



FEDERAL MINISTRY OF HEALTH

NATIONAL STRATEGIC PLAN

FOR TUBERCULOSIS CONTROL

2021 – 2026

Table of Contents

List of Figures.....	5
List of Tables	6
Foreword.....	7
Acknowledgements	8
Acronyms and Abbreviations.....	9
1. Executive Summary.....	12
2. Introduction	16
2.1. Purpose and organisation of the NSP-TB 2021 – 2026.....	16
2.2. Rationale for update of the NSP-TB.....	17
2.3. The NSP-TB development process	18
2.4. Guiding documents.....	20
3. Situation Analysis	21
3.1. Background Information	21
3.1.1. Country Profile.....	21
3.1.2. Governance Structure.....	21
3.1.3. Economy and economic indicators	22
3.1.4. Political and socioeconomic contexts.....	22
3.1.5. Demography.....	22
3.1.6. Organization of Health System.....	23
3.1.7. Health system financing.....	24
3.1.8. Health indicators	24
3.1.9. Relevant health sector policies, strategies, plans and initiatives.	25
3.1.10. The National Tuberculosis and Leprosy Control Programme.....	28
Organisational units of TB control and their functions.....	28
3.1.11. Programme infrastructure & processes	31
3.1.12. Epidemiology of tuberculosis and progress between 2015-2022	44
3.1.12.1. Programme performance indicators.....	44
3.1.12.2. Case Notification	45
3.1.12.3. Treatment outcomes.....	47
3.1.12.4. TB/HIV performance indicators.....	48
3.1.12.5. DR-TB case notification and treatment outcomes.....	50
3.1.12.6. Childhood TB	52
3.1.13. Key affected populations in Nigeria	53
3.1.14. TB and other comorbidities except TB/HIV	55
4. Programme gaps and contributing factors.....	60
4.1. SWOT Analysis	60
4.2. Key Findings from Programme Reviews and Mission Reports.....	61

4.2.2. Key findings from the 2017 KAP Survey	61
4.2.3. Lagos Inventory Study.....	62
4.2.4. TB patient catastrophic Survey 2017.....	63
4.3. Reviews and activities carried out since implementation of NSP 2021-2025	64
4.3.1. Mid-term review January 2023.....	64
4.3.2. TB epidemiological assessment (Epi-analysis) 2023.....	71
4.3.3. Regional Green Light (rGLC) Mission 2022	74
5. TB Programme risks, new strategic direction, and enablers.....	76
5.1. Risk Analysis and Mitigation Plan for the NSP.....	76
5.2. Community, Rights and Gender	77
5.3. TB Stigma Assessment	78
5.4. Advocacy, Communication and Social Mobilization (ACSM).....	79
5.5. Supply chain management and logistics	80
5.6. TB cross border issues	80
5.7. TB control in crisis situation	82
6. The National Strategic Plan for Tuberculosis 2021-2026	84
6.1. New strategic directions	84
6.1.1. Domestic resource mobilisation for funding of TB budget.....	84
6.1.2. TB case finding (including key populations)	85
6.1.3. Private sector involvement.....	86
6.1.4. TB laboratory services.....	87
6.1.5. Community system strengthening (including key populations).....	87
6.1.6. Human rights and gender consideration in provision of quality TB services.....	88
6.1.8. TB prevention and infection control.....	90
6.1.8.1. TB Preventive Therapy	90
6.1.8.2. TB infection Control.....	91
6.1.9. Childhood TB.....	91
6.1.10. Programmatic management of drug-resistant TB (PMDT)	92
6.1.11. Supply chain and logistics.....	93
6.1.12. Strategic information and research	93
6.2. Programme management and capacity	93
6.3. Performance targets	94
6.4. NSP goal, objectives, and strategic interventions	95
7. The monitoring and evaluation plan.....	109
7.1. Purpose	109
7.2. Data management system.....	110
7.3. Recording and reporting	110
7.4. E-TB Manager	111
7.5. Innovations in Data Management.....	112
7.5.1. Xmap.....	112
7.5.2. Interactive Voice Response (IVR) for Treatment Adherence	112
7.5.3. Digital Training.....	112

7.5.4. Aspect reporter.....	113
7.7. Flow of information	113
7.8. Data storage.....	120
7.9. Data Access	121
7.10. Data products, dissemination, and use	121
7.10.1. NTBLCP annual report	121
7.10.2. NTBLCP website.....	122
7.10.3. NTBLCP fact sheet	122
7.11. Data quality assurance	122
7.12. Zonal and state review meetings	122
7.13. Onsite data validation exercises.....	122
7.14. Data Quality Assessments.....	123
7.15. Supportive supervision	123
7.16. M&E coordination.....	123
7.17. Technical Assistance from WHO.....	124
7.18. Special assessments and surveys	124
7.19. Joint International Monitoring Mission.....	124
7.20. Operations research	125
8. Monitoring and Evaluation of NSP-TB 2021 – 2026	126
8.1. M&E Framework for the National Strategic Plan for Tuberculosis, 2021 – 2026 ..	126
9. The budget plan	151
9.1. Introduction	151
9.2. Budget for NSP-TB 2021-2026	151
9.3. Funding sources for the NSP-TB 2021 – 2026.....	153
9.4. Funding strategy for NSP-TB 2021-2026.....	153
10. Operational and technical assistance plan	155
Purpose	155
11. Annexure.....	156
Annex 1: The relationship of the NSHDP II (2018 – 2022) and the NSP-TB Response	156
Annex 2: Root cause analysis of the TB Programme.....	168
Annex 3: Framework of the Operational and Technical Assistance Plan NSP-TB 2021 – 2026	171

List of Figures

Figure 1: Map Showing Geo-political zones of Nigeria	21
Figure 2: Nigeria GDP (World Bank)	22
Figure 3: Population age and sex structure	24
Figure 4: The Nigeria laboratory network structure.	51
Figure 5: Current flow of TB data in Nigeria.	54
Figure 6: PMDT management structures	57
Figure 7: Spending versus projected need for TB activities, 2015 – 2019.	59
Figure 8: Trend in notification of all forms of TB cases, 2002 – 2019	64
Figure 9: New TB case notification (bacteriologically diagnosed and all forms), by zone 2015 – 2019	65
Figure 10: Trends in TB treatment outcomes of all forms of TB cases, 2009 - 2018	66
Figure 11: Treatment outcome data by state for all forms of TB, 2018	66
Figure 12: Scale-up of HIV services for people with TB	67
Figure 13: Trend of RR/MDR-TB cases diagnosed and enrolled on treatment in Nigeria	68
Figure 14: Paediatric TB case notifications, by case type and overall, 2014-2019	70
Figure 15: Key TB-affected populations and population size estimates, 2019	70
Figure 16: Risk Factors for TB in Nigeria	72
Figure 17: Conceptual framework of factors driving TB epidemic	72
Figure 18: Data flow chart	227
Figure 19: M&E Logical framework for the NSP-TB	239
Figure 20: M&E Framework for the National Strategic Plan for Tuberculosis, 2021 – 2025	240

List of Tables

Table 1: NSP 2021-2025 Budget	15
Table 2: National Strategic Plan Development Road Map	19
Table 3: Trend of basic health indicators 1990 - 2018	26
Table 4: Relationship of the NSHDP II (2018 – 2022) and the NSP-TB Response	27
Table 5: Organisational chart showing relationships of the operational levels of the NTBLCP	45
Table 6: GeneXpert MTB-Rif four-module machines distribution as at 4th quarter 2019	48
Table 7: DR-TB treatment centers	57
Table 8: Key NTBLCP partners for TB control.	60
Table 9: Programme performance indicators	63
Table 10: Estimated HIV burden in Nigeria, 2008, 2012 and 2018	67
Table 11: MDR-TB treatment outcome 2013 – 2017	69
Table 12: SWOT Analysis of the TB Programme	74
Table 13: Root cause analysis of the TB Programme	76
Table 14: National TB control 2019 baseline and 2025 targets for key indicators	103
Table 15: NSP goals, objectives, interventions and key indicators and targets	105
Table 16: Operational and Technical Assistance Plan for NSP-TB 2021 – 2025	127
Table 17: TB recording and reporting tools used by the NTBLCP	228
Table 18: NTBLCP Recording and Reporting tools used at the LGA/State/National level	231

Foreword

Acknowledgements

ACRONYMS AND ABBREVIATIONS

ACOMIN	Civil Society for Nutrition, Vaccination and Eradication of Malaria	DOTS	Directly Observed Treatment Short course
ACSM	Advocacy, Communication and Social Mobilization	DQA	Data Quality Assessment
ACT!	Africa Coalition on Tuberculosis - Nigeria	DRS	Drug Resistance Survey
ADR	Adverse drug reaction	DR-TB	Drug-Resistant Tuberculosis (here defined as rifampicin- and multidrug-resistant TB)
AFB	Acid-Fast Bacilli	DST	Drug Susceptibility Testing
AIDS	Acquired Immune Deficiency Syndrome	DV	Data Verification
ART	Antiretroviral Therapy	EPI	Expanded Program on Immunisation
ASM	American Society for Microbiology	FBO	Faith-Based Organization
ATM	AIDS, Tuberculosis and Malaria	FCT	Federal Capital Territory
CBO	Community-Based Organisation	FLDST	First-Line Drug Susceptibility Testing
CCM	Country Coordinating Mechanism	FMOH	Federal Ministry of Health
CDC	Centre for Disease Control	GDF	Global Drug Facility
CiSHAN	Civil Society for HIV and AIDS in Nigeria	GDP	Gross Domestic Product
CTBC	Community TB care	GF	Global Fund
CPT	Co-trimoxazole Preventive Therapy	GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
CSO	Civil Society Organisation	GHCW	General Health Care Worker
CSS	Community System Strengthening	GLC	Green Light Committee
CU	Central Unit	GON	Government of Nigeria
CV	Community Volunteer	HIV	Human Immunodeficiency Virus
DHIS 2	District Health Information System 2	HRH	Human Resource for Health
		HSS	Health System Strengthening
		HTC	HIV Testing and Counselling

HVAC	Heating Ventilation and Air Conditioning	NARHS	National AIDS and Reproductive Health Survey
ICT	Information and Communication Technology	NASCP	National AIDS & Sexually Transmitted Infections Control Programme
IDPs	Internally displaced persons	NGO	Non-Governmental Organization
IEC	Information, Education and Communication	NHI	National Health Insurance
ILEP	International Federation of Anti-Leprosy Associations	NHMIS	National Health Management Information System
IMCI	Integrated Management of Childhood Illness INH Isoniazid	NIMR	Nigerian Institute of Medical Research
IPT	Isoniazid Preventive Therapy	NPHCDA	National Primary Health Care Development Agency
JIMM	Joint International Monitoring Mission	NPO	National Professional Officer
KAP	Key Affected Population	NPSCMP	National Products Supply Chain Management Programme
KAP	Knowledge, Attitude and Practice	NRA	Nitrate Reductase Activity
KNCV	Dutch Tuberculosis Foundation	NRL	National Reference Laboratory
LFA	Local Fund Agents	NSHDP	National Strategic Health Development Plan
LGA	Local Government Area	NSP	National Strategic Plan
LGTBLS	Local Government Tuberculosis and Leprosy Supervisor	NSP-TB	National Strategic Plan for Tuberculosis
LPA	Line Probe Assay	NTBLCP	National Tuberculosis and Leprosy Control Programme
MARPS	Most At-Risk Populations	NTBLTC	National Tuberculosis and Leprosy Training Centre
MDR-TB	Multidrug-Resistant Tuberculosis	OR	Operations Research
MDAs	Ministries, Departments and Agencies	OSDV	Onsite Data Validation
M&E	Monitoring and Evaluation	PAF	Population Attributable Fraction
NACA	National Agency for the Control of AIDS	PCR	President's Comprehensive Response Plan for HIV/AIDS in Nigeria
NAFDAC	National Agency for Food and Drugs Administration and Control	PHC	Primary Health Care

PLHIV	People Living With HIV	SURE-P	Subsidy Reinvestment and Empowerment Programme
PMDT	Programmatic Management of Drug-resistant Tuberculosis	TA	Technical assistance
PSM	Procurement Supply Management	TB	Tuberculosis
PUDR	Progress Update and Disbursement Request	TBL	Tuberculosis and Leprosy
QA	Quality Assessment	TS	Treatment Supporter
RIF	Rifampicin	TWG	Technical Working Group
RR-TB	Rifampicin-resistant Tuberculosis	UNDP	United Nation Development Programme
R&R	Recording and Reporting	USAID	United States Agency for International Development
SARA	Service Availability and Readiness Assessment	USD	United States Dollars
SLD	Second Line anti-TB Drug	WHO	World Health Organization
SRL	Supranational Reference Laboratory	ZN	Ziehl–Neelsen
STBLCO	State TB and Leprosy Control Officer	ZRL	Zonal reference laboratory
STBLCP	State TB and Leprosy Control Programme		

1. Executive Summary

The National Strategic plan (2021-2026) for Tuberculosis (TB) was prepared in a participatory manner to address the future challenges and priorities in prevention, care and treatment of the TB and TB-HIV.

Several documents including programme review reports and WHO published documents were relied upon to develop this plan. This strategic plan serves as a resource mobilisation tool, sets future direction, and defines a baseline to monitor progress towards targets and impact of key priority interventions. This five-year plan has five components all linked together, i.e., Core, Operation and Technical, Monitoring and Evaluation (M&E), Budget and Emergency Preparedness Plan. The Core Plan includes an analysis of the TB burden and TB situation with a clear description of the challenges and programmatic gaps, definition of the goals and objectives and identification of strategic interventions and their related activities and sub-activities. The Operational Plan provides, for each activity and sub-activity, relevant and detailed information on the process of implementation. The M&E Plan is for tracking programme progress and impact using impact, outcome, and coverage/output indicators. The Technical Assistance Plan identifies interventions and activities that need technical assistance and providing detailed information on how the technical assistance should be carried out, while the Budget Plan is for required financial resources to finance the program interventions.

Tuberculosis (TB) is a serious public health challenge in Nigeria. The World Health Organization (WHO) estimates the incidence rate for all forms of TB in Nigeria at 219 per 100,000 population (WHO, 2020)¹. The case notification rate in Nigeria for all forms of TB in 2019 was approximately 60/100,000, in sharp contrast to the new estimated incidence rate of 219/100,000. It is estimated that 440,000 persons fell ill with TB in 2019¹, yet only about 120,266 were notified. This, therefore, means that about 73% of estimated TB cases were not diagnosed, treated and or notified annually. The trends for children are presumed to be similar. Regarding drug resistant TB (DRTB), it is estimated that Nigeria had 21,000 incident cases in 2019 out of whom 2,384 (11%) were detected and notified over the same period.

¹ World Health Organization. (2020). *Global Tuberculosis Report*. Geneva: World Health Organization.

The number of health facilities providing TB services increased from 5,681 in 2015 to 12,606 in 2019. All LGAs have at least one DOTS treatment facility. As of 2019, there were a total of 3,220 microscopy centers in the country. Since 2015, the NTBLCP has adopted Xpert MTB/Rif assay as the primary means of TB diagnosis in the country and by December 2019, a total of 398 GeneXpert MTB-Rif machines were in use, supported by numerous partners and placed in all 36 states and FCT.

Public Private Mix (PPM) activities are implemented in all 36 States and FCT. The private and public non-NTBLCP sectors are playing an increasingly important role in TB control, with engaged private health facilities contributing 14% of total TB cases notified by the TB programme in 2019. Engagement of communities and community-based organisation (CBOs) in TB control in Nigeria resulted in the detection of 22% of all forms of TB notified in 2019. The proportion of children under the age of 15 years diagnosed with TB in 2019 was eight percent. Given Nigeria's population structure, with almost 44 percent of Nigerians below the age of 15 and given the fact that the highest burden of TB occurs in adults in the childbearing ages, childhood exposure is likely to be high. The number of TB patients tested for HIV and those co-infected with HIV was 97 percent and 11 percent respectively in 2019.

