117,100** | **108,188,271** | **109,270,154** | **110,362,855** | **111,466,484** |

| 2010 - 2015 TUBERCLOSIS AND LEPROSY STRATEGIC PLAN | | | | | | | |
|---|---|---|---|---|---|---|---|
| **PSM** | | | | | | | |
| | | | **Year 1** | **Year 2** | **Year 3** | **Year 4** | **Year 5** |
| **Objective** | | **Activities** | **Amount** | | | | |
| To strengthen the existing PSM system in order ensure uninterrupted drugs and commodities supply in all TBL facilities throughout the plan period | 2.1. | Renovation and annual maintenance of national, 6 zonal and 37 states stores | 5,880,000 | 5,938,800 | 5,998,188 | 6,058,170 | 6,118,752 |
| | 2.2 | Procurement of both 1st and 2nd drugs for estimated number of patients | 583,228,608 | 589,060,894 | 594,951,503 | 600,901,018 | 606,910,029 |
| | 2.3. | Support commodities clearance and transport to different levels | 0 | 0 | 0 | 0 | 0 |
| | 2.4. | Procurement of laboratory reagents and consumables for 2, 216 laboratories | 184,800,000 | 186,648,000 | 188,514,480 | 190,399,625 | 192,303,621 |
| | 2.5. | Procurement of reagents and other consumables for culture, DST and line probe assay for the two (2) national and 6 zonal reference laboratories. | 3,101,120 | 3,132,131 | 3,163,453 | 3,195,087 | 3,227,038 |
| | 2.6 | Procurement and installation of equipments for the 2 national and six zonal laboratories. | 123,200,000 | 124,432,000 | 125,676,320 | 126,933,083 | 128,202,414 |

| 2010 - 2015 TUBERCLOSIS AND LEPROSY STRATEGIC PLAN | | | | | | | |
|---|---|---|---|---|---|---|---|
| PSM | | | | | | | |
| | | | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| Objective | | Activities | Amount | | | | |
| | 2.7. | Procurement of microscopes (light, LED and FM) for the additional laboratories as appropriate (1,247) | 63,700,000 | 64,337,000 | 64,980,370 | 65,630,174 | 66,286,475 |
| | 2.8. | Procurement of INH for prophylaxis among children and PLHIV . | 1,168,000 | 1,179,680 | 1,191,477 | 1,203,392 | 1,215,425 |
| | 2.9. | Procurement, installation and maintenance of X-ray machines at least one per state for diagnosis of TB in children and EPTB | 129,500,000 | 130,795,000 | 132,102,950 | 133,423,980 | 134,758,219 |
| | 2.10 | Procurement of Rifabutin for TB/HIV co-infected patients on 2nd line ARVs (estimate 2-5% of total TB cases) | 2,253,079 | 2,275,610 | 2,298,366 | 2,321,349 | 2,344,563 |
| | 2.11 | Procurement of CPT for TB/HIV co-infected patients at DOTS centers (27-40% co-infection rate) | 289,145,116 | 292,036,567 | 294,956,933 | 297,906,502 | 300,885,567 |
| | 2.12. | Procurement and support maintenance of TB infection control equipments (N95 respirator, vaneometer, surgical mask etc) | 121,094,400 | 122,305,344 | 123,528,397 | 124,763,681 | 126,011,318 |
| | 2.13. | Replacement and maintenance of project vehicles and motorcycles at various levels. | 196,520,000 | 198,485,200 | 200,470,052 | 202,474,753 | 204,499,500 |
| | 2.14. | Procurement of MDT & other drugs/POID materials for leprosy patients (using average of 5,000 patients annually). | 0 | 0 | 0 | 0 | 0 |
| | 2.15. | Plan quarterly meeting of TBL logistics TWG | 6,670,000 | 6,736,700 | 6,804,067 | 6,872,108 | 6,940,829 |
| **Total** | | | **1,710,260,323** | **1,727,362,927** | **1,744,636,556** | **1,762,082,922** | **1,779,703,751** |

## M&E workplan and budget 2010- 2015

| | | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
|---|---|---|---|---|---|---|
| Objective | Activities | Amount | | | | |
| To strengthen the M&E system at all levels in order line to ensure that over 95% planned activities are implemented, monitored and evaluated in line with the National Strategic plan 2010-2015 | Plan and conduct situation analysis to establish base line data for some of the program indicators. | 1,992,500 | 0 | 0 | 0 | 0 |
| | Develop, produce and disseminate an indicator reference book for the NTBLCP | 3,894,000 | 0 | 0 | 0 | 0 |
| | Conduct annual data audit on key Indicators | 960,000 | 969,600 | 979,296 | 989,089 | 998,980 |
| | Conduct a stakeholders meeting for harmonization of work plans annually | 3,245,000 | 3,277,450 | 3,310,225 | 3,343,327 | 3,376,760 |
| | Develop annual work plans with a costed budget at national level | 235,000 | 237,350 | 239,724 | 242,121 | 244,542 |
| | Plan and conduct quarterly meetings at zonal levels, including EQA. | 48,492,000 | 48,976,920 | 49,466,689 | 49,961,356 | 50,460,970 |
| | Plan and conduct quarterly meetings at states levels | 263,125,200 | 265,756,452 | 268,414,017 | 271,098,157 | 273,809,138 |

## M&E workplan and budget 2010- 2015

| | | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
|---|---|---|---|---|---|---|
| Objective | Activities | Amount | | | | |
| | Plan and conduct planning cell meetings quarterly | 7,380,000 | 7,453,800 | 7,528,338 | 7,603,621 | 7,679,658 |
| | Plan and conduct annual program review meeting with state program officers and partners | 12,305,000 | 12,428,050 | 12,552,331 | 12,677,854 | 12,804,632 |
| | Conduct mid and end term evaluation of the TBL strategic plan | | 0 | 9,861,307 | | 10,059,519 |
| | Plan and conduct biennial programme monitoring and periodic evaluation (JIMM) | 9,268,800 | 0 | 9,455,103 | 0 | 9,645,150 |
| | Plan and conduct program integrated supervision to all TBL health facilities monthly by LG TBLS | 216,720,000 | 218,887,200 | 221,076,072 | 223,286,833 | 225,519,701 |
| | Plan and conduct program integrated supervision to all LGAs quarterly by STBLCO | 145,145,000 | 146,596,450 | 148,062,415 | 149,543,039 | 151,038,469 |
| | Plan and conduct integrated supervision from national/zonal to at least 12 states per quarter | 38,304,000 | 38,687,040 | 39,073,910 | 39,464,650 | 39,859,296 |
| | Plan and conduct program integrated supervision to all states quarterly by TB NPO's | 20,905,000 | 21,114,050 | 21,325,191 | 21,538,442 | 21,753,827 |
| | Support CU Zonal coordinators to provide technical assistance through supportive supervisory visits to 3 states per quarter | 22,104,000 | 22,325,040 | 22,548,290 | 22,773,773 | 23,001,511 |
| | Conduct monthly coordination meeting at central unit level | 1,320,000 | 1,333,200 | 1,346,532 | 1,359,997 | 1,373,597 |
| **Sub Total** | | **795,395,500** | **788,042,602** | **815,239,438** | **803,882,258** | **831,625,750** |