Treatment success rates for drug susceptible TB among the 2019 cohort was 88 percent among all forms of TB. The treatment success rate has been consistently high over the last ten years. The treatment success for DR-TB patients was 80% for the 2019 cohort of treated DR-TB patients. The findings of the recent epidemiological analysis of the TB burden in Nigeria show that the programme has made some progress with regards to meeting some expected WHO standards in TB Surveillance. The findings of the 2020 End-term review of the TB National Strategic Plan 2021-2025 revealed that there is strong programme leadership at central level, with recent notable increases in TB case finding in 2019.

Despite the increase in the number of cases detected over the years, the true situation is that there is a slow decline in the incidence and mortality of TB in the country and this is worrisome to public health authorities. Under-diagnosis and under-reporting of TB are the major factors responsible for the low treatment coverage in the country². Another big challenge facing the programme is the low domestic funding to the programme and the high dependence on funding

² 2020 Epidemiological Analysis Report

from external funding sources, a situation that has resulted in huge gaps in programme implementation.

In the current NTBLCP National Strategy Plan 2021-2025, the programme has identified some crucial areas from which interventions will be developed that will help to address the major challenges militating against the achievement of the programme's targets. All these will be supported by strengthening health system and programme management with enough financial resources and removing barriers to service.

Vision of NTBLCP for TB: A Nigeria free of TB

Mission of NTBLCP for TB: Nigeria free of TB, expressed as, “zero death, disease and suffering due to TB”.

Goal of NTBLCP: End TB epidemic in Nigeria

Goal of the current NSP: The overall goal of the NTBLCP Strategic Plan 2021–2026 is to accelerate efforts at ending TB epidemic in Nigeria by ensuring access to comprehensive and high-quality patient-centred and community-owned TB services for all Nigerians.

Objectives:

The objectives of the NSP are as listed below:

1. To increase TB case notification rate for all forms of TB from 60 per 100,000 population in 2019 to 164 per 100,000 population in 2026 through universal scale up of patient-centered quality TB services addressing the need of all populations
2. To increase and sustain the treatment success rate for new drug-susceptible TB increases from 87% (2019) to 92% (2026) through incorporation of people-centered social support services into management of TB patients
3. To enhance childhood TB detection and treatment through innovative provision of integrated services towards achieving childhood TB proportion of 13% among all forms of TB cases by 2026
4. To increase proportion of estimated MDR/RR-TB cases notified from 11% in 2019 to 75% by 2026
5. To enroll 100% of diagnosed DR-TB cases on treatment in accordance with global standard of care
6. To rapidly scale up TB preventive services with the number of contacts receiving TB Preventive Therapy (TPT) increasing annually from 10,788 in 2019 to 702,076 by 2026
7. To improve access to quality TB care through comprehensive engagement of all private care providers with the sector accounting for 35% of notified TB cases by 2026.
8. To strengthen provision of integrated services for all co-infected with TB and HIV, Patients with Diabetes, and other co-morbidities

9. To strengthen domestic resource mobilisation with in-country funding of TB budget increasing from 8% in 2019 to 50% by 2026.
10. To strengthen community involvement in provision of quality TB care with the community contribution to TB case notification increasing from 22% in 2019 to 45% by 2026
11. To protect and promote human rights and gender-related factors in provision of quality TB services
12. Strengthen programme management and capacity at all levels for the achievement of the NSP 2021 - 2026 target

By Module - Intervention	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Total	%
Case detection and diagnosis	198,629	114,988,101	115,620,208	116,341,530	116,285,097	117,628,979	581,062,544	23.8%
Treatment (TB care and prevention)	288,911	208,052,365	213,983,480	220,004,112	233,628,855	236,328,854	1,112,286,577	45.0%
Engaging all care providers (TB care and prevention)	5,940	1,782,107	1,719,511	838,450	824,329	833,856	6,004,193	0.3%
Other TB care and prevention intervention(s)	2,303	1,470,264	1,796,453	1,419,866	1,435,848	1,452,442	7,577,176	0.3%
Other program management intervention(s)	52,222	34,509,551	33,993,132	33,338,287	33,701,745	34,091,229	169,686,166	7.0%
Policy, planning, coordination and management of national disease control programs	0	0	29,962	29,398	0	0	59,360	0.0%
Treatment: MDR-TB	374,425,145	3,442,113	3,379,682	3,668,766	3,884,941	3,929,838	392,730,485	20.0%
Grant management	30	19,984	19,669	19,299	19,516	19,742	98,240	0.0%
Key populations (TB care and prevention) - Others	24,006	15,893,655	15,643,309	15,348,853	15,521,614	15,700,994	78,132,431	3.2%
Key populations (TB care and prevention) - Prisoners	999	661,199	650,785	638,535	645,722	653,184	3,250,424	0.1%
Case detection and diagnosis: MDR-TB	492	332,501	334,010	333,819	344,029	348,005	1,692,856	0.1%
Community MDR-TB care delivery	30	19,587	19,278	18,916	19,128	19,349	96,288	0.0%
Other MDR-TB intervention(s)	0	0	0	0	0	0	0	
Prevention (TB care and prevention)	1,257	828,572	815,521	800,171	809,177	818,528	4,073,226	0.2%
Routine reporting	35	0			0	0	35	0.0%
Total	375,000,000.00	382,000,000.00	388,005,000.00	392,800,000.00	407,120,000.00	411,825,000.00	2,356,750,000.00	1

2. Introduction

2.1. Purpose and organisation of the NSP-TB 2021 – 2026

This NSP-TB is developed to focus the efforts of the NTBLCP and all its partners in achieving the ambitious goal of universal access to high quality, patient-centred TB prevention, diagnosis, and treatment services for all in Nigeria by 2026. The NSP-TB frames its goals and objectives within the context of Nigeria's National Health Strategic Development Plan 2018 – 2022. It describes the current challenges to TB control and the Program's approach to addressing them. It also sets ambitious targets for this five-year period and describes in detail the activities that will be required to reach these targets.

The NSP-TB comprises of six related components:

1. The Core Plan which includes an analysis of the TB burden and TB situation with a clear description of the challenges and programmatic gaps, definition of the goals and objectives and identification of strategic interventions and their related activities and sub-activities
2. The Operational Plan that provides, for each activity and sub-activity, relevant and detailed information on the process of implementation
3. The Monitoring and Evaluation (M&E) plan with the indicators that need to be assessed for the goal(s), the operational objectives, the strategic interventions, and some important activities and will describe how the NTBLCP will assess progress towards each of the targets set in the core plan
4. The Technical Assistance Plan identifying interventions and activities that need technical assistance and providing detailed information on how the technical assistance should be carried out
5. The Detailed Budget Plan that includes the costs for each intervention, activity, and sub-activity over the next five years with reference to the relevant operational objective.
6. The Emergency Preparedness Plan that describes TB control during health emergencies, epidemics and in areas with security challenges or prone to natural disaster.

2.2. Rationale for update of the NSP-TB

Nigeria is among the 10 countries that are on the three WHO lists of high burden countries for TB, TB/HIV and MDR/TB³. The country is among the very few countries that recorded an increase in TB notification in 2020 at the height of the lockdown measure introduced to combat COVID-19 pandemic which significantly affects all sphere of human endeavour including health services. The integration of TB into COVID-19 interventions and other disease control efforts; focused reviews and supportive supervisions among others including comprehensive engagement of private and community sector access to services resulted in significant and consistent increase in TB notification⁴.

Nigeria is currently implementing a 2021 – 2025 NSP-TB. Many changes have taken place in the TB control space since the commencement of the NSP especially in the areas of DR-TB management and new TB diagnostic tools. The main rationale for the update of the NSP-TB and extension to 2026 are:

1. The Mid-term review of the NSP equally revealed areas of weakness that need to be addressed and recent epidemiological analyses of the TB burden in Nigeria (Epi-analysis),
2. Findings of People Centred Framework (PCF) that triangulated TB indicators and defined interventions intervention priorities,
3. Alignment with the Grant Cycle 7 (GC7) implementation period and the changing landscape of the Global Fund TB Essentials
4. Updates and new developments from new studies and national guidance; TB Stigma assessment, TB Public Private Mix (PPM), new interventions and strategies; Community Rights and Gender (CRG). And
5. The country already achieved higher than the set targets in some indicators leading to a need to set new targets.

To incorporate the new developments in TB control and address challenges militating the achievement of set program targets, the NTBLCP initiated the updating of this new NSP 2021-2026 to ensure high impact response to the TB epidemic in the country.

³ Global lists of high burden countries (HBCs) for TB, TB/HIV and MDR/RR-TB to be used by WHO, 2021–2025

⁴ Compendium of best practices in TB case finding in Nigeria 2018 -2021

The NSP interventions are premised on the following principles and commitments:

1. **Leadership and stewardship of the national response:** Strong political leadership and stewardship of the NTBLCP and commitment to transparency and prudent management of financial and other resources at all levels of the response.
2. **Multi-sectoral response:** Commitment to forge consistent and effective partnership and collaboration with development partners, the private sector, and civil society through harmonized and aligned ways of working to support the TB control activities at all levels
3. **TB Patients' rights:** Protection and promotion of the rights and access of TB patients to comprehensive prevention, treatment, care, and support services as well as reduction of stigma and discrimination and ensuring meaningful involvement of TB patients in TB control at all levels.
4. **Addressing key populations:** Nomads, IDPs and persons with diabetes mellitus are at risk of TB and services will be extended to them.
5. **Addressing gender factors** that might limit access of women and girls to quality TB services.
6. **Address Community Rights and Gender (CRG)** issues including Community Led Monitoring
7. **Delivery of integrated services:** Commitment to strengthen linkages and optimize synergies between the TB programme and other programs like TB/HIV and RMNCAH+N
8. **Evidence-based TB programming:** Commitment to evidence-based approach to planning and implementing interventions.

2.3. The NSP-TB development process

This NSP-TB was developed through an inclusive and transparent process in response to the new information available to the NTBLCP and its desire to aggressively address urgent issues related to TB control in Nigeria. A multi-sectoral approach was adopted in the development of the plan. Stakeholders engaged included people with TB; PLHIV; community-based organizations (CBOs); faith-based organizations (FBOs); technical partners; donors; National Agency for the Control of AIDS (NACA); National AIDS & Sexually Transmitted Infections Programme (NASCP); Ministries, Departments and Agencies (MDAs); Ministries of Labour; Ministry of Women Affairs; the Police; The Nigerian Correctional Services; State TB

Programme Managers; Local Government TB and Leprosy Supervisors (LGTBLS); the Country Coordination Mechanism (CCM); WHO; Global Fund Principal Recipients, academia and others. The participants performed a thorough SWOT analysis, identification of root causes of programme underperformance with a focus on identifying interventions and setting provisional targets for the new NSP based on the current epidemiological information available. Based on the rationale provided above, an updated version was developed and circulated for stakeholders' consultation and validation.

Table 1: National Strategic Plan Development Road Map

	January 2020			February 2020			Oct - Dec 2020	March 2023
	Jan 6-14	Jan 20-30	Jan 31,	Feb 6-7	Feb 10-15	Feb 24-28	Oct - Dec 2020	Mar – Apr 2023
NSP Development Activity								
Epi-analysis								
End-term evaluation of NSP-TB 2015 - 2010								
End-term evaluation debrief								
NSP broad stakeholder analysis workshop								
NSP draft zero workshop								
NSP broad stakeholder analysis workshop on the zero draft NSP								
Broad stakeholder feedback on the zero draft NSP								
Engagement of CSOs on the zero draft NSP								
Development of the first draft of the NSP based on inputs								
Finalisation of the NSP 2021-2025								
Revision and Extension of NSP 2021-2026								

2.4. Guiding documents

The following documents were relied upon in the development of this NSP:

- WHO Toolkit to develop a national strategic plan for TB prevention, care, and control - Methodology on how to develop a national strategic plan (2015)
- Mid-term review report (2023)
- Epi-analysis report (2023)
- Recommendations for data driven NSP development taking into consideration the People Centred Framework and the Patient Pathway Analysis
- Tuberculosis patient cost surveys: a handbook (2017)
- Nigerian TB catastrophic cost study (2017)
- Updated and consolidated WHO guidelines for programmatic management of LTBI (2018)
- Updated WHO guidelines for DR-TB (2018)
- Roadmap towards ending TB in children and adolescents (2018)
- Updated WHO guidelines on TB infection control and prevention (2019)
- Rapid Communication: Key changes to the treatment of drug-resistant TB (2022)
- Rapid Communication: Molecular assays as initial tests for the diagnosis of TB and rifampicin resistance (2020)
- Stop TB Strategic Tools for Implementing Effective TB Case Finding Programmes
- TB NSP of some developing countries
- WHO guidelines for treatment of drug-susceptible TB and patient care
- TB Stigma Assessment (2023)
- MDR patient assessment
- Appraisal of Tuberculosis Patient Pathway Analysis of Clients in Nigeria (2023).

3. Situation Analysis

3.1. Background Information

3.1.1. Country Profile

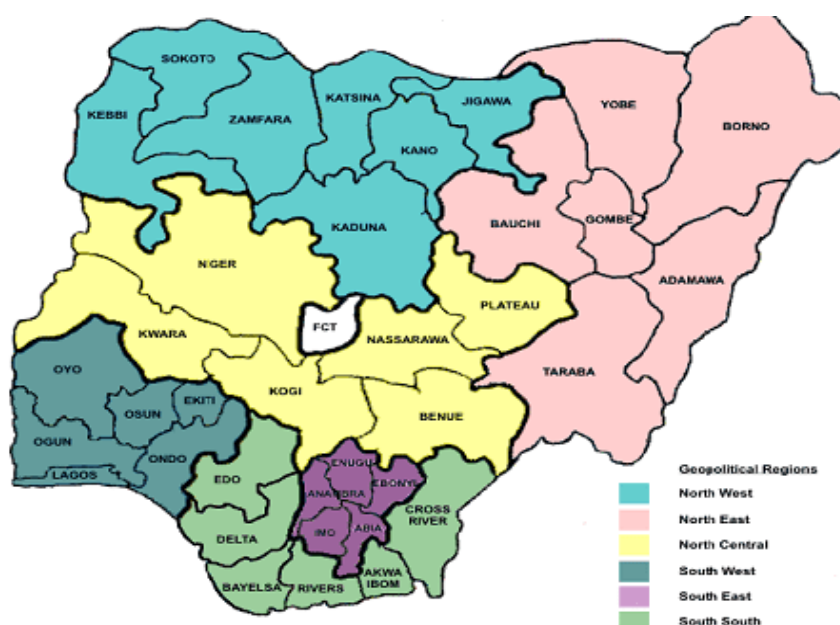
Nigeria is a country in West Africa, sharing borders with Benin, Niger, Chad, and Cameroon, as well as a coastline on the Gulf of Guinea. It has an area of 923,768 square kilometres and is the most populous country in Africa, with an estimated population of 215 million in 2022⁵. The official language of Nigeria is English, although there are more than 250 ethnic groups with diverse languages and religious faiths.

Although Nigeria is relatively stable, intergroup violence fuelled by a complex mix of religious, ethnic, political, and economic tensions remains a major concern for the country. Along with other fundamental health systems challenges, the civil unrest affects the ability of the health system to function effectively in certain regions, particularly the North East.

3.1.2. Governance Structure

There are three levels of government: federal, state, and local government area (LGA). There are 36 states and a Federal Capital Territory (FCT), which are organized into six geopolitical zones. The number of LGAs in each state is variable, ranging from 8 to 44. There are a total of 774 LGAs in the country.

Figure 1: Map Showing Geo-political zones of Nigeria



⁵ Nigeria Demographic and Health Survey 2022. https://www.statista.com/topics/6477/demographics-of-nigeria/#topicHeader__wrapper

3.1.3. Economy and economic indicators

Nigeria was declared a Federal Republic in October 1963. There are three (3) arms of government: Executive, Legislature and Judiciary. Nigeria's gross domestic product (GDP) is USD 397.27 billion while the per-capita gross national income (GNI) is USD 1,960. Analysis of multidimensional poverty in Nigeria shows that Half of the Nigerian population (50.6%) are multidimensionally poor and use dung, wood, or charcoal as their main cooking fuel⁶. Nigeria's economy is heavily dependent on oil exports, which currently makes up more than two-thirds of the government's total revenue. Oil price fluctuations have significant impacts on Nigeria's income and affect the government's ability to budget effectively. There are ongoing efforts to diversify the country's income base to provide better economic stability.

3.1.4. Political and socioeconomic contexts

Nigeria operates the three arms of government, the **Executive, the Legislative and the Judiciary system of government**. The Nigerian president serves as both the Chief of State as well as the Head of Government. The president undertakes all required duties as the Commander-in-Chief of the nation's armed forces. The Nigerian president assents to and signs bills and can return a bill to Parliament for reconsideration. The House of Representatives and the Senate undertake legislative duties in Nigeria. The Judiciary system of Nigeria is headed by the National Judicial Council, an independent executive institution. The Chief Justice chairs Nigeria's Supreme Court with the help of other associate judges.

3.1.5. Demography

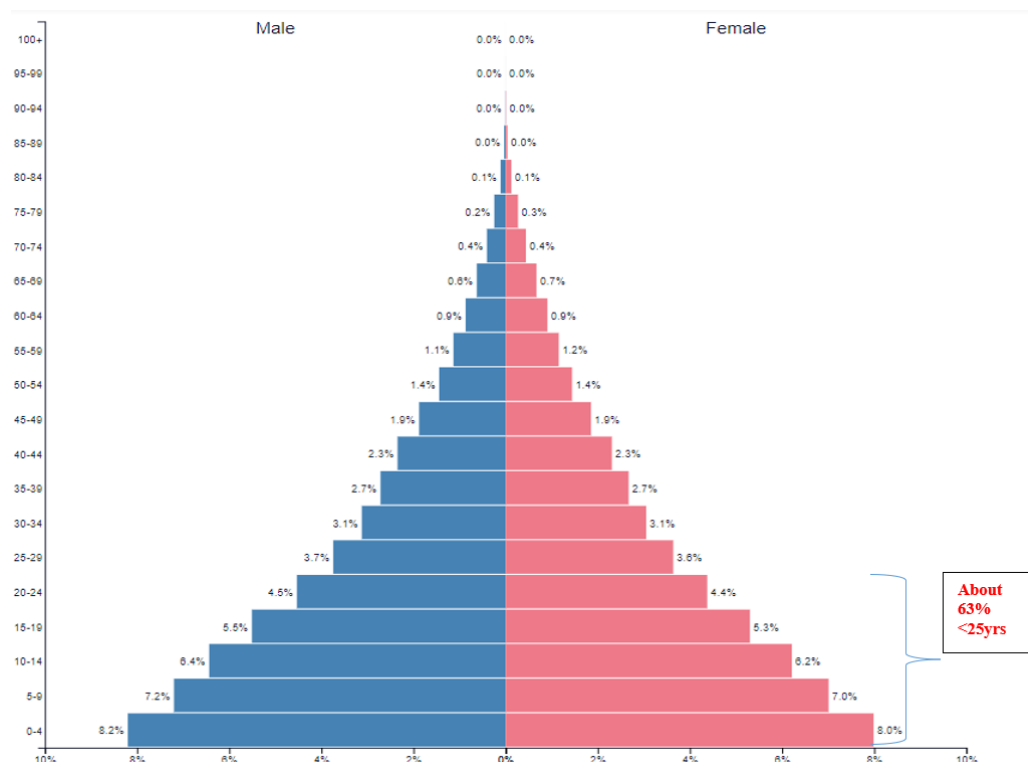
Nigeria is the country with the highest population in Africa. In 2022, its population amounted to over 215 million and was estimated to constantly increase in the next decades, as shown in the population pyramid in Figure 3 below. The population growth rate is estimated at 3.2 percent per year. An estimated 63 percent of the population is under the age of 25⁷. This population distribution has implications for the dynamics of TB transmission and for the approaches to TB education, case-finding and case holding. This emphasizes the need for more intensive efforts to diagnose paediatric TB and use of modern communication methods to reach young people at risk of TB, with appropriate messages. The annual rate of growth in

⁶ National Poverty Map. Multidimensional Poverty in Nigeria. <https://www.nigeriapovertymap.com/>

⁷ Nigeria Demographic and Health Survey 2022. https://www.statista.com/topics/6477/demographics-of-nigeria/#topicHeader__wrapper

urbanization was estimated at 3.9 percent. The average life expectancy for both sexes is 53 years, males is 52 years and females 53 years⁸. Nigeria like many developing countries is undergoing a slow demographic transition as high birth and death rates persist in the country.

Figure 3: Population age and sex structure



3.1.6. Organization of Health System

Health system organization mirrors the governance structure of the country. Health is in the concurrent list and functions at and is the responsibility of the respective level of governance. With some exceptions, the federal level oversees and operates tertiary care facilities, the state level oversees and operates secondary care facilities, and the local government area (LGA) level oversees and operates primary care facilities. The public health service is organized into primary, secondary, and tertiary levels. While the Constitution is silent on the roles of the different levels of government in health services provision, the National Health Policy ascribes responsibilities for primary health care to local governments, secondary care to states and tertiary care to the federal level. At the same time, several parastatals based at the federal level, for example, the National Primary Health Care Development Agency (NPHCDA), are currently engaged in primary health care services development and provision; the latter is evidently part of its mandate. Although national policies formulated by the Federal Ministry of

⁸ World Bank Data. <https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=NG>

Health provide some level of standardization, each level is largely autonomous in the financing and management of services under its jurisdiction.

3.1.7. Health system financing

Financing of the health system at the federal level is through an annual ministerial budget approved by the national assembly. Within the Federal Ministry of Health (FMOH), each department and Programme, including the NTBLCP has a specific budget line for TB within the FMOH budget. To utilize the appropriated funds, NTBLCP develops a proposal in line with the appropriated funds stating clearly what it intends to do and achieve. Funds are later disbursed after approval from the Ministry authority. However, there are often delays in fund disbursement and instances of non-disbursement are not uncommon.

State funding for all health services is allocated through a similar process as at the federal level. State funding for health is derived from two sources: a federal monthly allocation to each state from the consolidated federation account and the state internally generated revenue. In most states, there is no line item in the budget for TB control.

LGAs are also allocated funds from the federation account but their funds go through the states who then disburse them to the LGAs. Most states have a system of joint accounts with their LGAs. Funds for health at this level are in the form of a lump sum allocation for primary health care, which includes staffing, facilities, and basic commodities. Delays in disbursement, non-disbursement of the LGAs 'funds by the states and weak capacity at the LGA level, have weakened the ability of the primary health care system to provide needed services. As a result, it is reported that many patients seek first-line care at secondary or tertiary facilities instead.

3.1.8. Health indicators

The average life expectancy for both sexes in Nigeria is 55.8 years, males is 54.8 years and females 56.8 years⁹. The total fertility rate for Nigeria is 5.4 and infant mortality 54.7 per 1000 live births. A Nigerian woman has a 1 in 22 lifetime risk of dying during pregnancy, childbirth, or postpartum/post-abortion, whereas in the most developed countries, the lifetime risk is 1 in 4900. Every single day, Nigeria loses about 2,300 under-five year olds and 145 women of

⁹ Nigeria Demographic and Health Survey 2018

childbearing age. This makes the country the second largest contributor to the under-five and maternal mortality rate in the world.

Table 2: Trend of basic health indicators 1990 – 2018 (NDHS), 2019-2020 (WB)¹⁰

Indicator	1990	2003	2008	2013	2018
Total fertility rate/woman aged 15-49	6.0	5.7	5.7	5.5	5.3
Infant mortality per 1000 live births	87	100	75	69	67
Under 5 mortality per 1000 live births	193	201	157	128	132
Women accessing antenatal care at least once (%)	57.0	58.0	58.0	61.0	67.0
Women accessing antenatal care at least 4 and more (%)	51.0	47.0	45.0	51.0	57.0
Births attended by skilled personnel (%)	32.0	36.3	39.0	38.1	37.7
Delivered in health facility (%)	32.0	33.0	35.0	36.0	39.0
Children 12-23 months with all basic vaccinations (%)	29.0	13.0	23.0	21.0	31.0
BCG coverage for children aged 12-23 months (%)	60.7	48.3	49.7	51.0	66.1

3.1.9. Relevant health sector policies, strategies, plans and initiatives.

There are several health sector policies and initiatives that have relevance for the approaches developed as part of the NSP-TB. The potential synergies with or effects on the NSP-TB are described briefly below.

3.1.9.1. National Strategic Health Development Plan (NSHDP) (2018 – 2022)

The NSHDP II provides a common strategic framework for health sector development that will guide all health interventions by all stakeholders during the period 2018 – 2022. Specifically, the NSHDP II provides a framework for mobilizing resources for the health sector, guiding the development of a Medium-Term Sector Strategy, Medium-Term Expenditure Framework, health sector Annual Operational Plans and budgets at all levels; and aligning and coordinating the partner support in health development in the country. The NSHDP II is arranged into five Strategic Pillars and fifteen Priority Areas with 15 Goals and 48 Strategic Objectives. Within each objective are strategic interventions and key actions, specific indicators, and targets.

¹⁰ World Bank Data. <https://data.worldbank.org/indicator/SP.DYN.IMRT.IN?locations=NG>

The NSHDP provides the umbrella framework that should guide and inform approaches to all disease specific Programmes, including TB. These priority areas are in line with the priorities identified for the new NSP-TB, which reflects the need to consider the larger health systems challenges as an integral part of addressing issues specific to TB control. The explicit relationship between the NSHDP priorities and the NSP-TB objectives and strategic interventions is presented in table 4 below. A key strategic objective in the NSHDP is to ensure universal access to high quality client-centered TB diagnosis and treatment services for the reduction in the incidence and prevalence of TB in Nigeria. While the NSHDP II (2023 – 2027) is still being finalised, the relationship of the NSHDP II (2018 – 2022) and the NSP-TB Response is well documented in Annex 1.

3.1.9.2. National Health Bill

The National Health Bill 2014¹¹ was passed by the National Assembly in 2014 and was signed by the President in December 2014. The bill seeks to provide a framework for the regulation, development and management of a national health system and set standards for rendering health services in the federation, and other matters connected therewith (National Health Bill, 2014). It lays out the roles and responsibilities of the three levels of the health system, required health personnel and facilities to follow set national standards, establishes a National Council on Health, establishes a national primary health care development fund, and sets other provisions to govern the functions of and relationships between the various levels of the health system. The bill will help strengthen the linkages between the three levels of the health system and provide the resources and structures for the much-needed health system strengthening.

3.1.9.3. National Health Insurance Commission Act

This act seeks to repeal the existing National Health Insurance Scheme Act, Cap. N42, LFN 2004 and to enact the National Health Insurance Commission Act. This is to ensure a more effective implementation of a national health insurance policy that will enhance access to healthcare services for all Nigerians, as well as promote and effectively regulate health insurance schemes in Nigeria. The act has passed the second reading at the National Assembly as at the time of completion of this NSP. The act would help to establish various health insurance schemes like the Community-based social health insurance scheme and State health insurance schemes to increase access to health care for Nigerians. Of note, it would establish a

¹¹ Federal Republic of Nigeria Official Gazette – National Health Act, 2014

National Vulnerable Groups Health Insurance Fund to provide subsidized and /or free health insurance to disadvantaged Nigerians. At present, the act contains no language on TB. The companion National Health Insurance (NHI) operational guideline specifically excludes TB, giving the rationale that TB control activities are covered under the NTBLCP, but some State health insurance schemes have included TB in their benefit package.

3.1.9.4. National Council on Health declaration on TB reporting

A declaration at the 2017 NCH made “the mandatory submission of data by private healthcare providers as a prerequisite for the renewal of certificate of standards in conformity with the NHAct section 38 Sub section 1 and 2”¹²

3.1.9.5. Basic Healthcare Provision Fund (BHCPF)

The Nigerian government approved the Basic Healthcare Provision Fund (BHCPF) as part of the 2018 Appropriation Bill passed by the National Assembly on June 3rd, 2018. The move allows Nigeria's government to fund a basic package of healthcare across the country, taking it one step closer to its goal of implementing a universal healthcare system by 2030. The need for the BHCPF was outlined in the National Health Act (NHAct) 2014¹³, which came into effect in 2016. According to the Act, 50% of the Fund will be used to provide a basic package of services in PHC facilities through the National Health Insurance Scheme (NHIS); 45% will be disbursed by the National Primary Health Care Development Agency (NPHCDA) for essential drugs, maintaining PHC facilities, equipment, and transportation, and strengthening human resource capacity; and the final 5% will be used by the Federal Ministry of Health (FMOH) to respond to health emergencies and epidemics. A key component of the NHAct is the establishment of the BHCPF which aims to extend PHC to all Nigerians by substantially increasing the level of financial resources to PHC services. The program will ensure that TB patients benefit from this care package.

3.1.9.6. Saving One Million Lives

Saving One Million Lives¹⁴ is an initiative launched in 2012 with the objective of addressing preventable causes of maternal and child mortality. The approach encompasses many of the

¹² Council Communique from the 59th National Council On Health (NCH) Meeting Held at International Conference Centre, Umuahia, Abia State, 23rd- 27th January, 2017

¹³ Federal Republic of Nigeria Official Gazette – National Health Act, 2014

¹⁴ Giwa,Abdulrazzaq Salaudeen.2018. *Saving One Million Lives Project (English)*. Washington, D.C. : World Bank Group.

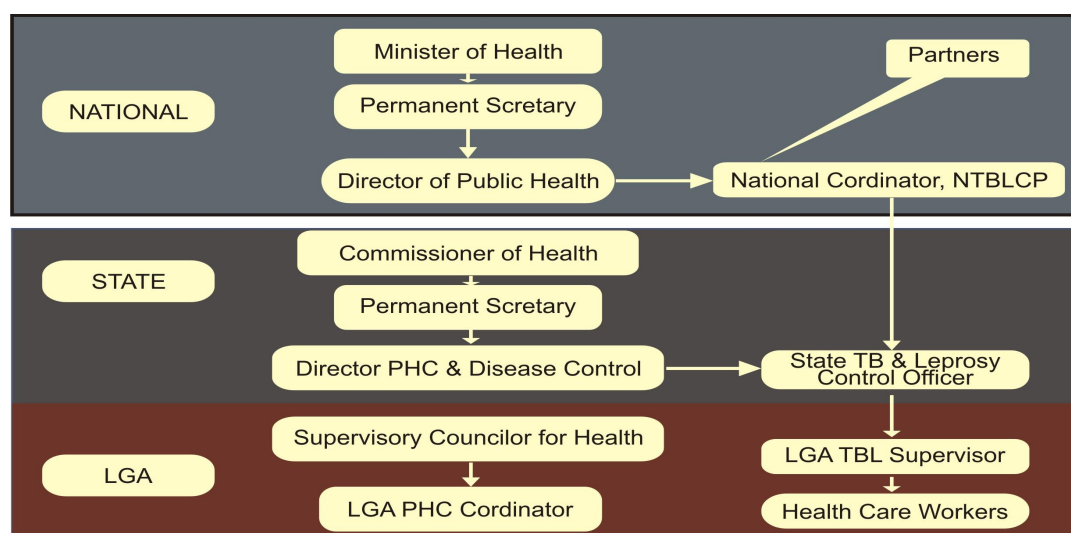
same health systems strengthening activities envisioned in this new NSP-TB. For instance, it focuses on results-based planning, strengthening of accountability, engagement of private providers and community outreach as activities to support reductions in mortality. While TB is not specifically included in this initiative, many State TB programmes were able to leverage on some of the interventions in the initiative to implement key TB control activities in their States. It is expected that this collaboration with the initiative will be intensified in the 2021 – 2026 NSP.

3.1.10. The National Tuberculosis and Leprosy Control Programme

Organisational units of TB control and their functions

The National Tuberculosis and Leprosy Control Programme (NTBLCP) was established in 1989 by the Government of Nigeria to coordinate TB and leprosy control efforts in Nigeria. Its mandate was further expanded to include Buruli ulcer control in 2006. The operations of the NTBLCP are in line with the three levels of governance in the country: national, state, and local government area (LGA).