## M&E workplan and budget 2010- 2015

| | | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
|---|---|---|---|---|---|---|
| Objective | Activities | Amount | | | | |
| To institute and strengthen electronic data management system at all levels (facilities, LGAs, States and National) | Identify and engage a TA for the development of a database for NTBLCP | 450,000 | 0 | 0 | 0 | 0 |
| | Conduct situation analysis, inventory and IT assessment at the National, States and LGA levels for M&E | 1,604,000 | 0 | 0 | 0 | 0 |
| | Develop IT specification for IT requirements at all levels | 717,000 | 0 | 0 | 0 | 0 |
| | Develop a suitable software for data management at all levels | 450,000 | 0 | 0 | 0 | 0 |
| | Procure and Distribute IT infrastructure to all the points of need at all levels (including laptops) | 131,200,000 | 0 | 0 | 0 | 0 |
| | Support maintenance of the IT supportive structures/ National website | 6,624,000 | 6,690,240 | 6,757,142 | 6,824,714 | 6,892,961 |
| | Provision of regular feedbacks on completeness and quality of data transmitted at all levels | 0 | 0 | 0 | 0 | 0 |
| **Sub Total** | | **141,045,000** | **6,690,240** | **6,757,142** | **6,824,714** | **6,892,961** |

## M&E workplan and budget 2010- 2015

| | | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
|---|---|---|---|---|---|---|
| Objective | Activities | Amount | | | | |
| To build capacities in M&E, Strategic Information and Data management for the program at all levels (health facilities, LGAs, States and National) by 2015 | Review the National M&E training curriculum/module | 560,500 | 0 | 0 | 0 | 0 |
| | Plan a Training of trainers for the M&E course | 2,850,200 | 0 | 0 | 0 | 0 |
| | Train all the LGA TBLS on M&Es and Health Facilities | 119,332,300 | 0 | 0 | 0 | 0 |
| | Develop SOP and checklists for data quality review at all levels (LGA, State, National) | 1,542,200 | 0 | 0 | 0 | 0 |
| | Develop SOP for addressing data quality challenges ( such as missing, inconsistencies, updates on already submitted data) | 1,061,300 | 0 | 0 | 0 | 0 |
| | Training of all Management units on the use of the data management software | 5,732,100 | 0 | 0 | 0 | 0 |
| | Provide facility registers for all DOTS facilities | 3,052,800 | 0 | 0 | 0 | 0 |
| **Sub-Total** | | **134,131,400** | **0** | **0** | **0** | **0** |

## M&E workplan and budget 2010- 2015

| | | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
|---|---|---|---|---|---|---|
| Objective | Activities | Amount | | | | |
| To develop a system and process for data dissemination at all levels by 2015 | NTBLCP hold Stakeholders meeting with the Heads of ILEP partners, WHO, USG, USG and CDC IPs to discuss policy on data dissemination | 977,500 | 0 | 0 | 0 | 0 |
| | Develop Policy document on data dissemination | 1,568,500 | 0 | 0 | 0 | 0 |
| | Printing and distribution of the policy document on data dissemination to all in-country partners | 450,000 | 0 | 0 | 0 | 0 |
| | Monitor compliance of all in-country partners to the policy on data dissemination through tracking of reports and communication products (e.g. Newsletters and Journals) | 0 | 0 | 0 | 0 | 0 |
| | Produce Quarterly TB newsletter | 1,500,000 | 1,515,000 | 1,530,150 | 1,545,452 | 1,560,906 |
| **Sub Total** | | **4,496,000** | **1,515,000** | **1,530,150** | **1,545,452** | **1,560,906** |
| **OVERALL TOTAL** | | **1,075,067,900** | **796,247,842** | **823,526,730** | **812,252,424** | **840,079,617** |

| LABORATORY | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| Objective | | Activities | Amount | | | | |
| To strengthen and expand quality laboratory services such that one lab will serve a population of at least 80,000 in Nigeria | 1.3 | Establish 1,247 addition AFB microscopy centers | 523,740,000 | 528,977,400 | 534,267,174 | 539,609,846 | 545,005,944 |
| | 1.4 | Support renovation of both new and old labs (i.e 2,216) | 217,168,000 | 219,339,680 | 221,533,077 | 223,748,408 | 225,985,892 |
| | 1.5 | Completion of the reference laboratories (2 National and 6 Zonal laboratories) | 44,800,000 | 45,248,000 | 45,700,480 | 46,157,485 | 46,619,060 |
| | 2.4. | Procurement of laboratory reagents and consumables for 2, 216 laboratories (see PSM) | 184,800,000 | 186,648,000 | 188,514,480 | 190,399,625 | 192,303,621 |
| | 2.5. | Procurement of reagents and other consumables for culture, DST and line probe assay for the two (2) national and 6 zonal reference laboratories. | 3,101,120 | 3,132,131 | 3,163,453 | 3,195,087 | 3,227,038 |
| | 2.6 | Procurement and installation of equipments for the 2 national and six zonal laboratories. | 123,200,000 | 124,432,000 | 125,676,320 | 126,933,083 | 128,202,414 |
| | 2.7. | Procurement of microscopes (light, LED and FM) for the additional laboratories as appropriate (1,247) | 63,700,000 | 64,337,000 | 64,980,370 | 65,630,174 | 66,286,475 |
| | 4.1. | Conduct a 5 day training for lab staff on AFB microscopy and QA (2 per lab for 1,247 additional labs) | 106,237,720 | 107,300,097 | 108,373,098 | 109,456,829 | 110,551,397 |
| | | Maintenance of 6ZRL and 2 NRL | 31,600,000 | 31,916,000 | 32,235,160 | 32,557,512 | 32,883,087 |
| | | Provide 36 KVA battery operated inverters and 10,000 volts UPS for the 2 national reference laboratories. | 6,050,000 | 6,110,500 | 6,171,605 | 6,233,321 | 6,295,654 |
| | | Review/update of draft national guidelines on QA- culture/DST, SOPs and FM including safety | 3,131,300 | 0 | 0 | 0 | 0 |
| | | Print and disseminate 3,000 copies of the finalized national guidelines on QA- culture/DST, SOPs on FM | 360,000 | 363,600 | 367,236 | 370,908 | 374,617 |
| | | Train all the 37 SLFP on quality assured FM (see HRH) | | 0 | 0 | 0 | 0 |
| | | Develop, print and disseminate 3,000 copies of quality and safety manual | 2,924,400 | 2,953,644 | 2,983,180 | 3,013,012 | 3,043,142 |
| | | Identify and support training of 22 Medical laboratory scientist/ Technicians safety officers in all facilities at all levels (see HRD)and central unit. | 4,000,000 | 4,040,000 | 4,080,400 | 4,121,204 | 4,162,416 |
| | | Training of laboratory data management staff at National and Reference laboratory | 3,130,200 | 3,161,502 | 3,193,117 | 3,225,048 | 3,257,299 |
| | | Provide and install communi cation gadget, unit computer system with internet connection for 6 zonal and 2 national reference laboratories | 2,432,000 | 2,456,320 | 2,480,883 | 2,505,692 | 2,530,749 |