Table 3: Organisational chart showing relationships of the operational levels of the NTBLCP



3.1.10.1. The Central Unit

The NTBLCP at the national level is referred to as the Central Unit (CU). The Central Unit of the NTBLCP is a division in the Department of Public Health of the Federal Ministry of Health

and is headed by a national coordinator, responsible for the entire Programme in the country. The National Tuberculosis and Leprosy Training Centre (NTBLTC), Zaria is the human resource development arm of the NTBLCP. The centre also incorporates a referral hospital with a 140-bed capacity for management of leprosy and drug-susceptible TB patients, with an additional 20-bed capacity for the treatment of drug-resistant TB patients. Furthermore, one of the two National TB Reference Laboratories (NRL) is in NTBLTC, Zaria.

Functions

The central unit of the NTBLCP is responsible for the following functions:

- Facilitates the development of policies on TB, TB/HIV, Leprosy and Buruli Ulcer control in the country.
- Coordinates all activities of TB, Leprosy and Buruli Ulcer control in the country.
- Provides oversight to the National TB and Leprosy Training Centre (including the National Reference Laboratory) in Zaria as an arm of the NTBLCP.
- Provides managerial and technical support to the Zonal TBLCP Coordinators and the State TBL Control Officers.
- Procures and distributes equipment and supplies of the NTBLCP (anti-tuberculosis, anti-leprosy and anti-lepra reaction drugs, laboratory equipment and reagents, stationery, and transport, etc.).
- Mobilizes resources for Programme implementation.
- Ensures adequate human resources for the Programme at the federal level and advises sub-national level on staffing needs.
- Organises periodic reviews and evaluations of the TB, leprosy and Buruli ulcer control Programme.
- Maintains active collaboration with national and international non-governmental organisations and voluntary agencies including private health establishments.

3.1.10.2. State level

At the State level, the TB and Leprosy Control Programme functions under the State Department of Disease Control or Department of Public Health and is known as the State TB and Leprosy Control Programme (STBLCP). The STBLCP headed by a State TB and Leprosy Control Programme Manager (STBLCPM) coordinates TB and leprosy control activities in their respective states and provides secondary care and technical assistance to the LGA level.

Functions

The STBLCP is responsible within its jurisdiction for the following activities:

- Managing TB, TB/HIV, Leprosy and Buruli Ulcer activities at the State level.
- Managing, coordinating, and supervising all Programme activities at State and Local Government level.
- Assisting in the diagnosis and management of difficult TB and leprosy cases.
- Ordering and distributing supplies to LGAs.
- Collecting, collating and analysing data on leprosy and TB activities in the State and disseminating reports to the Federal and Local Governments, as well as other organisations and institutions as appropriate.
- Maintaining active cooperation with NGOs supporting the State Programmes.
- Setting up and maintaining a laboratory quality assessment (QA) system in the State
- Maintaining adequate procurement supply management to prevent stock-outs of commodities.

3.1.10.3. LGA level

The LGA is the basic management unit of the NTBLCP. At this level, the LGTBLS coordinates TB and Leprosy control activities. S/he oversees all health facilities within their respective LGAs, where TB and leprosy activities are carried out including primary, secondary, and tertiary health facilities in public, private, (FBO sectors, as well as military and para-military health facilities.

Functions

The LGTBLS is responsible for the following activities at LGA level:

- Managing and coordinating TB, TB/HIV and Leprosy control activities in the LGA.
- Assisting the STBLCO in planning, organizing, and conducting training Programmes.
- Ensuring proper sputum collection and prompt transportation to the laboratory.
- Assisting in diagnosis and management of difficult TB and leprosy cases.
- Supervising treatment by other health workers throughout the LGA and ensuring that the national guidelines are followed.
- Keeping an up-to-date and accurate record of activities of TB and leprosy control activities in the LGA, including the LGA Central Registers. Ensuring that patient record cards are properly filled and kept by the health unit staff.

- Ordering supplies (drugs, laboratory supplies, records cards, and forms) from the State level for the LGA and ensure their distribution to all health units.
- Liaising with the PHC Coordinator in carrying out health education activities
- Undertaking activities for disability prevention and rehabilitation.

3.1.10.4. Health facility level

The health facilities are the points of delivery of TB and leprosy services. It is the operational level, where different cadres of health workers provide diagnostic and treatment services for TB and leprosy depending on the level of care (primary, secondary, and tertiary) available. The health workers include medical doctors, pharmacists, laboratory scientists, nurses, Community Health Officers, Community Health Extension Workers, health assistants and others. Their roles in identification and examination of presumptive TB cases as well as diagnosing, treating and follow up of TB cases vary according to their training and qualifications.

3.1.11. Programme infrastructure & processes

3.1.11.1. Diagnosis

The NTBLCP in collaboration with partners has made tremendous efforts in ensuring that the primary diagnostic tool (Xpert MTB/RIF Assay) provides positive impact in increasing case detection among presumptive TB for both pulmonary and extra pulmonary TB cases. Various strategies to enhance accessibility through specimen referral and optimization is ongoing. The number of GeneXpert machines increased from 318 in 2016 to 503 machines in 2022. (See table 6 below showing the distribution of the GeneXpert machines by state). Also, the programme has increased the diagnostic menu by procuring 372 TrueNat machines, 169 TB LAMP machines and 380 portable digital X-ray with AI distributed across the country.

The programme recommends AFB microscopy for use in diagnosing TB only in places where molecular test is not available or accessible. In addition, Microscopy is recommended for use in monitoring all bacteriologically positive TB cases and as part of monitoring tests for DR-TB patients. The development of the Public Private Mix Action Plan (2022-2025) is part of an ongoing effort to ensure appropriate integration of private medical laboratories into the laboratory network. The diagnosis of drug resistant TB cases is further strengthened using other approved rapid molecular tools namely Line Probe Assay (for 1st and 2nd line anti-TB drugs) and phenotypic Drug Susceptibility Testing.

Table 4: GeneXpert MTB-Rif machines distribution as of 2022

S/No	ZONE	STATE	Number of Xpert Machines
1	North Central	Benue (28), FCT (20), Kogi (9), Kwara (8), Nasarawa (19), Niger (14), Plateau (15)	113
2	North East	Adamawa (10), Bauchi (15), Borno (7), Gombe (8), Taraba (9), Yobe (6)	55
3	North West	Jigawa (10), Kaduna (20), Kano (26), Katsina (14), Kebbi (8), Sokoto (12), Zamfara (8)	98
4	South East	Abia (10), Anambra (14), Ebonyi (8), Enugu (16), Imo (13)	61
5	South West	Oyo (17), Ekiti (6), Osun (13), Lagos (38), Ogun (16), Ondo (11)	101
6	South South	Akwa Ibom (14), Bayelsa (8), Cross River (14), Delta (12), Edo (10), Rivers (17)	75
TOTAL	6 ZONES	36 STATES + FCT	503

3.1.11.2. The TB Laboratory Network

The NTBLCP laboratory network is set within the health system and organized in a pyramidal structure illustrated in Figure 4. Each tiered level has specific requirements for infrastructure and biosafety which are defined by the various activities and diagnostic methods being performed in the laboratories. As the level of the laboratory increases from the base of the pyramid to the apex, the demand for skills, proficiency and training requirements increases for the personnel. The organisation and operations found at different levels of the laboratory network for TB services are as described below in Figure 4.

Overall, there are 14 existing TB reference laboratories in the country out of which 10 are functional with capacity for LPA (1st & 2nd line). The programme also enjoys the laboratory services of private, faith-based, military, and paramilitary health facilities.

3.1.11.2.1. Supra national reference laboratories

At the peak of the pyramid is the Supra national reference laboratories which is located outside the country.

3.1.11.2.2. National Reference Laboratories

At the top of the pyramidal structure are the two NRLs, located at the National TB and Leprosy Training Centre (NTBLTC), Zaria and the Nigerian Institute of Medical Research (NIMR) in

Lagos, in the northern and southern parts of the country, respectively. The Zaria NRL is structurally located within the NTBLCP and as such reports directly to the NTBLCP central unit. NIMR, however, is a parastatal within the Federal Ministry of Health that does not report directly to the NTBLCP. The NRL is linked to Supranational Laboratory (SRL) for purpose of technical support and external quality assessment (EQA).

The activities implemented at the NRLs include microscopy (LED and/or light), culture (solid and liquid), identification of MTB complex by immunochromatographic methods and the most common species of non-tuberculous Mycobacteria (NTMs) by LPA; molecular methods for detection of drug resistance (LPA and GeneXpert); and DST according to the WHO guidelines for first-line anti-TB drugs (FLDs) and second-line anti-TB drugs (SLDs). FLDs tested include isoniazid, rifampicin, and ethambutol. SLDs tested include capreomycin, kanamycin, amikacin, aminoglycosides, levofloxacin, ofloxacin, ethionamide and cycloserine. In the course of the new all oral regimen, the testing for moxifloxacin Bedaquiline and pyrazinamide is now being done. Trainings, panel testing, supervision of ZRLs, preparation of media and research activities are also regularly performed. The NRLs are affiliated with the supranational reference laboratory (SRL) in Milan, Italy. The SRL provides support in programmatic and technical aspects related to laboratory network implementation, DR-TB diagnostics activities and EQA.

3.1.11.2.3. Zonal Reference Laboratories (ZRLs)

The third level of the laboratory is known as the Zonal TB reference laboratories and are strategically located in the six geo-political zones of Nigeria. These laboratories are sited within university teaching hospitals and are meant to carry out the following activities: culture (solid and nitrate reductase activity-NRA-method) and identification; DST for first-line TB drugs on solid media; TB molecular methods (LPA and GeneXpert); TB microscopy (LED and/or ZN), trainings, supervision of state reference laboratories, panel proficiency testing, preparation of reagents for smear microscopy and research activities. The population coverage per ZRL is approximately 29 million persons.

3.1.11.2.4. State TB Reference Laboratory (STBRL)

State laboratories (Level 2 laboratories) perform AFB smear microscopy and EQA for AFB except for one state laboratory, DLHMH, Calabar which is also equipped to perform culture,

DST for first-line TB drugs and molecular assays (LPA and GeneXpert). There is a plan to have at least one Level 2 laboratory per State and to gradually upgrade the diagnostic services provided by all the state labs to include culture, DST, and molecular tests. The population coverage per laboratory at full implementation, with one laboratory per state, would be approximately 3,000,000 persons (still insufficient to cover the needs of the country for these diagnostic services).

3.1.11.2.5. Peripheral Laboratories

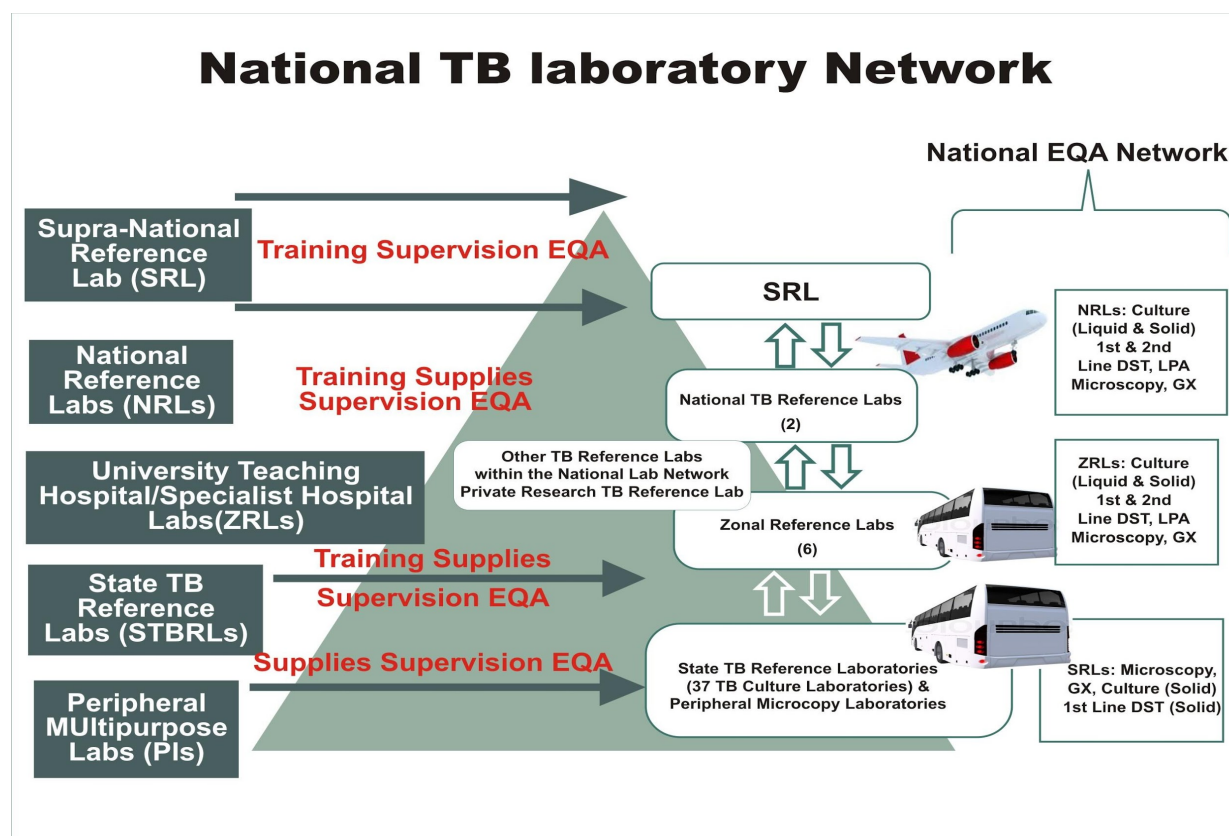
Peripheral laboratories are at the base of the pyramidal structure and are located within primary health centres, general hospitals, specialist hospitals and local government health clinics. This is also known as the Level 1 laboratories. Activities implemented at this level include sputum collection, sputum smear microscopy with conventional or LED fluorescent microscopes, recording/reporting of smear results, TB molecular diagnosis (GeneXpert in a few facilities only) and slide storage for EQA. Personnel requirements are for 1-2 lab staff for a workload of ≤ 25 smears per day.

3.1.11.2.6. Approved Innovations on TB Laboratory Diagnostic methods for Case Finding

Improvement in case detection will be greatly facilitated by the introduction of approved diagnostic innovations and approaches. In an effort towards achieving the End-TB strategy and in line with global recommendations, the government has given approval for the use of the following diagnostic innovations and there are ongoing engagements for expansion at appropriate levels:

1. The Loop-isothermal mediated amplification test (TB LAMP) is a unique technique used for the diagnosis of pulmonary TB based on the amplification of DNA
2. The QuantiFERON TB Gold PLUS (QFT- Plus) is a diagnostic tool for Latent TB Infection (LTBI)
3. The lateral flow urine lipoarabinomannan assay (LF-LAM) is a commercially available point-of-care test for active TB in PLHIV.

Figure 5: The Nigeria laboratory network structure.



3.1.11.3. Treatment

As at the end of 2019, there were 12,606 DOTS, this increased to 20,148 in 2022, a 62% increase in number of centres providing TB treatment services in Nigeria. All LGAs have at least one DOTS treatment facility. The number of DOTS treatment facilities has doubled since 2015 (5,861). The standard TB treatment regimen for DSTB patients is six months using fixed-dose combination drugs. The treatment regimen for DR-TB patients is described in the section below on DR-TB. The Programme provides both in-patients and out-patient treatment using a combination of health facility staff, family members and community volunteers to support directly observed treatment.

Community TB care (CTBC) is being implemented in Nigeria and relies heavily on the engagement of technical partners to manage community-based organizations and volunteers involved in CTBC. CBOs are used by the programme to implement community PMDT nationwide. Linkages between CBOs and the local health system is improving.

3.1.11.4. TB/HIV services

The NTBLCP, NACA and NASCP coordinate the provision of joint TB/HIV services through the National TB/HIV Working Group. National policy supports universal HIV counselling and testing for all individuals suspected of or diagnosed with TB, provision of CPT and ART to HIV-positive TB patients, regular screening for TB among PLHIV and provision of TPT to PLHIV without active TB.

According to government policy, TB/HIV services provided at DOTS centres are aimed at reducing the burden of HIV among TB patients. These include HIV counselling and testing for all presumptive and diagnosed TB cases as well as linking or providing CPT and ART for HIV-positive TB patients. At HIV service delivery centres, the services are aimed at reducing the burden of TB among PLHIV. These include screening all PLHIV for TB, provision of TB diagnosis and treatment for co-infected patients, IPT for PLHIV without active TB and infection control measures are also put in place to reduce the transmission of TB to PLHIVs at service delivery points.

As at the end of 2019, there were 1,435¹⁵ facilities providing ART services with more than 90% of these co-located at facilities offering TB services. The ratio of DOTS services to ART services is 9:1, indicating limited access of HIV- positive TB patients to ART services. The existing 20,148 DOTS centres provide opportunity for rapid decentralization of ART services across the country.

3.1.11.5. Procurement and supply management

Most Anti-TB drugs and other commodities are currently procured from the Global Drug Facility (GDF), through grants and funding from the Global Fund, United States Agency for International Development (USAID) and Government of Nigeria (GON). The procurement process is coordinated by the NTBLCP in partnership with the Global Fund Principal Recipients and other partners. The NTBLCP oversees quarterly distribution to the zones, from where they are further distributed to the states and facilities based on reported case load and consumption data. A third-party logistics system is used to transport the commodities.

¹⁵ 2019 HIV Health Sector Annual Report

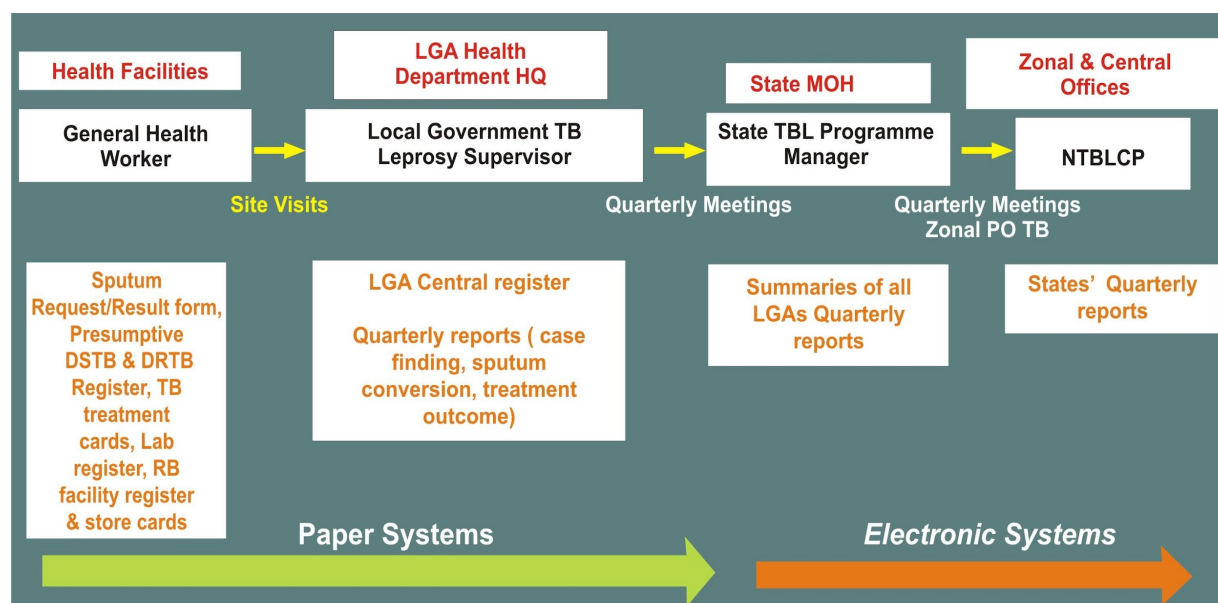
The NTBLCP had recognized the weaknesses in the procurement and supply management (PSM) system and has taken steps to strengthen management of commodities, particularly at the state and facility levels. It has built a sophisticated access database called —PICKnPACK|| to improve pipeline visibility and drug management at lower levels. An excel-based tool and the e-TB manager is used for tracking the utilization of 2nd line anti-TB medicine. Though stock outs have been greatly minimized, poor recording and reporting and therefore management for drugs and related commodities have however been observed. This may not be linked to the fact that most GHCWs are yet to be trained on use of basic logistics management information system tools. The storage system at lower levels for some facilities, need to be upgraded to meet minimum standards of storage. The logistics system for the management of GeneXpert cartridges is not well coordinated because of parallel systems of procurement and supply management, however, the NTBLCP has begun to harmonize the processes and a web-based tool known as the GxAlert system which is used to monitor and manage the use of cartridges.

DR-TB patients in the community are not sufficiently monitored for adverse drug reactions (ADRs). The Programme in collaboration with the National Agency for Food and Drugs Administration and Control (NAFDAC), is currently building the capacity of GHCWs to be able to report any suspected ADRs. At the moment, the country has no quality assurance Policy, but this is being developed by the National Products Supply Chain Management Programme (NPSCMP). Quality assurance testing is not done in-country because there is no laboratory certified for this purpose yet.

3.1.11.6. Information management system

Currently the NTBLCP information management system is built on both a paper-based and an electronic recording and reporting system that use the WHO-recommended recording and reporting formats. The system permits timely flow of information from the basic management unit of the Programme to the central unit of the NTBLCP as described in Figure 6.

Figure 6: Current flow of TB data in Nigeria.



Standardised paper-based recording tools are used to capture information directly from patients and are maintained and protected at the facilities. The LGTBLS during site visits, transfers patient level information from the primary tools into the LGA central register using a unique identification number for each patient. At the end of every quarter, the LGTBLS uses standardized quarterly summary forms to aggregate and collate each data set in line with the NTBLCP indicator reference booklet. These quarterly reports are made available to the state M&E officer after verification and validation by the State TBL team members during the state quarterly review meetings.

Similarly, the state team through its M&E officer collates all the submitted LGA reports into a single state data using an automated excel-based quarterly summary reporting format. These state-summarised data are equally transferred to the NTBLCP zonal officers and the zonal WHO National Professional Officers (NPOs) during the quarterly zonal review meetings. At the CU of the NTBLCP, all state data are entered into an automated standardised excel-based quarterly summary form (which is identical to that used at the state level). All collated data are verified, and feedbacks provided to the states as appropriate. Data quality checks through quarterly on-site data validation (OSDV) and bi-annual data quality assessment (DQA) are in place to improve data quality at all levels.

As part of the efforts to improve current information flow and analysis, the NTBLCP and stakeholders have concluded plans to migrate fully to an electronic reporting system from the LGA level upwards. A review of the electronic data capturing tools with detailed assessment

has been done to identify challenges in its implementation and to upgrade the use the e-TB manager and the Gx Alert system using the Gx connect and more recent update of the tools. With the proposed system, it is expected that all patient information captured on the paper-based reporting tools will be transferred by LGTBLS into the e-TB manager which allows for real time patient management and availability of patient data for Programme use. The newly instituted information system will be augmented with the already existing data quality management system which is built into the routine Programme supervision and quarterly meetings at all levels where feedback is provided on identified data challenges. The entire TB surveillance system is also expected to key into the current District Health Information System 2 (DHIS 2) national instance to ensure the timely availability of a harmonised data for the country.

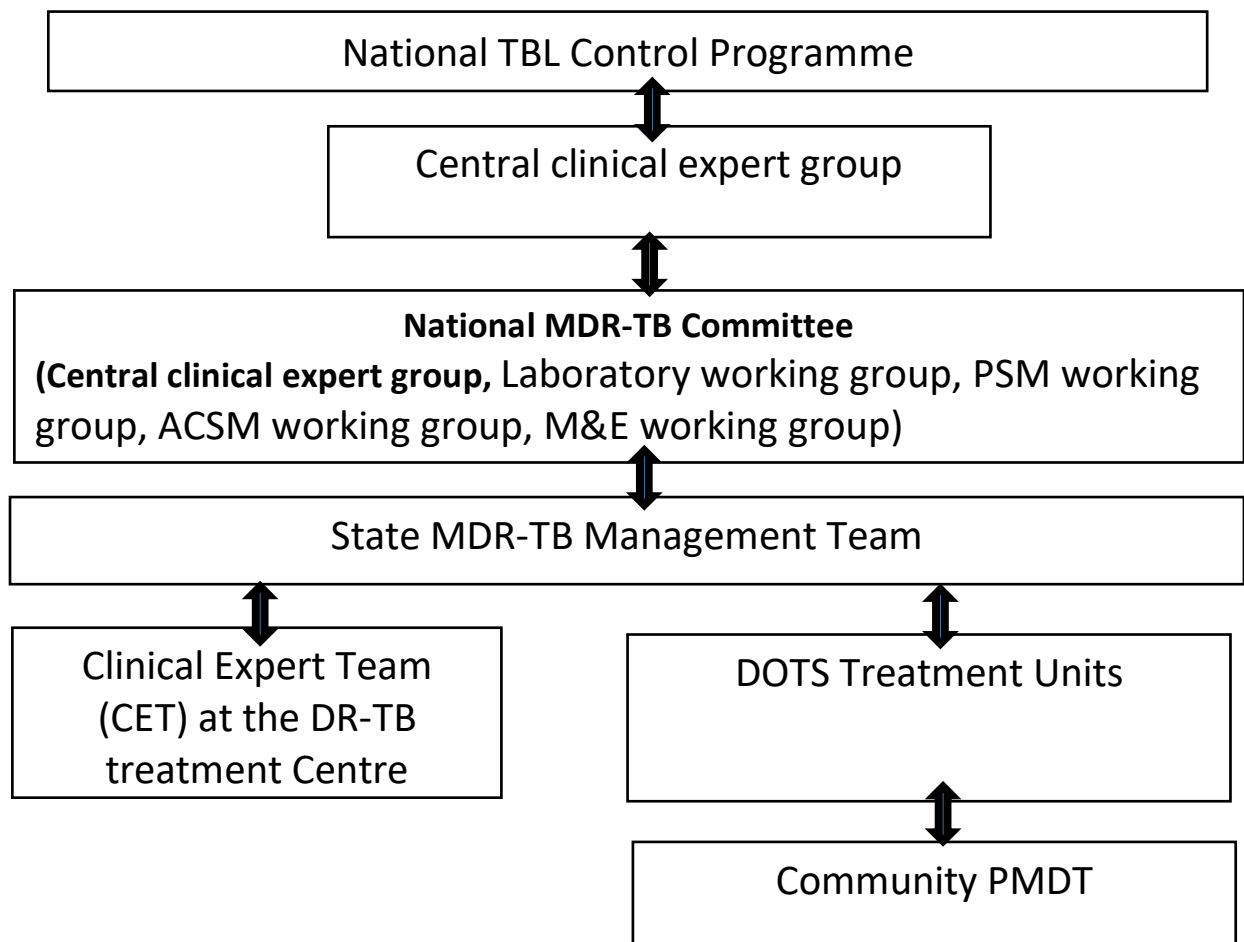
3.1.11.7. DR-TB diagnosis and treatment

Diagnosis of DR-TB patients (defined here as rifampicin-resistant and multidrug-resistant TB) is currently based on examination of presumptive DR-TB cases using Xpert MTB/Rif (GeneXpert) or LPA. The categories of patients currently recommended for drug resistance testing (presumptive DR-TB cases) include patients who; fail Regimen 1 treatment (i.e., treatment for Rifampicin-susceptible TB), remain sputum smear positive after repeat AFB microscopy follow-up examination at the end of the 3rd month of Regimen 1 treatment, have been previously treated for TB (Treatment after failure, Treatment after loss to follow-up and Other previously treated) and symptomatic contacts of DR-TB cases. Sputum specimens from presumptive DR-TB cases are collected from DOTS centres and transported to GeneXpert sites for examination. Currently, all 36 states and the FCT have at least one GeneXpert machine for diagnosis of TB and/or resistance to rifampicin. Logistics for transporting of specimens from the DOTS centres to the GeneXpert sites is the responsibility of the LGTBLS.

Following a positive result for drug resistance by GeneXpert or LPA, a sputum specimen is collected for confirmatory TB culture and DST for first line anti-TB drugs prior to commencing the patient on treatment. Currently, culture and DST for first line anti-TB drugs are performed at the two NRLs and four other reference laboratories (UCH, Ibadan; Aminu Kano Teaching Hospital, Kano; DLHMH, Calabar and Zankli Medical Centre, Abuja). In addition, NRLs provide DST for second-line anti-TB drugs by both solid and liquid methods.

Patients with RR-TB by GeneXpert are started on a standardised category IV regimen. Patients are monitored clinically and bacteriologically while on treatment. Bacteriological monitoring includes monthly sputum smear examination for AFB and culture throughout the duration of treatment for patients on the shorter regimen. Sputum samples for follow up culture examination are transported from the central state collection points to the reference laboratories by courier, except for states that have reference laboratories, where specimens are transported by the LGTBLS.

Figure 7: PMDT management structures



The PMDT management structure includes groups with specific responsibilities for guiding clinical and programmatic management of patients, ensuring that there is sufficient stock of second-line anti TB drugs, ancillary drugs, and supplies, providing supervision, managing patients on an in-patient or ambulatory basis, providing treatment support and tracking of treatment defaulters.

According to the directive of the National Council on Health, each state should have a DR-TB treatment centre. Currently, there are 28 treatment centers for patients who do not fall within the criteria for community PMDT and are shown below in Table 5.

Table 5: DR-TB treatment centers

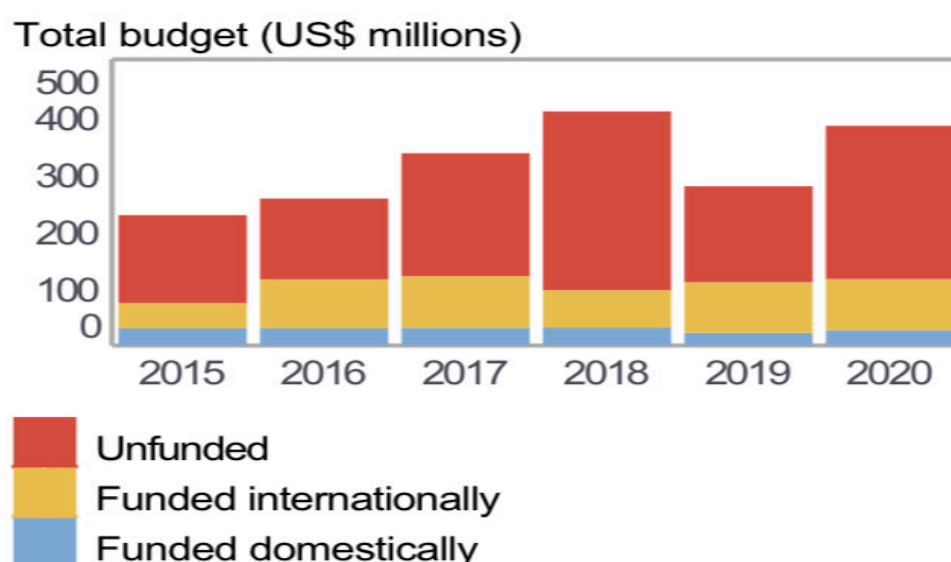
S/no	State	DR-TB Treatment Centre
1.	Bauchi State	Abubakar Tafawa Balewa University Teaching Hospital
2.	Plateau State	Jos University Teaching Hospital
3.	Oyo State	University College Hospital, Ibadan (UCH)
4.	Oyo State	Government Chest Hospital, Jericho, Ibadan
5.	Oyo State	Chest Hospital Jericho Ibadan Extremely Drug-Resistant TB Treatment Center
6.	Akwa-Ibom State	University of Uyo Teaching Hospital, Uyo, (UUTH)
7.	Rivers State	University of Port Harcourt Teaching Hospital, Port Harcourt (UPTH).
8.	Cross River State	Dr. Lawrence Henshaw Memorial Hospital, Calabar,
9.	Kaduna State	National Tuberculosis and Leprosy Training Center, Zaria
10.	Kano State	Infectious Diseases Hospital
11.	Ogun State	Sacred Hearts Hospital, Abeokuta
12.	Imo State	Federal Medical Center Owerri
13.	Sokoto State	State Specialist Hospital, Sokoto
14.	Taraba	State Hospital Jalingo
15.	Benue State	St. Vincent Alaide
16.	Osun State	General Hospital Iwo
17.	Anambra State	Nnamdi Azikiwe University Teaching Hospital, Neni
18.	Abia State	Federal Medical Center Umuahia
19.	Adamawa State	Federal Medical Center Yola
20.	Nasarawa State	ERCC Alushi
21.	Kogi State	Kogi State University Teaching Hospital Anyigba
22.	Ebonyi State	Mile 4 Hospital Abakaliki
23.	Lagos State	Mainland Hospital Yaba,
24.	Zamfara State	King Fahd Hospital
25.	Gombe State	Infectious Diseases Hospital, Zambuk
26.	Kwara State	Specialist Hospital, Sobi
27.	Ondo State	Infectious Diseases Hospital, Akure (State Hospital Akure Annex).
28.	Ogun State	Sacred Heart Hospital, Abeokuta

The recording and reporting of data related to DR-TB is captured both in a paper-based and an electronic-based system. The electronic tool, e-TB manager, is a web-based tool that incorporates all aspects of PMDT (case notification & management, medicine supply & stock control as well as data management) and offers real time access to data and data analysis. A summary page is accessible to partners and the general public for regular update of analysed data. Incomplete data upload has limited its full utilisation. Therefore, due to the inefficiency of the e-TB Manager an assessment has been done to identify the challenges in the use of the e-TB Manager in Nigeria and the result of this qualitative assessment will inform further actions that will be taken to improve the quality of the electronic web-based data capturing tool.