| LABORATORY | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| Objective | | Activities | Amount | | | | |
| | | Train and retrain 2 NRL, 6ZRL, 37 SRL and 6 laboratory staff from the central unit on QA procedures, QA data management and utilization | 106,237,720 | 107,300,097 | 108,373,098 | 109,456,829 | 110,551,397 |
| | | Plan and conduct lab supervision to National and Reference twice a year from CU (see M&E) | 0 | 0 | 0 | 0 | 0 |
| | | Plan and conduct quarterly meetings at zonal levels, including EQA. | 48,492,000 | 48,976,920 | 49,466,689 | 49,961,356 | 50,460,970 |
| | | Laboratory facilty tour from NRL, Zonal reference lab and NTBLCP | 750,000 | 757,500 | 765,075 | 772,726 | 780,453 |
| | | Organize and conduct Lab TWG meeting quartertly | 652,500 | 659,025 | 665,615 | 672,271 | 678,994 |
| **Total** | | | **1,476,506,960** | **1,488,109,417** | **1,502,990,511** | **1,518,020,416** | **1,533,200,620** |

| 2010 - 2015 TUBERCLOSIS AND LEPROSY STRATEGIC PLAN | | | | | | | |
|---|---|---|---|---|---|---|---|
| MDR | | | | | | | |
| | | | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| Objective | | Activities | Amount | | | | |
| 5.A. To establish a routine drug resistance surveillance system by end of 2011 | 5.1. | Support quarterly meeting of MDR committee | 9,635,000 | 9,731,350 | 9,828,664 | 9,926,950 | 10,026,220 |
| 5.B. To ensure that all CAT 2 failures have access to lab diagnostic services for MDR by end of 2012 and all CAT 1 failures by end of 2015 | 5.2 | A. Establish and support referral network and transport logistics between peripheral health facilities/laboratories and the reference laboratories/treatment centers. | 10,200,000 | 10,302,000 | 10,405,020 | 10,509,070 | 10,614,161 |
| 5.C. To provide 2nd line anti-TB drugs for at least 85% of diagnosed MDR cases by end of 2015 | 5.2 | B. Support referral/linkage of diagnosed or confirmed MDR patients to treatment centres for management with 2nd-line drugs | 3,720,000 | 3,757,200 | 3,794,772 | 3,832,720 | 3,871,047 |
| | 5.3. | Support cost for ancillary investigations for all MDR TB patients on treatment | 15,500,000 | 15,655,000 | 15,811,550 | 15,969,666 | 16,129,362 |
| | 5.4. | Provide support and incentives/ enablers to all TB patients on treatment (e.g bed fees, food packages, and transport cost and sustenance allowance). | 1,002,100,000 | 1,012,121,000 | 1,022,242,210 | 1,032,464,632 | 1,042,789,278 |
| | 5.5. | Support the renovation of 2 treatment center per zone for MDR treatment | 720,000,000 | 727,200,000 | 734,472,000 | 741,816,720 | 749,234,887 |
| | 5.6. | 2nd line drugs and other commodities see section PSM | 0 | 0 | 0 | 0 | 0 |
| | 5.7. | Facilitate linkage to Supra-NRL and support for annual EQA | 0 | 0 | 0 | 0 | 0 |
| | 5.8 | Review QA guideline to include EQA by SNRL (see lab) | 0 | 0 | 0 | 0 | 0 |
| | 5.9 | Conduct quarterly supervision to MDR treatment centres | 880,000 | 888,800 | 897,688 | 906,665 | 915,732 |
| | 5.10 | Conduct periodic DRS (by 2014) | | 0 | | | |

| 2010 - 2015 TUBERCLOSIS AND LEPROSY STRATEGIC PLAN | | | | | | | |
|---|---|---|---|---|---|---|---|
| MDR | | | | | | | |
| | | | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| Objective | | Activities | Amount | | | | |
| | 5.11 | Support monthly review meetings at MDR-TB treatment facilities | 2,592,000 | 2,617,920 | 2,644,099 | 2,670,540 | 2,697,246 |
| | 5.12 | Provide TA for MDR-TB implementation (TA for GLC/Drug management, Lab and Programmatic/clinical mgt) | 2,700,000 | 2,727,000 | 2,754,270 | 2,781,813 | 2,809,631 |
| **Total** | | | **1,767,327,000** | **1,785,000,270** | **1,802,850,273** | **1,820,878,775** | **1,839,087,563** |

| 2010 - 2015 TUBERCLOSIS AND LEPROSY STRATEGIC PLAN | | | | | | | |
|---|---|---|---|---|---|---|---|
| CTBC | | | | | | | |
| | | | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| Objective | | Activities | Amount | | | | |
| To establish CTBC activities in at least 5 LGAs per state by end of 2015 | 6.1. | Mapping of CSOs and CBOs in 36 states and FCT | 0 | 0 | 0 | 0 | 0 |
| | 6.2. | Plan and conduct a consensus meeting with CSOs and CBOs on CTBC activities | 5,027,500 | 5,077,775 | 5,128,553 | 5,179,838 | 5,231,637 |
| | 6.3 | Conduct situation analysis and advocacy visits to identified communities within the 5 selected LGAs | 12,580,000 | 0 | 0 | 0 | 0 |
| | 6.4. | Establish appropriate linkage between CTBC and the state programs using appropriate R&R forms | 0 | 0 | 0 | 0 | 0 |
| | 6.5. | Identify and Support 1 umbrella CSO/CBO per state for implementation of CTBC activities at community level. | 17,632,500 | 17,808,825 | 17,986,913 | 18,166,782 | 18,348,450 |
| | 6.6. | Provide incentives and enablers for TS and CVs | 66,600,000 | 67,266,000 | 67,938,660 | 68,618,047 | 69,304,227 |
| | 6.7. | For R&R formats, guidelines and trainings (see approporiate section) | 0 | 0 | 0 | 0 | 0 |
| | 6.8 | Adoption and printing of community based Patient charter by CBOs and CSOs | 3,192,500 | 1,250,000 | 1,262,500 | 1,275,125 | 1,287,876 |
| **Total** | | | **105,032,500** | **91,402,600** | **92,316,626** | **93,239,792** | **94,172,190** |