3.1.11.8. Financing and key partners

Financing of the TB programme in Nigeria is heavily dependent on external donors. Major donors include the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), USAID, which together contribute most of the overall funding available for TB control in Nigeria, as shown in Figure 9. The Federal Government of Nigeria is committed to TB control, as evidenced by the creation of the NTBLCP under the department of Public Health of the Federal Ministry of Health, with state-level teams in each of the 36 states and the FCT.

Figure 7: Spending versus projected need for TB activities, 2015 – 2020.



As at the time of revising the NSP, the NTBLCP is developing the Global Fund grant for Grant Cycle 7 (GC7). The Principal Recipients under this grant are NTBLCP, Institute for Human Virology Nigeria (IHVN) and Lagos State Ministry of Health.

The NTBLCP has several local and international technical partners supporting TB control efforts. Key NTBLCP partners, their main roles and areas of coverage are listed in Table 5 below.

Table 6: Key NTBLCP partners for TB control. (Need to exhaust the list)

Partner	Category	Technical area(s) of support	Geographic areas of support
FMOH, SMOH, LGA	Government	Staffing of health facilities, health infrastructure etc.	Nationwide
NACA	Government	TB/HIV service integration	Nationwide
NASCP	Government	TB/HIV service integration	Nationwide
NPHCDA	Government	Primary Health Care	Nationwide
GFATM	Donor	TB care and prevention (diagnosis and treatment), TB/HIV, DR-TB, PSM, Health workforce, CSS, Health Information System	Nationwide
USAID	Donor	TB care and prevention (diagnosis and treatment), TB/HIV, PMDT, PSM, Health workforce, CSS, ACSM, Health Information System	Nationwide
US CDC	Donor	TB/HIV, Reference laboratory strengthening M&E	Nationwide
WHO	TA	TB care and prevention (diagnosis and treatment), TB/HIV, PMDT, PSM, Health workforce, CSS, ACSM, Health Information System	Nationwide
KNCV	TA/IP	TB care and prevention (diagnosis and treatment), TB/HIV, PMDT), Health Information System	14 States
Agbami Partners	Donor (Private)	Chest clinics, GeneXpert machines and cartridges	Nationwide
IHVN	GFPR	PPM and PMDT	Nationwide
ARFH	GFSR	TB active case search in communities, community PMDT	Nationwide
Breakthrough Action Nigeria	TA/IP	ACSM	National level
CHAI	TA/IP	TB/HIV	National level
RedAid Nigeria	TA/IP	TB care and prevention (diagnosis and treatment) and Leprosy control	7 states
Damien Foundation Belgium	TA/IP	TB care and prevention (diagnosis and treatment) and Leprosy control	10 states
Department of Defence (DOD)	TA/IP	TB/HIV, Laboratory	National Level
The Leprosy Mission Nigeria	TA/IP	TB care and prevention (diagnosis and treatment) and Leprosy control	7 states
Leprosy and TB Relief Nigeria	TA/IP	TB care and prevention (diagnosis and treatment) and Leprosy control	13 states
TB Network	CSO/IP	ACSM, CSS	Nationwide

GFPR = Global Fund Principal Recipient; TA = Technical Assistance; IP = Implementing Partner; CSO = Civil Society Organization

3.1.11.9. Private and Non-NTBLCP sectors

The private and public non-NTBLCP sectors are playing an increasingly important role in TB control. Private sector engagement is extremely important in Nigeria, as an estimated 60% of all health care is delivered by the private sector. The NTBLCP has stepped up its engagement through a public-public/public-private mix (PPM) approach, developed a PPM Action Plan 2022-2025 to guide implementation of activities in all 36 States and FCT. By the end of 2019, approximately 4,945 private facilities (including faith-based, private for profit) were participating in PPM and providing TB services. Private sector contribution to TB case finding was 14% in 2019. This increased to 4,038 private facilities and 24% contribution of the private sector to the TB program in 2022.

3.1.11.10. Community TB Care

Community TB Care is organized under the NTBLCP Focal persons for CTBC and ACSM at National level. Similarly, a focal point person exists at the State level. There are technical partners - both local and international supporting CSS and ACSM efforts, notably USAID and KNCV. CBOs and CSOs continue to contribute to case detection, advocacy, treatment support, sputum transportation and contact tracing. Community contribution to TB case finding increased was 22% in 2019 and currently 43% in 2022. Treatment success rate among TB patients (all forms) supported by Treatment Supporter (TS) throughout their TB treatment is good (91%).

3.1.12. Epidemiology of tuberculosis and progress between 2015-2022

Nigeria is classified as a high TB, HIV and MDR-TB-burden country. The last national TB prevalence and drug resistance surveys have supplied hard data from which to estimate the magnitude of these challenges.

3.1.12.1. Programme performance indicators

In general, the NTBLCP continues to strengthen its performance, with slow but steady increases in case notification and treatment success. The programme has made progress in expanding DOTS, integrating HIV into TB services, and initiating a DR-TB diagnosis and treatment system. With the support of its technical partners, NTBLCP has developed numerous plans and guidelines covering laboratory scale-up, PMDT scale-up, DR-TB, paediatric TB, TB/HIV, infection control, CTBC, PPM and ACSM. Table 9 summarizes programme performance on key indicators over the last eight years for which complete data are available.

Table 7: Programme performance indicators 2015-2022

Indicator	2015	2016	2017	2018	2019	2020	2021	2022
Case notification, all forms	90,584	100,433	104,904	106,533	120,266	138,591	207,785	285,561
Case notification rate, all forms/100,000	50.3	55.8	57	54	60	67	98	131
Paediatric case notification, all forms	4,773	5,414	7,450	8,293	9,540	8,441	12,977	20,411
Treatment success for All forms	87%	86%	85%	86%	87%	88%	89%	91%
TB patients with documented HIV status	96%	94%	96%	97%	97%	95%	97%	97%
HIV positive TB patients on CPT	75%	81%	84%	87%	92%	91%	92%	91%
HIV positive TB patients on ART	85%	86%	85%	89%	91%	91%	92%	91%
DR-TB patients notified	1241	1686	2286	2275	2384	2,061	2,975	3,932
DR-TB patients enrolled on treatment	656	1,251	1,786	1,895	1,975	1,492	2,197	3,185
DR-TB treatment success rate (Proportion of DR-TB cases who were cured at twenty month – preliminary treatment outcome)	77%	74%	78%	77%	77%	78%	80%	83%

3.1.12.2. Case Notification

The case notification rate in Nigeria for all forms of TB in 2019 was approximately 60/100,000, in sharp contrast to the new estimated incidence rate of 219/100,000. It is estimated that 467,000 persons fell ill with TB in 2022¹⁶, yet only about 285,561 were notified. This therefore means that about 61% of estimated TB cases were not diagnosed, treated and/or notified annually. However, this is an improvement from 73% in 2019. The trends for children are presumed to be similar. Regarding drug resistant TB (DRTB), it is estimated that Nigeria had 21,000 incident cases in 2019 out of whom 2,384 (11%) were detected and notified over the same period. The age and sex distribution of TB cases notified in 2022 is shown below. More males fell ill of TB in 2022 than the female.

¹⁶ World Health Organization. (2019). *Global Tuberculosis Report. 2022*. Geneva: World Health Organization.

Figure 8: Trend of all forms of TB notifications 1999 – 2022

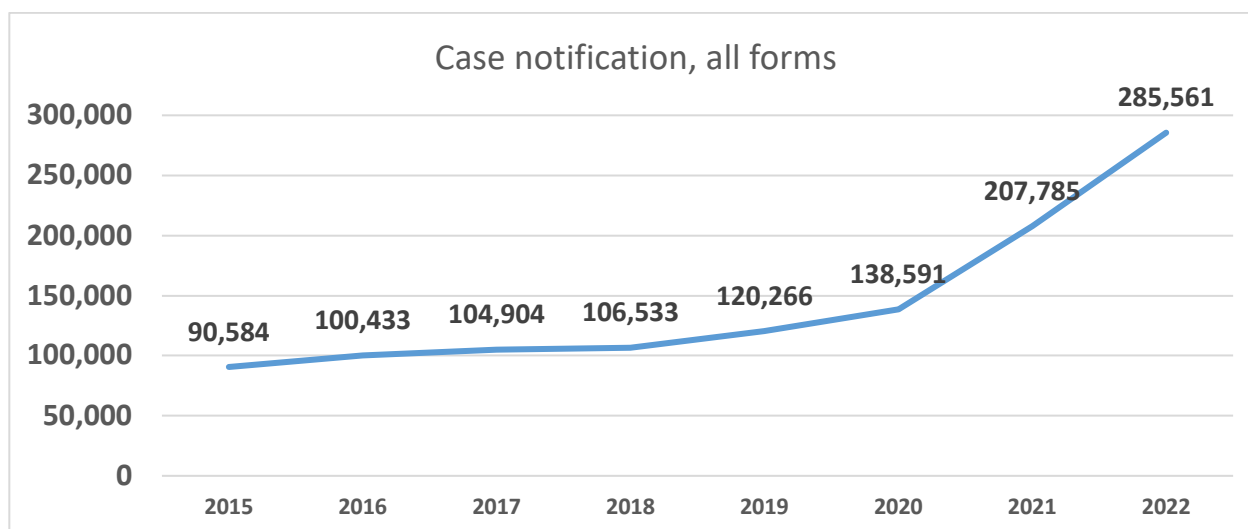
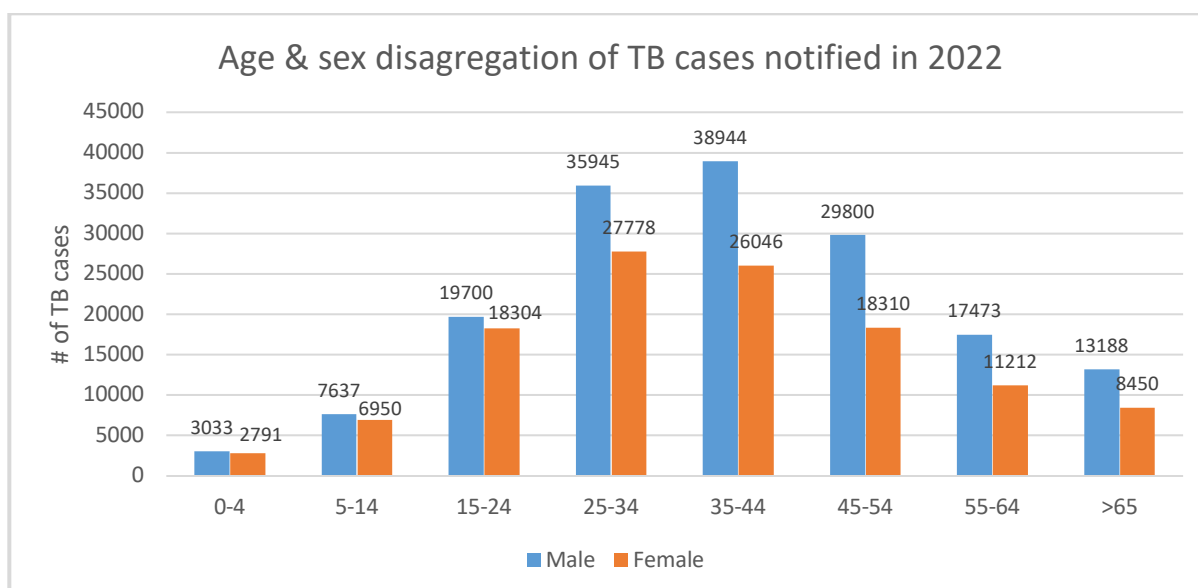


Figure 9: Age and sex disaggregation of TB cases notified in 2022.



Overall, case notifications have been consistently on the rise during DOTS expansion in the country. There is also a marked variation in case notification rates across the zones and states of Nigeria. It is not clear to what degree this represents true variability in the burden of TB in different geographic areas (as is suggested by the prevalence survey) and/or differences in the capacity to diagnose and report accurately. Regardless, the clear message from the data presented is that in all regions of the country, notifications are far behind the incident cases predicted by the prevalence survey.

Table 8: New TB case notification (bacteriologically diagnosed and all forms), by zone 2015 – 2022

Zone	2015 All forms	2016 All forms	2017 All forms	2018 All forms	2019 All forms	2020 All forms	2021 All forms	2022 All forms
North Central	15,408	16,126	16,312	15,664	16,513	17,771	24,177	31,521
North East	13,481	14,556	14,847	14,364	17,486	17,531	22,532	27,340
North West	21,336	27,574	28,822	31,369	35,679	44,444	72,882	105,830
South East	6,753	7,035	7,217	7,520	7,879	8,900	13,878	20,325
South South	11,348	11,858	12,490	12,784	15,739	19,570	26,775	38,803
South West	22,258	23,285	25,216	24,832	26,970	30,375	47,541	61,742
Total Case Notification	90,584	100,434	104,904	106,533	120,266	138,591	207,785	285,561

3.1.12.3. Treatment outcomes

The treatment success rate for patient registered in 2018 at the national level is 87% (Figure 12). The percentage of patients cured compared to those who complete treatment is higher, probably a reflection of the high proportion of bacteriological positive patients diagnosed in the programme. The treatment success rate ranges from 71% in Taraba State to 98% in Gombe State. Lost to follow up was lowest in Gombe and Kogi States (1%) and highest in Akwa Ibom (17%). Reasons for low performance have not been determined for each of these areas and warrant further investigation, but likely include a variety of contributing factors such as high proportions of mobile populations, poorly trained and motivated health workers, insufficient numbers of health workers, frequent industrial actions (strikes) by health workers, civil unrest, lack of community engagement and poor access to services. Lower treatment outcome (<80%) was found more in the southern part of the country compared with the northern part of the country (Figure 20).

The WHO-estimated TB mortality (excluding HIV-related TB) rate for Nigeria stood at 63 per 100,000 in 2019. However, actual TB-related mortality is difficult to estimate at present because of the weakness of data in the recently implemented vital registration system. As that system is scaled up and strengthened, more accurate estimations may be possible. There are some limited data sets from which to draw inferences about excess mortality from TB.