| 2010 - 2015 TUBERCLOSIS AND LEPROSY STRATEGIC PLAN | | | | | | | |
|---|---|---|---|---|---|---|---|
| ACSM | | | | | | | |
| | | | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| Objective | | Activities | Amount | | | | |
| 7.A. To ensure budgetary allocation and release of annual funds for TB and leprosy activities at all levels | 7.1. | Develop a comprehensive ACSM plan | 3,682,500 | 3,719,325 | 3,756,518 | 3,794,083 | 3,832,024 |
| 7.B. To improve community awareness on TB and Leprosy such that at least 60% of the public are aware of signs and symptoms of TB and Leprosy and service points by end 2015 | 7.2. | A Support Quarterly meeting of ACSM committees at National quartely | 2,580,000 | 2,605,800 | 2,631,858 | 2,658,177 | 2,684,758 |

| 2010 - 2015 TUBERCLOSIS AND LEPROSY STRATEGIC PLAN | | | | | | | |
|---|---|---|---|---|---|---|---|
| **ACSM** | | | | | | | |
| | | | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| Objective | | Activities | Amount | | | | |
| | 7.2. | B Support Quarterly meeting of ACSM committees at all states | 64,010,000 | 64,650,100 | 65,296,601 | 65,949,567 | 66,609,063 |
| | 7.3. | Plan annual advocacy visit to National and state assembly | 19,055,000 | 19,245,550 | 19,438,006 | 19,632,386 | 19,828,709 |
| | 7.4. | Support STOP TB Partnership to carry advocacy and conduct quarterly executive meetings | 1,552,000 | 1,567,520 | 1,583,195 | 1,599,027 | 1,615,017 |
| | 7.5. | Develop appropriate context specific advocacy kits and IEC materials for TB and Leprosy control | 3,082,500 | 3,113,325 | 3,144,458 | 3,175,903 | 3,207,662 |
| | 7.6. | Plan TB and Leprosy conference biennially | 24,410,000 | 24,654,100 | 24,900,641 | 25,149,647 | 25,401,144 |
| | 7.7. | Plan World TB and Leprosy Day annually | 27,980,000 | 28,259,800 | 28,542,398 | 28,827,822 | 29,116,100 |
| | 7.8. | Plan public awareness campaigns on TB and Leprosy using appropriate channels quarterly at all levels ( print, TV and radio | 169,204,000 | 170,896,040 | 172,605,000 | 174,331,050 | 176,074,361 |
| **Total** | | | **315,556,000** | **318,711,560** | **321,898,676** | **325,117,662** | **328,368,839** |

| 2010 - 2015 TUBERCLOSIS AND LEPROSY STRATEGIC PLAN | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **RESEARCH** | | | | | | | | |
| | | | | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| Objective | | Activities | | Amount | | | | |
| To develop capacity and environment for research on TB, HIV and leprosy among program managers at all levels. | 12.1. | TBL training institute to ally with academic institutions and other implementing partners in areas of research to set up research committee | 9,872,000 | 9,970,720 | 10,070,427 | 10,171,131 | 10,272,843 | 10,375,571 |
| | 12.2. | Support bi-annual meeting of research committee ( Emphasis on 14.1) | 0 | 0 | 0 | 0 | 0 | 0 |
| | 12.3. | Plan and conduct research training workshops for program managers at different levels | 187,217,300 | 189,089,473 | 190,980,368 | 192,890,171 | 194,819,073 | 196,767,264 |
| | 12.4. | Conduct situation analysis and develop research agenda for TBL annually | 0 | 0 | 0 | 0 | 0 | 0 |
| | 12.5. | Plan scholarship for presentations of research findings at international conferences | 13,200,000 | 13,332,000 | 13,465,320 | 13,599,973 | 13,735,973 | 13,873,333 |
| | 12.6. | Support the conduct of at least 6 researches annually based on priorities and need | 31,200,000 | 31,512,000 | 31,827,120 | 32,145,391 | 32,466,845 | 32,791,514 |
| | 12.7. | Subscribe international journals for all programme managers | 1,125,000 | 1,136,250 | 1,147,613 | 1,159,089 | 1,170,680 | 1,182,386 |
| | 12.8. | Support the dissemination of research findings in appropriate journals and newsletters | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | | | **242,614,300** | **245,040,443** | **247,490,847** | **249,965,756** | **252,465,413** | **254,990,068** |

| 2010 - 2015 TUBERCLOSIS AND LEPROSY STRATEGIC PLAN | | | | | | | |
|---|---|---|---|---|---|---|---|
| **HRD** | | | | | | | |
| | | | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| Objective | | Activities | Amount | | | | |
| To develop the management and leaderrship capacity of programme managers at all levels by 2015 | 1.1 | Train at least 15 LG TB and Leprosy supervisors annually | 3,750,000 | 3,787,500 | 3,825,375 | 3,863,629 | 3,902,265 |
| | 1.2 | Training of at least 15 program managers on TBL program management (including new initiatives) annually. | 8,103,200 | 8,184,232 | 8,266,074 | 8,348,735 | 8,432,222 |
| | 1.3 | Provide and maintain office space, equipment including internet facility for national, state and local government control offices | 0 | 0 | 0 | 0 | 0 |
| | 1.4 | Organize a training workshop for all program officers on WHO costing tool (20 participants per year) | 16,762,400 | 16,930,024 | 17,099,324 | 17,270,317 | 17,443,021 |
| | 1.5 | Support 12 participants for international courses annually (Union, Sondalo, Bangkok or other relevant courses) | 3,750,000 | 3,787,500 | 3,825,375 | 3,863,629 | 3,902,265 |
| | 1.6 | Support at least 12 program officers to attend annual international conference on TB and Leprosy | 2,250,000 | 2,272,500 | 2,295,225 | 2,318,177 | 2,341,359 |
| **Sub total** | | | **34,615,600** | **34,961,756** | **35,311,374** | **35,664,487** | **36,021,132** |

| 2010 - 2015 TUBERCLOSIS AND LEPROSY STRATEGIC PLAN | | | | | | | |
|---|---|---|---|---|---|---|---|
| **HRD** | | | | | | | |
| | | | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| Objective | | Activities | Amount | | | | |
| Objective 2: To ensure that the human resource need of TB and leprosy at all levels are met. (Recruitment, retention, and motivation) | 2.1 | Recruit and redeploy 10 medical officers, 48 nurses, 6 laboratory scientists, 2 pharmacists, physiotherapist and 10 medical lab technicians | 0 | 0 | 0 | 0 | 0 |
| | 2.2 | Recruit and train 2 maintenance officers for both NRLs and ZRLs | 62,160,000 | 62,781,600 | 63,409,416 | 64,043,510 | 64,683,945 |
| | 2.3 | Conduct leadership and management course for at least 15 program officers twice yearly | 9,126,700 | 9,217,967 | 9,310,147 | 9,403,248 | 9,497,281 |
| | 2.4 | Train 4 national M & E officers and 2 state M & E officers per states on Harmonized formats, data management and use of soft ware (3 days training) | 4,124,700 | 4,165,947 | 4,207,606 | 4,249,683 | 4,292,179 |
| | 2.5 | Provide monetary incentives to program management staff at all levels | 12,000,000 | 12,120,000 | 12,241,200 | 12,363,612 | 12,487,248 |
| | 2.6 | Plan a stakeholders meeting with professional bodies and heads of pre-service institutions on TBL control | 8,120,000 | 8,201,200 | 8,283,212 | 8,366,044 | 8,449,705 |

| 2010 - 2015 TUBERCLOSIS AND LEPROSY STRATEGIC PLAN | | | | | | | |
|---|---|---|---|---|---|---|---|
| **HRD** | | | | | | | |
| | | | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| Objective | | Activities | Amount | | | | |
| | 2.7 | Support the integration of TBL control activities into existing curriculum of pre-service training school | 0 | 0 | 0 | 0 | 0 |
| | 2.8 | Develop a pool of facilitators within the academia and private sector ( Plan TOT for 15 participants per zone) | 20,923,800 | 21,133,038 | 21,344,368 | 21,557,812 | 21,773,390 |
| **Sub total** | | | **116,455,200** | **117,619,752** | **118,795,950** | **119,983,909** | **121,183,748** |

| 2010 - 2015 TUBERCLOSIS AND LEPROSY STRATEGIC PLAN | | | | | | | |
|---|---|---|---|---|---|---|---|
| **HRD** | | | | | | | |
| | | | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| Objective | | Activities | Amount | | | | |
| Objective 3; To develop and provide all program tools (guidelines, manuals and R&R forms) for effective implementation of TB and Leprosy Control Programme | 3.1 | Review, print and disseminate the NTBLCP Workers Manual (Print 1000 annually) | 3,930,000 | 3,969,300 | 4,008,993 | 4,049,083 | 4,089,574 |
| | 3.2 | Review and harmonize all training materials (inclusion of TB/HIV, infection control, ISTC) | 3,930,000 | 0 | 0 | 0 | 0 |
| | 3.3 | Print 8,000 copies of the TB training module (1,600) copies annually | 720,000 | 727,200 | 734,472 | 741,817 | 749,235 |
| | 3.4 | Review and harmonize all laboratory guidelines and training modules to include HIV rapid testing and safety | 3,131,300 | 0 | 0 | 0 | 0 |
| | 3.5 | Print 4,000 copies of laboratory guidelines and training module (800 copies annually) | 360,000 | 363,600 | 367,236 | 370,908 | 374,617 |
| | 3.6 | Develop a training module for physician/pediatrician on TB and Leprosy | 3,107,500 | 0 | 0 | 0 | 0 |
| | 3.7 a | Print 2,500 copies of MO training module and (500 copies annually) | 225,000 | 227,250 | 229,523 | 231,818 | 234,136 |
| | 3.7b | Printing laminated copies of score chart for children diagnosis of TB | 100,000 | 101,000 | 102,010 | 103,030 | 104,060 |
| | 3.8 | Develop M & E training module | 2,846,000 | 0 | 0 | 0 | 0 |
| | 3 9 | Print 2,500 copies of M & E training module (500 copies annually) | 225,000 | 227,250 | 229,523 | 231,818 | 234,136 |
| | 3.10 | Develop training materials for PLHIV support groups and community home based care providers for TB/HIV. | 2,846,000 | 0 | 0 | 0 | 0 |
| | 3.11 | Review and finalized MDR TB management guideline (5 days workshop for a group of 15 participants) | 3,852,000 | 0 | 0 | 0 | 0 |
| | 3.12 | Print and distribute 1,000 copies of MDR TB guidelines | 450,000 | 454,500 | 459,045 | 463,635 | 468,272 |
| | 3.13 | Develop guidelines/protocol for routine MDR TB surveillance and finalization of R & R for MDR TB (12 participants | 3,852,000 | 0 | 0 | 0 | 0 |

| 2010 - 2015 TUBERCLOSIS AND LEPROSY STRATEGIC PLAN | | | | | | | |
|---|---|---|---|---|---|---|---|
| **HRD** | | | | | | | |
| | | | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| Objective | | Activities | Amount | | | | |
| | 3.14 | Develop MDR TB training module (5 days workshop for a group of 15 participants) | 3,852,000 | 0 | 0 | 0 | 0 |
| | 3.15 | Develop and finalize SOPs for BSL3, LED microscopy, HAIN assay and DST (15 participants) | 2,946,000 | 0 | 0 | 0 | 0 |
| | 3.16 | Print and distribute 500 copies of MDR TB training module | 225,000 | 227,250 | 229,523 | 231,818 | 234,136 |
| | 3.18 | Review and update leprosy training modules (suspect/ refer and leprosy management module) | 2,123,000 | 0 | 0 | 0 | 0 |
| | 3.19 | Print and distribute 5,000 copies of Leprosy training modules (1,000 copies annually) | 450,000 | 454,500 | 459,045 | 463,635 | 468,272 |
| | 3.20 | Review and harmonize all recording and reporting formats | 2,123,000 | 2,144,230 | 2,165,672 | 2,187,329 | 2,209,202 |
| | 3. 21. | Printing and distribution of ALL program recording and reporting formats including IEC materials for TB and Leprosy | 1,250,000 | 1,262,500 | 1,275,125 | 1,287,876 | 1,300,755 |
| | 3.22 | 3Review of ALL program policy documents and guidelines | 1,250,000 | 1,262,500 | 1,275,125 | 1,287,876 | 1,300,755 |
| | 3.23 | Develop a web based soft ware for data management at all levels | 10,000,000 | 0 | 0 | 10,303,010 | 0 |
| | 3.24 | Develop a national M & E country plan | 2,967,000 | 0 | 0 | 0 | 0 |
| | 3.25 | Develop a procurement plan for TBL commodities | 2,967,000 | 0 | 0 | 0 | 0 |
| | 3.26 | Review and print LMIS recording and reporting formats | 1,250,000 | 0 | 0 | 0 | 0 |
| | 3.27 | TOT workshops on the training tools for each of the stated tool above; 30 participants each for DOTS, Microscopy, MDT TB and Leprosy training (30 *4) | 26,846,000 | 0 | 27,385,001 | 27,658,851 | 27,935,440 |
| **Sub total** | | | **86,573,800** | **10,158,580** | **37,645,167** | **48,324,628** | **38,401,835** |

| 2010 - 2015 TUBERCLOSIS AND LEPROSY STRATEGIC PLAN | | | | | | | |
|---|---|---|---|---|---|---|---|
| **HRD** | | | | | | | |
| | | | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| Objective | | Activities | Amount | | | | |
| To empower health care workers to provide a comprehensive TB and Leprosy services through training in all components of Stop TB strategy and enhance global strategy for leprosy. | 4.1. | Conduct a 5 day training for lab staff on AFB microscopy and QA (2 per lab for 1,247 additional labs) | 106,237,720 | 107,300,097 | 108,373,098 | 109,456,829 | 110,551,397 |