Figure 10: Trends in TB treatment outcomes of all forms of TB cases, 2009 – 2021

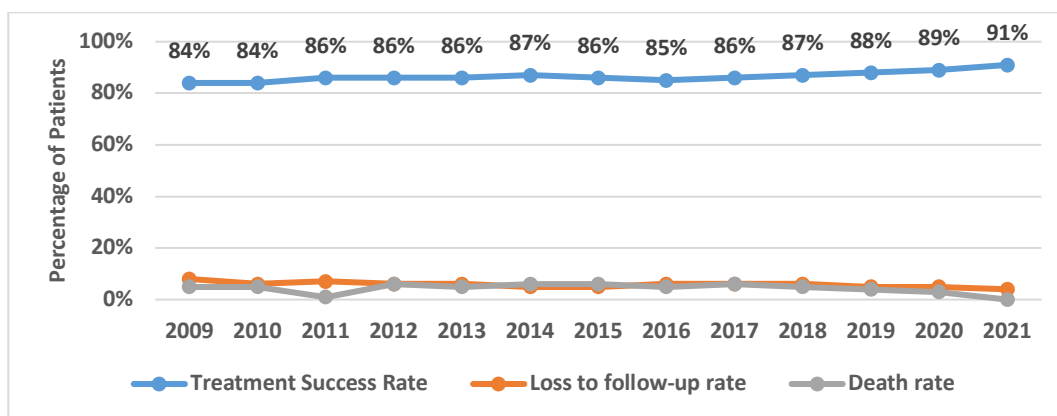
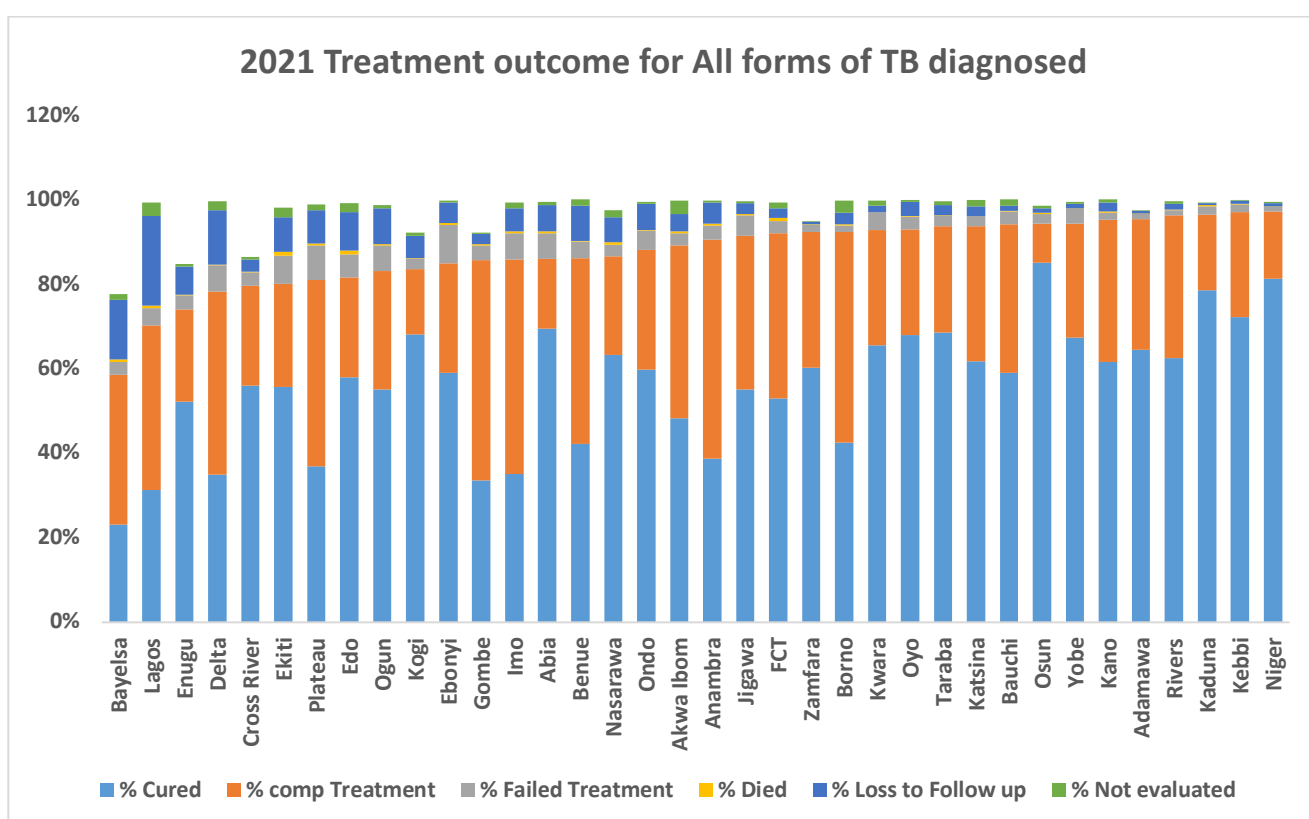


Figure 11: Treatment outcome data by state for all forms of TB, 2021

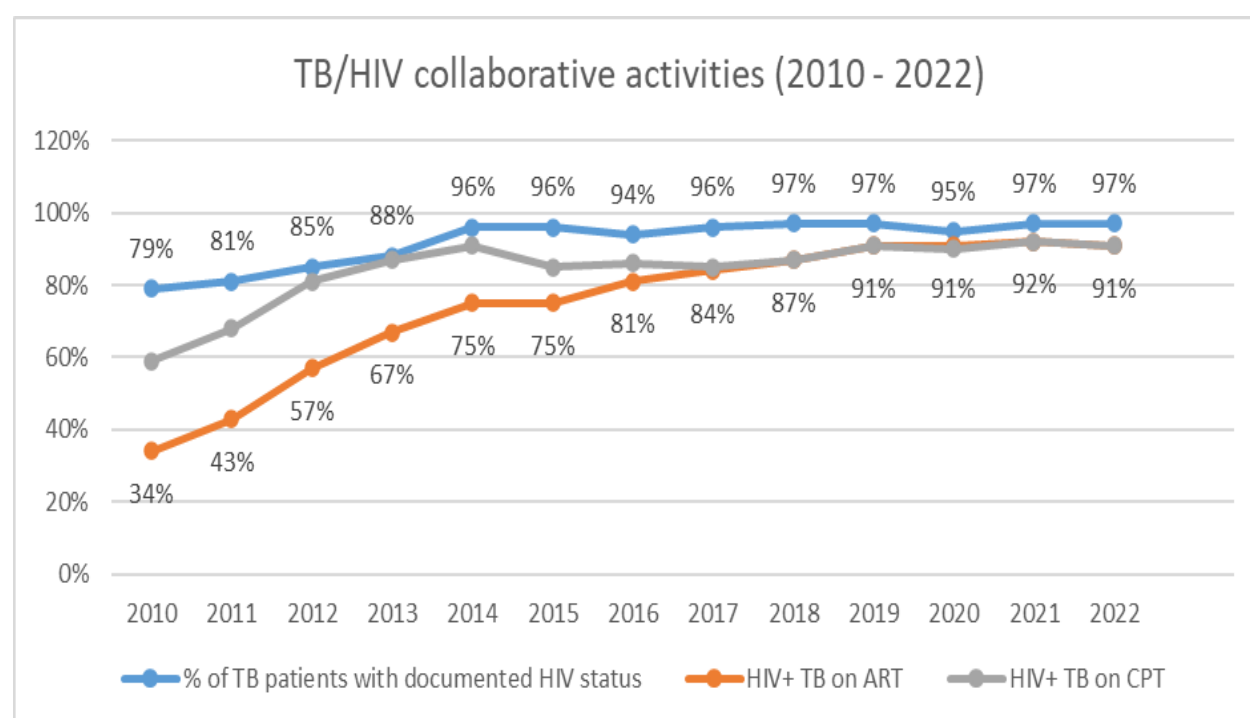


3.1.12.4. TB/HIV performance indicators

HIV testing among TB patients in 2019 was universal at 97 percent, while ART uptake among HIV positive TB patients is at 91 percent (2019) compared to 79 percent (2010). 73% PLHIVs of newly enrolled PLHIV in care were initiated on TPT in 2019 against a 90% target of TPT among all PLHIV. Of all recommended medical interventions, IPT for PLHIV without active TB lags the furthest behind in implementation. In general, TPT is provided infrequently with

only 73% of PLHIV (newly enrolled in care) by 2019 receiving TPT¹⁷. Barriers to expansion of TPT include weak capacity to implement by service providers and lack of enough knowledge among service providers. In 2022, 97% of patients registered for TB treatment had a documented HIV status. In 2022, 91% of the HIV positive TB patient had received ART and CPT. On the other hand, TB case detection among PLHIV is suboptimal, with only 56% (16,121) of the estimated incident TB cases among PLHIV notified in 2022.

Figure 12: Scale-up of HIV services for people with TB



The improvement in HIV indicators can be partly attributed to adoption of a test and treat policy in 2016. This measure has increased access to treatment for people living with HIV and accelerated referrals to treatment facilities for people who test positive for the virus. From 2010 to 2022, the number of people living with HIV having access to antiretroviral therapy increased to more than 1 million people¹⁸. The number of sites providing treatment tripled, those providing prevention of mother-to-child transmission of HIV services increased eightfold and the number of HIV counselling and testing sites increased fourfold.

TB Preventive Therapy

¹⁷ World Health Organization. (2020). *Global Tuberculosis Report*. Geneva: World Health Organization.

¹⁸ 2019 HIV Health Sector Annual report

The country experienced remarkable increase in TPT uptake across the country by 600% in 2022 relative to 2021. (2021: 17,517 & 2022: 77,083). This was due in part to improved data management on TPT uptake and the introduction of a shorter regimen 3HP which showed improved adherence. This was due in part to improved data management on TPT uptake and the introduction of a shorter regimen 3HP which showed improved adherence.

Table 9: Estimated HIV burden in Nigeria, 2008, 2012 and 2018

Indicator	2008	2012	2018
Median national HIV prevalence	4.6%	4.1%	1.4%
Estimated number of people living with HIV	2,980,000	3,459,363	1,900,000
Estimated annual new infections	336,379	388,864	130,000
Estimated number requiring ART	857,455	1,449,166	893,000
Annual AIDS-related deaths	192,000	217,148	53,000
Estimated total number of AIDS orphans	2,175,760	2,193,745	

There were an estimated 1.9 million people living with HIV in Nigeria as of 2018 with prevalence of 1.4% among adults aged 15–49 years [women 1.9% and men 0.9%] against approximately 3.5 million (4.1%) in 2012. The gender disparity in prevalence is greatest among those aged 20–24 years [females 1.3% and males 0.6%]. Highest prevalence for females was among those aged 35–39 years at 3.3%, and for males aged 50–54 years at 2.3%. Among children aged 0–14 years, HIV prevalence was 0.2%. The prevalence is widely varied across zones with highest in South-South at 3.1% and lowest in North West zone at 0.6%. These differences may reflect differences in access to prevention services, gender power relations and ability to negotiate sexual relationships and other risk factors related to gender.

3.1.12.5. DR-TB case notification and treatment outcomes

Great progress has been made with PMDT with the establishment of 28 specialized DR-TB treatment centers and other supportive infrastructures across the country, in a largely patient centered approach. There has been an increase in the coverage of molecular diagnostics with the expansion of GeneXpert network as well as provision of supportive package to the patients (Social & transport). The number of DR-TB cases notified was 2,384 against a target of 21,000 in 2019, and a high treatment success rate of 77% (2017 cohort).

The MDR/RR-TB notification has been on consistent increase in the last three years and after a decline in 2020, a 32% increase in MDR/RR-TB notification was recorded from 2,975 MDR/RR-TB cases in 2021 to 3,932 MDR/RR-TB cases in 2022¹⁹.

Figure 13: Trend of RR/MDR-TB cases diagnosed and enrolled on treatment in Nigeria

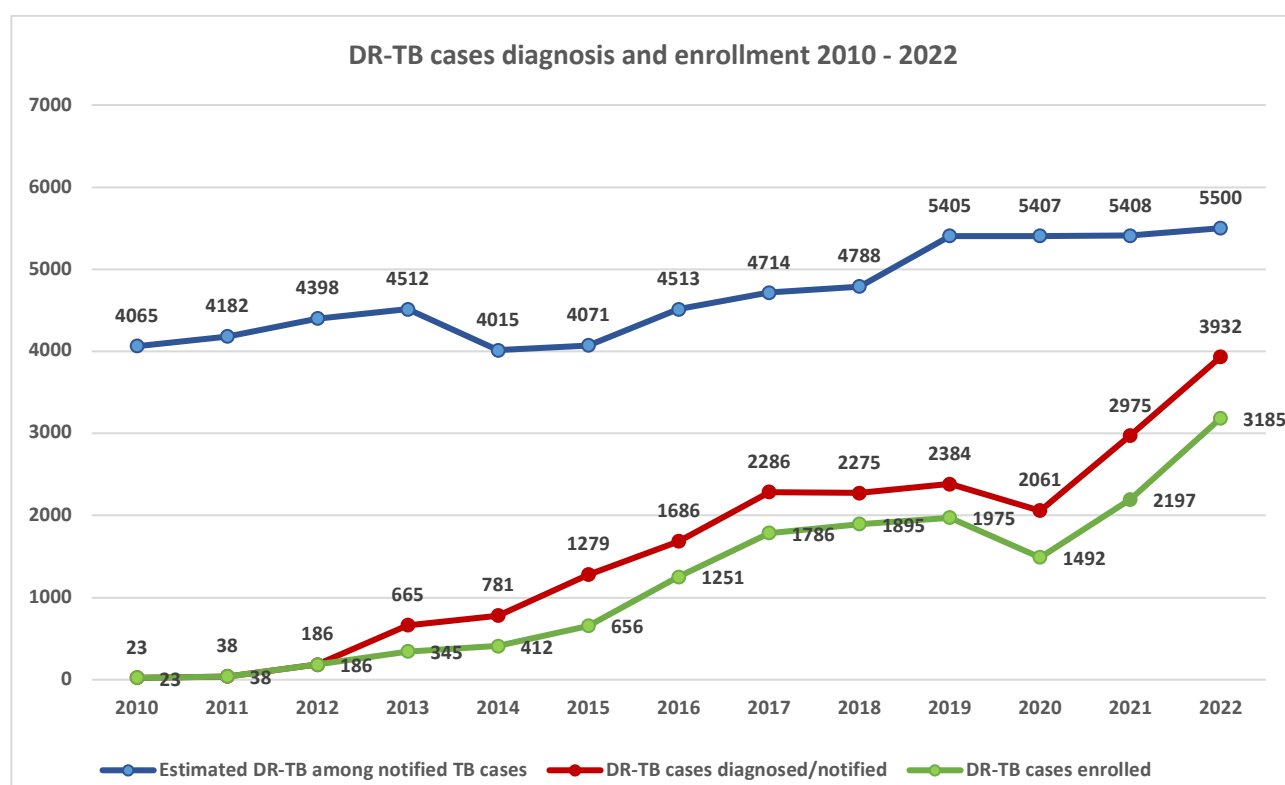


Table 10: MDR-TB treatment outcome 2013 – 2019

Year	Treatment success	Cured	Treatment completed	Lost to follow-up	Died	Failed	Not evaluated	Total
2013	77%	53%	24%	4%	13%	1%	5%	100%
2014	74%	47%	27%	5%	17%	0.2%	3.5%	100%
2015	78%	58%	20%	2%	16%	2%	2%	100%
2016	77%	65%	12%	2%	13%	2%	6%	100%
2017	77%	61%	16%	5%	12%	2%	2%	100%
2018	78%	63%	16%	6%	11%	2%	3%	100%
2019	80%	61%	19%	6%	11%	1%	0%	100%