| 2010 - 2015 TUBERCLOSIS AND LEPROSY STRATEGIC PLAN | | | | | | | |
|---|---|---|---|---|---|---|---|
| **HRD** | | | | | | | |
| | | | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| Objective | | Activities | Amount | | | | |
| | 4.2 | Plan a refresher course for lab staff (2/lab for 969 existing labs) | 84,255,360 | 85,097,914 | 85,948,893 | 86,808,382 | 87,676,465 |
| | 4.3 | Plan and conduct 4 day training workshop for 3 GHCW per facility on DOTS for 2,346 additional DOTS centers (3 *2,346 = 7,038) each training session for maximum of 25 participant and 3 facilitators. | 211,785,120 | 213,902,971 | 216,042,001 | 218,202,421 | 220,384,445 |
| | 4.4 | Plan a 3 day refresher training for national and state QA officers (15participants annually) | 3,451,200 | 3,485,712 | 3,520,569 | 3,555,775 | 3,591,333 |
| | 4.5 | Plan a 2 day training for physician and pediatrician on TB management (6 participants per tertiary institution for 45 tertiary centers) | 34,918,700 | 35,267,887 | 35,620,566 | 35,976,772 | 36,336,539 |
| | 4.6 | Plan a 3 day TOT workshop among selected private practitioners (10 participants per zone) | 10,127,100 | 10,228,371 | 10,330,655 | 10,433,961 | 10,538,301 |
| | 4.7 | Train 5 health care workers from each selected prison health facilities on TB DOTS (85% of prison health facilities) | 12,468,800 | 12,593,488 | 12,719,423 | 12,846,617 | 12,975,083 |
| | 4.8 | Train and retrain health workers at all levels on the LMIS tools | 140,612,800 | 142,018,928 | 143,439,117 | 144,873,508 | 146,322,244 |
| | 4.9 | Train state teams on the use of patients kits for treatment of TB | 17,125,700 | 17,296,957 | 17,469,927 | 17,644,626 | 17,821,072 |
| | 4.10 | Train zonal pharmacists/store officers on PSM and store management | 1,950,200 | 1,969,702 | 1,989,399 | 2,009,293 | 2,029,386 |
| | 4.11 | Collaborate with JSI Deliver to institutionalize PSM training at NTBLTC | 0 | 0 | 0 | 0 | 0 |
| | 4.12 | Plan 5 day training of GHW on counseling and testing (3 GHWs per DOTS site for 2,742 sites) | 334,947,080 | 338,296,551 | 341,679,516 | 345,096,311 | 348,547,275 |
| | 4.13 | Days training of PLHIV and TB patients on adherence (2 participants per site for 100 sites implementing TB/HIV collaborative activities annually. | 44,785,600 | 45,233,456 | 45,685,791 | 46,142,648 | 46,604,075 |
| | 4.14 | Plan 5 day training on 3Is (infection prevention and control, Intensify case finding and IPT) for health facilities providing TB and TB/HIV collaborative activities (5 participants per site for at least 5 sites per state) | 203,433,400 | 205,467,734 | 207,522,411 | 209,597,635 | 211,693,612 |
| | 4.15 | Plan 5 days training for PLHIV support groups and community home based care providers for TB/HIV. (4 participants per support group from 5 communities per LGA) | 70,407,000 | 71,111,070 | 71,822,181 | 72,540,403 | 73,265,807 |

| 2010 - 2015 TUBERCLOSIS AND LEPROSY STRATEGIC PLAN | | | | | | | |
|---|---|---|---|---|---|---|---|
| **HRD** | | | | | | | |
| | | | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| Objective | | Activities | Amount | | | | |
| | 4.16 | Conduct 5 day training for all program managers on programmatic management of MDR TB (including PSM personnel) 20 participants per course annually (20*5) | 4,813,700 | 4,861,837 | 4,910,455 | 4,959,560 | 5,009,156 |
| | 4.17 | Plan 5 day training on MDR TB for physician and nurses for MDR TB management (2 MO, 6 nurses, 2 lab staff and 1 pharmacist, 2 social workers per centre for 12 treatment centers) | 37,249,100 | 37,621,591 | 37,997,807 | 38,377,785 | 38,761,563 |
| | 4.18 | Plan 2 weeks training for 4-6 staff of the 2 NRL and 6 zonal Rls on culture and DST | 8,428,400 | 8,512,684 | 8,597,811 | 8,683,789 | 8,770,627 |
| | 4.19 | Support study tour to countries with function MDR TB program for key program staff at national, state and facility level (a team of 10 annually) | 7,900,000 | 7,979,000 | 8,058,790 | 8,139,378 | 8,220,772 |
| | 4.20 | Plan training for CBOs and CSOs on MDR TB (support adherence for patients on treatment) | 0 | 0 | 0 | 0 | 0 |
| | 4.21 | Support 2 TAs annually on MDR TB management | 1,700,000 | 1,717,000 | 1,734,170 | 1,751,512 | 1,769,027 |
| | 4.22 | Plan a one day sensitization training for at least 4 participants per CSO for 2 CSO per state | 7,801,200 | 7,879,212 | 7,958,004 | 8,037,584 | 8,117,960 |
| | 4.23 | Plan 2 day training for 4 CVs per community for 5 communities per state (2*4*37) | 5,888,200 | 5,947,082 | 6,006,553 | 6,066,618 | 6,127,285 |
| | 4.24 | Plan 5 day training for all program managers on advocacy and lobby skills (25 participants per course for 2 courses) | 6,281,400 | 6,344,214 | 6,407,656 | 6,471,733 | 6,536,450 |
| | 4.25 | Train identified Journalist and CSO stakeholders involved in TBL services on ACSM (20 participants per state for 37 states) | 162,026,000 | 163,646,260 | 165,282,723 | 166,935,550 | 168,604,905 |
| | 4.26 | Plan a 1 day training on leprosy suspect and referral for 3 GHWs per facility for 2 health facilities per LGA (i.e 3 *2*774) for the period of 5 years | 6,672,600 | 6,739,326 | 6,806,719 | 6,874,786 | 6,943,534 |
| | 4.27 | Plan a 3 day on leprosy diagnosis and treatment for 3 Physician/dermatologist for one secondary/tertiary health facility for 774 LGA (3*774) | 17,950,700 | 18,130,207 | 18,311,509 | 18,494,624 | 18,679,570 |
| | 4.28 | Plan 3 day training on leprosy for 3 GHWs per PHC for 2 PHC facilities in 150 high endemic LGAs. ( 3*2*150) | 13,670,100 | 13,806,801 | 13,944,869 | 14,084,318 | 14,225,161 |
| | 4.29 | Plan 5 day training on community dermatology for one site per state (4 participants per site) 4*37 | 34,365,400 | 34,709,054 | 35,056,145 | 35,406,706 | 35,760,773 |

| 2010 - 2015 TUBERCLOSIS AND LEPROSY STRATEGIC PLAN | | | | | | | |
|---|---|---|---|---|---|---|---|
| **HRD** | | | | | | | |
| | | | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| Objective | | Activities | Amount | | | | |
| | 4.30 | Plan 5 days training workshop for all program officers and partners on rehabilitation based on CBR (30 participants per course for 2 course) | 14,231,100 | 14,373,411 | 14,517,145 | 14,662,317 | 14,808,940 |
| | 4.31 | Train 2 identified surgeon and a physiotherapist on preventive rehabilitative surgery for 2 zones (North/South) 2-3 months training at ALERT | 4,100,000 | 4,141,000 | 4,182,410 | 4,224,234 | 4,266,476 |
| | 4.32 | Train CVs and ex-leprosy patients on leprosy control activities in selected high endemic LGA (150LGAs ) 2 days training for 4 participants per LGA | 26,162,700 | 26,424,327 | 26,688,570 | 26,955,456 | 27,225,011 |
| | 4.33 | Recruit a focal person for research for NTBLTC Zaria | 0 | 0 | 0 | 0 | 0 |
| | 4.34 | Plan HSR training workshop for 6 teams (4-6 participants per team) annually based on research agenda of the TBL program | 187,217,300 | 189,089,473 | 190,980,368 | 192,890,171 | 194,819,073 |
| **Sub total** | | | **1,822,963,680** | **1,841,193,317** | **1,859,605,250** | **1,878,201,302** | **1,896,983,315** |
| **Using expected 5% attrition rate of trained staff.** | | | **1,832,078,498** | **1,850,399,283** | **1,868,903,276** | **1,887,592,309** | **1,906,468,232** |

| 2010 - 2015 TUBERCLOSIS AND LEPROSY STRATEGIC PLAN | | | | | | | |
|---|---|---|---|---|---|---|---|
| **HRD** | | | | | | | |
| | | | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| Objective | | Activities | Amount | | | | |
| Objective 5: To establish and maintain health information management system for human resource for NTBLCP | 5.1 | Organize a stakeholders meeting among all partners on HIMS for HR | 2,587,500 | 0 | 0 | 0 | 0 |
| | 5.2 | Develop and print HIMS for HR | 1,955,000 | 0 | 0 | 0 | 0 |
| | 5.3 | Disseminates HIMS for HR for NTBLCP to all stakeholders and at the control officers meeting. | 0 | 0 | 0 | 0 | 0 |
| **Sub Total** | | | 4,542,500 | 0 | 0 | 0 | 0 |
| **Overall Total** | | | **2,074,265,598** | **2,013,139,371** | **2,060,655,766** | **2,091,565,334** | **2,102,074,947** |

# ANNEX D: MID-TERM REVIEW OF THE 2006-2010 STRATEGIC PLAN

The NTBLCP strategic plan was reviewed during April-May 2009 to assess progress, challenges, and limitations relative to the objectives and targets established in the 2006-2010 National Strategic Plan for TB & Leprosy Control. The recommendations drawn from the review informed the development of the current strategic plan.

## PROGRAM ACHIEVEMENTS AND CONSTRAINTS

The Midterm Review Team identified a range of key program achievements. The NTBLCP has successfully increased program resources and engaged more partners; increased partnership among stakeholders; developed a range of tools and guidelines for various program components; and increased DOTS coverage, especially in microscopy centers. TB/HIV collaborative activities have shown significant improvements: patient care improves, new initiatives are launched, and special committees are established to address pressing issues.

However, challenges also exist. For example, the NTBLCP depends too heavily on external funding and technical assistance, while counterpart funding at the federal and state level tends to be insufficient, unreliable, or even non-existent. Communication and coordination are weak among stakeholders and partners. There is a large disparity in program reach and functioning among the states and LGAs. Internally, managerial and supervisory capacities are inadequate to meet the challenges of strategic program management, patient management, and laboratory system operations. High staff turnover at the managerial and implementation levels hinders proper program functioning. Additionally, no comprehensive MDR management system exists. The case detection rate (CDR) is low and stagnating, access to quality DOTS is low, and stock-outs of drugs and lab consumables plague several states and facilities. The program's M&E system is also weak, with regard to data presentation and interpretation at various levels.

Focusing specifically on leprosy program management, case finding, patient care, prevention of impairment and disability (POID), and rehabilitation, the review team found additional challenges and constraints. While the program is competently managed at the state level, there is little government commitment in most states, with LGAs sometimes suffering inadequate management capacity. Supervision is also inadequate at the state and LGA levels. Case detection has been stable at about 5,000 cases annually and some LGAs report high numbers, but case finding is mainly passive. Some states have limited active case finding (mini-LEC). The child proportion is above the target of <5 percent, suggesting active transmission is taking place. Moreover, the rate of grade-2 disability detected among new cases, between 7 and 44 percent, suggests late case detection. MB patient contacts are not examined.

Additionally for leprosy, the Midterm Review Team found all patients detected were being treated with MDT, although some states experienced stock-outs in Q4 2007 and Q1 2008. Community members and community volunteers were poorly informed on the signs and symptoms of leprosy; prevention of disability is inadequate, including reaction management and the provision of footwear; care-after-cure services were unavailable in most states; and most states lack a systematic rehabilitation service to empower leprosy patients.

## RECOMMENDATIONS OF THE MIDTERM REVIEW

The following recommendations were proposed by the Midterm Review Team, for consideration and action as next steps toward program success:

- The current Strategic and Emergency plans address most issues, but require adjustment on SMART objectives (objectives that are Specific, Measurable, Achievable, Realistic, and Timed); they also need better focus on DOTS expansion, MDR-TB, PPM, ACSM, community-based distribution (CBD), and infection control (IC).
- All levels of government should regularly allocate and disburse funds for TB and leprosy activities.
- Leadership, management, and supervision need to be strengthened at all levels.
- A new NTBLCP strategic plan, including attention to HRD and designed to meet the MDGs, needs to be developed for the period 2010-2015, including clear budget lines and sources.
- Develop a comprehensive ACSM strategy to reach population more effectively; increase commitment and broaden sustainable counterpart funding at different levels.
- The federal and state governments should urgently address the impact of delay (or possible non-approval) of the Global Fund Round 5 phase 2 funding and the shortfall of counterpart funding.
- Modern computer- and Internet-based technologies should be used for Knowledge Management.
- The Stop TB Partnership should be expanded to include all major stakeholders including academia and disciplined forces. CBOs/FBOs and other parties should form committees to address issues such as TB in major metropolitan areas.
- The FMOH should decentralize state-level authority to accelerate DOTS roll-out.
- Revise the composition of the MDR-TB technical committee to include specialist physicians managing MDR-TB patients.
- Create an operational research committee to establish an agenda on key studies such as the reasons for low CDR, recording and reporting system functioning, stigma, and TB

among health workers.

- Continue the case-finding cluster approach, instituting micro-monitoring using mapping of existing cases in low-endemic LGAs to plan targeted interventions.
- Reorganize leprosy services and train all secondary and tertiary health institution TB clinic staff on leprosy.
- Ensure adequate supply of MDT.

## SWOT ANALYSIS RESULTS

### Strengths

- Availability of free TB, leprosy and HIV treatment
- Established TB and leprosy program structures at all levels
- Available programmatic guidelines, training manuals, and other strategic documents
- Existence of national task forces and committees for program thematic areas
- Existence of focal persons at national level

### Public-Private Mix (PPM)

- Ongoing capacity building
- Professional association involvement
- Absence of strikes in the private sector
- Availability of independent sector treatment centers (ISTC) and patient charter

### DOTS

- Strong DOTS LGA coverage (98 percent: 765 out of 774 LGAs)
- Training center (NTBLTC) for training all cadres of health workers
- QA system for microscopy services
- Improving treatment success rate, 82-85 percent

### Procurement and Supply Management (PSM)

- Existing PSM structure
- Availability of some trained personnel for commodity management at all levels
- Availability of storage facilities at the national and zonal levels, and in some states
- Availability of Logistics Management Information System (LMIS) reporting format

### MDR-TB

- Regular reporting of MDR-TB data from existing facilities
- Existing plan for Drug Resistance Survey

- Availability of four functioning TB reference labs with diagnostic capacity
- Availability of trained laboratory personnel on good laboratory practice (GLP), culture, and molecular technique

**TB/HIV**

- Routine M&E tool captures TB/HIV information
- Increasing access to TB/HIV services

**Leprosy**

- Regular supply of free MDT drugs
- Availability of dedicated program vehicles at the state and LGA levels

**M&E**

- Existing M&E framework in the Strategic Plan
- Availability of standardized recording and reporting formats
- Formats are regularly updated in line with new initiatives
- Regular periodic review meetings
- Structured data collection from facility→LGA→state →zone →national level
- Regular external evaluation missions on TB and leprosy

**Weaknesses**

- Poor coordination of partners supporting TB Program
- Poor management and supervision
- Program officers' non-adherence to guidelines
- Inadequate incentives and enablers for staff motivation and for treatment adherence
- Poorly motivated staff
- High staff turnover

**Community TB Care (CTBC)**

- Limited coverage and poor community participation in CTBC and DOTS
- Weak linkage of trained community volunteers (CVs) to the national program

**PPM**

- PPM facilities not located according to need
- Inadequate linkages and support for private practitioners
- Non-use and dissemination of patient charter
- Too few stand-alone labs for PPM activities

- Low specialist physician involvement in PPM
- Non-involvement of patent medicine vendors
- Low coverage of external QA activities in private hospitals and laboratories
- Lack of training among private health care providers on standardized national diagnosis and case management protocols

**DOTS**

- Inadequate DOTS population coverage, DOTS not practiced in most centers, poor defaulter prevention and retrieval system
- Weak laboratory quality control
- Poor dissemination of national guidelines
- Limited and inappropriate information, education and communication (IEC) materials
- No funding for radiological and other ancillary investigations

**PSM**

- Inadequate funding for drugs and materials distribution at all levels
- Non-involvement of NTBLCP in FMOH-initiated in-country procurement
- Poor logistics management, including delayed clearing of consignments from ports
- Poor supervision/control of commodity usage; wastages/leakages/accumulation of expired drugs
- Inadequate storage facility/equipments at zones and in some states
- Non-harmonized training manuals/materials among supporting partners
- Existing recording and reporting formats do not capture adverse drug reactions

**MDR-TB**

- Exact burden of MDR-TB is unknown
- Inadequate number of facilities
- Inadequately trained personnel to manage MDR-TB patients (including lab personnel)
- Inadequate HR and system to maintain equipment
- Non-functioning reference laboratories in six zones

- Absence of second-line drugs
- Inadequate patient support (feeding, laboratory and radiological investigations, family, transportation)
- Weak dissemination of developed guidelines and other MDR-TB strategic documents
- Weak system for infection control
- NIMR reference laboratory not yet upgraded to Biosafety Level 3 (BSL3)
- No system for community/patient involvement in MDR-TB control
- Program managers at all levels lacking comprehensive MDR-TB programmatic training
- No plan to sustain the supply of reagents and materials
- Limited awareness among communities, program managers, and professionals

**TB/HIV**

- Non-availability of Rifambutin for people living with HIV (PLHIV) on second-line ARV who develop TB
- Inadequate TB-IC measures in facilities
- Poor involvement of CBOs/ CSOs/PLHIV
- Poor linkages and referral system
- Lack of enablers for patients
- Lack of HIV preventive services at most DOTS sites
- Lack of integrated TB-HIV services at health facilities

**Leprosy**

- Non-functional integration into General Health Services (GHS)
- Inadequate knowledge and skills among General Health Care Workers
- Inappropriate application of rehabilitative measures by stakeholders
- Inadequate community involvement
- Inadequate involvement of tertiary and secondary institutions in leprosy control activities
- Weak referral system
- Weak ACSM component
- Skewed distribution of HR for leprosy
- Inadequate funding
- Inability to leverage on Global Fund grant

**M&E**

- No clear targets for some M&E indicators
- Shortage of recording and reporting (RR) materials
- Too-frequent changes in the RR format, with new formats not systematically introduced, resulting in different RR formats and versions in the field

- Weak feedback and data utilization at all levels
- Weak supervisory activities in tertiary and private institutions
- Non-coordination of multiple data sources in tertiary and secondary institutions
- Untrained newly appointed M&E focal persons

**Opportunities**

- Partners' financial and technical support, including the Stop TB Partnership for advocacy and coordination
- Availability of professional bodies, a large private sector, civil society, and religious and patient/support groups and organizations for designing and implementing program interventions
- Availability of public and private sector infrastructure for DOTS expansion and other programmatic activities, including training for various groups of health workers
- Human resources for training
- Presence of mobile telephone networks for tracking patients and other program-relevant communications

**Threats**

- Donor dependence
- Lack of coordination among international partners, including the non-standardization of incentives
- Difficulty in sustaining incentives and enablers where available
- Non/incomplete release of budgetary allocation
- Poor governance
- Lack of regulatory policy for anti-TB drugs and their availability outside of the NTBLCP
- Inadequate enforcement of control/regulation governing private facilities
- Emergence of drug-resistant TB
- Stigma and discrimination
- Weak PHC
- High staff attrition/turnover
- Lack of HIV/AIDS control program structure at the LGA level
- Limited number of Antiretroviral Therapy (ART) sites for collaborative activities
- Private/industrial sector human resources strikes
- Irregular power supply
- Global economic crisis, civil unrest, and militancy

## ANNEX E: REFERENCES

Federal Ministry of Health (FMOH). 1991. *Annual report*.

Federal Ministry of Health (FMOH). 2001. *Annual report.*

Federal Ministry of Health (FMOH). 2008. *Annual report.*

National Population Commission. 2006. *Census*.

National Tuberculosis and Leprosy Control Program (NTBLCP). 2010. *Annual Report 2010.*

United Nations Development Program (UNDP). 2008. *Human Development 2007/2008.*

World Health Organization (WHO). 2009. *Global Tuberculosis Control: Epidemiology, Strategy, Financing*.