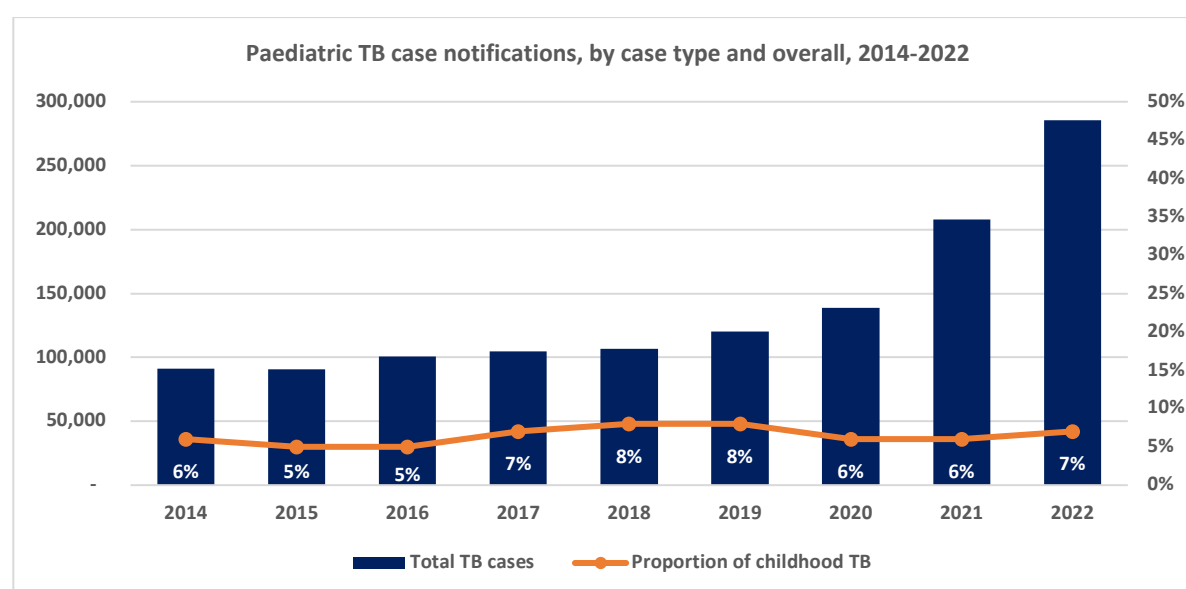
¹⁹ Annual Reports

3.1.12.6. Childhood TB

At present, children under the age of 15 years comprise eight percent of the TB cases notified in Nigeria in 2019. Given Nigeria's population structure, with almost 44 percent of Nigerians below the age of 15 and given the fact that the highest burden of TB occurs in adults in the childbearing ages, childhood exposure is likely to be high. Coupled with poor access to diagnostic services and malnutrition for children, particularly in a high TB burden country like Nigeria, it can be assumed that there is a significant burden of undetected paediatric TB.

There was an increase in the percentage of childhood TB to the overall TB case notification. The engagement of Childhood TB Focal persons in all 36 states and FCT and active TB case search for childhood TB in orphanage homes and during Immunization Plus Days (IPDs) contributed to this increase. The increase in access to chest Xray, stool testing and focused outreaches for children significantly increased childhood TB notification by 7 folds in Sokoto state from 2% in 2019 to 14% in 2022. TB screening in orphanages, nutritional clinics and in schools increased proportion of children among notified TB cases in Anambra state from 8% (202) in 2019 to 17% (1437) in 2022. Screening for childhood TB in primary schools in Lagos resulted in a high yield of paediatric TB patients including the DRTB cases among children.

Figure 14: Paediatric TB case notifications, by case type and overall, 2014-2022



3.1.13. Key affected populations in Nigeria

Several different sub-populations have been identified as key affected populations in Nigeria, based on a combination of modelling, globally recognised risk factors for TB, prevalence survey data, programme data and project data. This NSP-TB prioritises active case-finding and expansion of service accessibility to the following known or suspected key affected populations in Nigeria, where the benefits from intensified case-finding and case-holding activities are expected to be highest.

Table 11: Key TB-affected populations and population size estimates, 2019

Sub Population	Estimated size in general population
PLHIV	1,900,000 ²⁰
Contacts of bacteriologically positive pulmonary TB cases	345,512 ²¹
Nomads	9,400,000 ²²
IDPs	2,216,000 ²³
Prisoners	74,106 ²⁴
Diabetics	3,900,000 ²⁵
Children	58,736,297 ²⁶
Health care workers	486,280 ²⁷

3.1.13.1. PLHIV

About 1.9 million people are estimated to be living with HIV according to NABS survey in 2018. In 2021 only 5.9% of TB patients with known HIV status are HIV positive and 92% are the positive HIV status were put on treatment. A 2020 systematic review conducted in Nigeria showed that overall, the pooled prevalence of TB/HIV coinfection was 25.8%. The highest coinfection prevalence of 34.3% was recorded among the North Central States of Nigeria,

²⁰ NAIIS SURVEY 2018

²¹ Assumes average of 4 contacts per adult bacteriologically positive TB case. (Adult TB patients represent about 92% of all TB cases and bacteriologically positive TB cases constitute approximately 72% of all TB cases.)

²² S. John, M. Gidado, T. Dahiru, A. Fanning, A. J. Codlin, J. Creswell. Tuberculosis among nomads in Adamawa, Nigeria: outcomes from two years of active case finding.

²³ Internal Displacement Monitoring Centre (2018) *Nigeria*. Available at: <https://www.internal-displacement.org/countries/nigeria>

²⁴ World Prison Brief (2020) <https://www.prisonstudies.org/country/nigeria>

²⁵ Tukur Dahiru, Alhaji A Aliyu, AU Shehu (2016 A review of population-based studies on diabetes mellitus in Nigeria. *Sub-Saharan African Journal of Medicine*. Available at:

<http://www.ssajm.org/article.asp?issn=23845147;year=2016;volume=3;issue=2;page=59;epage=64;aulast=Dahiru>

²⁶ Nigerian Open Data <https://nigeria.opendataforafrica.org/htmbvze/nigeria-population-by-age-and-sex>

²⁷ Second National Strategic Health Development Plan 2018 - 2022

while the least prevalence of 19.3% was recorded among the South-eastern states of Nigeria. There was a paucity of published articles from the North-eastern states of Nigeria²⁸.

3.1.13.2. Nomadic populations

Nomadic groups comprise approximately 9.4 million people in Nigeria. One TB REACH project has contributed TB data specific to nomadic populations. Nomads in Nigeria face several risk factors for TB, including limited access to health care because of their mobility, overcrowding and poor ventilation in tents, malnutrition, consumption of raw milk products in a setting of high bovine TB, poor BCG coverage and low levels of education and knowledge of TB. In 2012, the TB REACH project identified 4,433 symptomatic among 20,907 nomads screened (21%). Using AFB smear microscopy for diagnosis, a total of 884 cases of TB (all forms) were notified (20% of those tested), including 614 sputum smear-positive cases (14% of those evaluated). A total of 642 people with TB received HIV counselling. Of those 416 were tested for HIV and 40 (9%) were positive.

3.1.13.3. Children

The childhood TB notification after the initial drop in 2020 increased by 57% from 12,977 in 2021 to 20,411 in 2022. The childhood proportion among notified TB cases in 2022 is 7% this is far below the target of 15%, the TB treatment coverage among children in 2021 was 15% compared with 44% among general population, thus indicating a higher proportion of missed TB cases among children. Nigeria has the 2nd highest global malnutrition burden with 17 million undernourished children²⁹ and hence the main driver of TB in children. Therefore, finding the missing TB cases among children through innovative interventions including integration of TB case finding in nutritional services and in settings with high number of malnourished children is one the prioritized areas in this application.

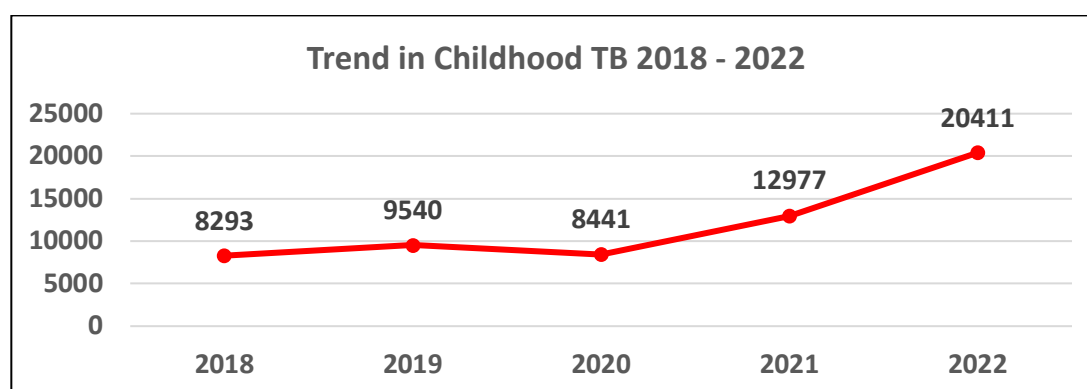
TB diagnosis in children is complicated by the inability of most young children to produce adequate sputum specimens and the general lack of access to services. Globally, children under the age of 15 are estimated to contribute approximately 12% of TB cases (all forms). In Nigeria, with more than 40% of the population under the age of 15, only 11% (9540) of the estimated

²⁸ Ike, Anthony & Eleazar, Reward & Muo, Sophia & Soga-Oke, Busola & Em, Mbaawuaga. (2020). Coinfection of Tuberculosis and HIV in Nigeria: A Systematic Review and Meta-analysis. *AIDS reviews*. 22. 1-12. 10.24875/AIDSRev.20000068. Available at https://www.researchgate.net/publication/346876464_Coinfection_of_Tuberculosis_and_HIV_in_Nigeria_A_Systematic_Review_and_Meta-analysis

²⁹ UNICEF report published in 2021 entitled: "Fed to Fail."

(83,000) TB cases among children were detected leaving a huge number of undetected childhood TB cases.

Figure 15: Trend in childhood TB 2018-2022



3.1.14. TB and other comorbidities except TB/HIV

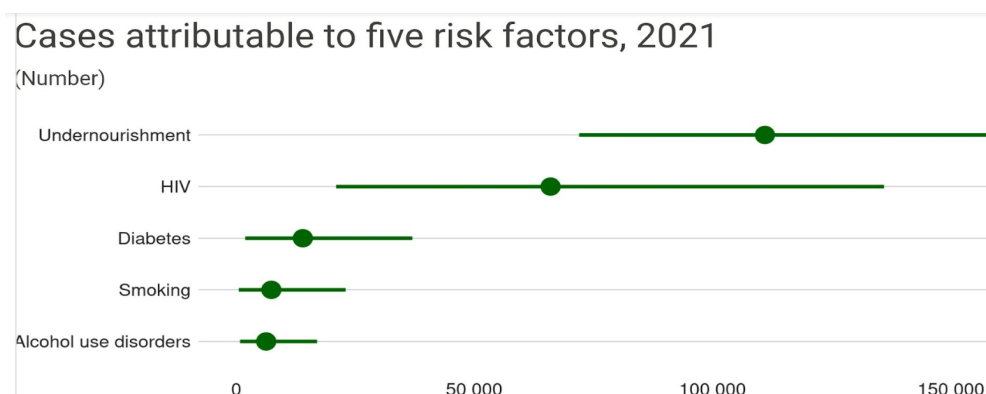
The NTBLCP recognizes Undernutrition, HIV, Diabetes Mellitus, Tobacco smoking and Alcohol use disorders as 5 major risk factors for TB in Nigeria. The NTBLCP guideline (7th Ed.) emphasizes integrated services for NCD prevention, care, and treatment in persons with TB. Undernutrition as could be seen in table 12 and figure 16 below is the major risk factor for TB. The impact of HIV on the TB burden has already been described under the section on TB/HIV and PLHIV as a key TB affected population. Diabetes mellitus is of a growing concern to the programme because of its relatively high contribution to the burden of TB. As could be seen from the table 12 below, as much as 3% of the total TB burden is attributable to diabetes mellitus. In recognition of the contribution of smoking to the TB burden, the programme is collaborating with relevant agencies to adopt the TB in Lung health approach to mitigate against this impact of smoking on the TB burden in Nigeria.

Table 12: Risk Factors for TB in Nigeria

Risk Factor	Number of TB cases attributed to risk factors	% contribution to estimated TB cases
HIV	66,000 ³⁰	14%
Undernutrition	111,000	24%
Diabetes Mellitus	14000	3%
Alcohol use disorders	6300	1%
Smoking	7,400	2%

³⁰ WHO. (2022) Global TB report. <https://www.who.int/tb/country/data/download/en/>

Figure 16: Cases Attributable to five risk factors in Nigeria



3.1.14.1. Undernutrition

Globally, 2.2 million TB cases were attributed to undernutrition in 2021. In Nigeria, 111,000 TB cases were attributable to undernutrition in the same period making it the biggest driver of the TB epidemic in Nigeria. With undernutrition contributing about 24% to the estimated TB cases in Nigeria, there is therefore need for a multi-sectoral approach to mitigate the impact of undernutrition on the TB burden in Nigeria.

3.1.14.2. Alcohol use Disorder

Alcohol use disorder is another non communicable driver of TB. Globally, 740,000 TB cases were attributed to alcohol use disorder in 2021. In Nigeria 6,300 TB cases were attributed to alcohol use in 2021. Alcohol use disorder also leads to undernourishment, and it triples the risk of TB disease. People with TB who consume alcohol are twice as likely to have a poor TB treatment outcome. There are considerable sex differences in the proportion of TB episodes attributed to alcohol use disorder. In 2020, the proportion of TB episodes attributed to alcohol was 13% among men and 1.7% among women.

3.1.14.3. Diabetes Mellitus

Diabetes is a strong risk factor for development of TB disease. Diabetes Mellitus (DM) occupied the 9th position among the 20 top causes of death globally in 2019, 1% of deaths in Nigeria and is responsible for between 250,000 and 500,000 new cases of TB (Global TB Report, 2022). The prevalence of DM among TB patients ranged from 9.4% to 15.1% and is thought to have the highest prevalence of DM among TB patients.

In 2021, an estimated 14, 000 new episodes of TB were attributable to diabetes in Nigeria. Among two studies done in the country, one found that a high proportion of patients in Abuja have markers of DM and pre-diabetes at the time of TB diagnosis. The second one found that screening can detect more than half of undiagnosed DM among newly diagnosed TB patients. Given the impact of diabetes on TB treatment and outcomes it would be necessary to initiate a systematic screening of diabetes among TB patients and have TB screening in diabetes clinics routinely.

3.1.14.4. Mental Health

Person suffering from mental illnesses are at an increased risk for TB, presenting a need to ensure that they are screened for TB. A study in Kano in 2020 estimated that 48.6% of people with any form of TB had depression. The most common social stressors reported were stigma, discrimination, isolation, and a lack of social support. There are opportunities in Neuropsychiatrist and specialist hospitals opening up to general health services and having DOT Clinics. An example is Federal Neuropsychiatrist Hospital Aro, Ogun State that started a DOT Clinic with a corresponding increase in TB case finding in the state.

Integrating mental health intervention into already existing TB services can lead to a reduction in the incidence of several mental disorders among patients with TB and which will in turn improve TB treatment outcomes.

3.1.14.5. Tobacco

Nicotine contained in tobacco is highly addictive and tobacco use is a major risk factor for cardiovascular and respiratory diseases, over 20 different types or subtypes of cancer, and many other debilitating health conditions. Every year, more than 8 million people die from tobacco use. Smoking is a strong risk factor for TB disease at the individual level and is among the 20 top causes of death in 2019. It is among the risk factors of TB, and it was responsible for 7,400 (2%) TB cases in 2021 (Global TB Report, 2022).

3.1.14.6. COVID—19:

The country diagnosed the first case of COVID19 on 27th February 2020. The NTBLCP proactively engaged a rapid response that ensured minimal interruption of TB services. By 1st Feb 2023 the country notified 266,463 cases of Covid with 3155 deaths (CMR-1.2).

Some of the interventions instituted by the NTBLCP during the COVID-19 pandemic included:

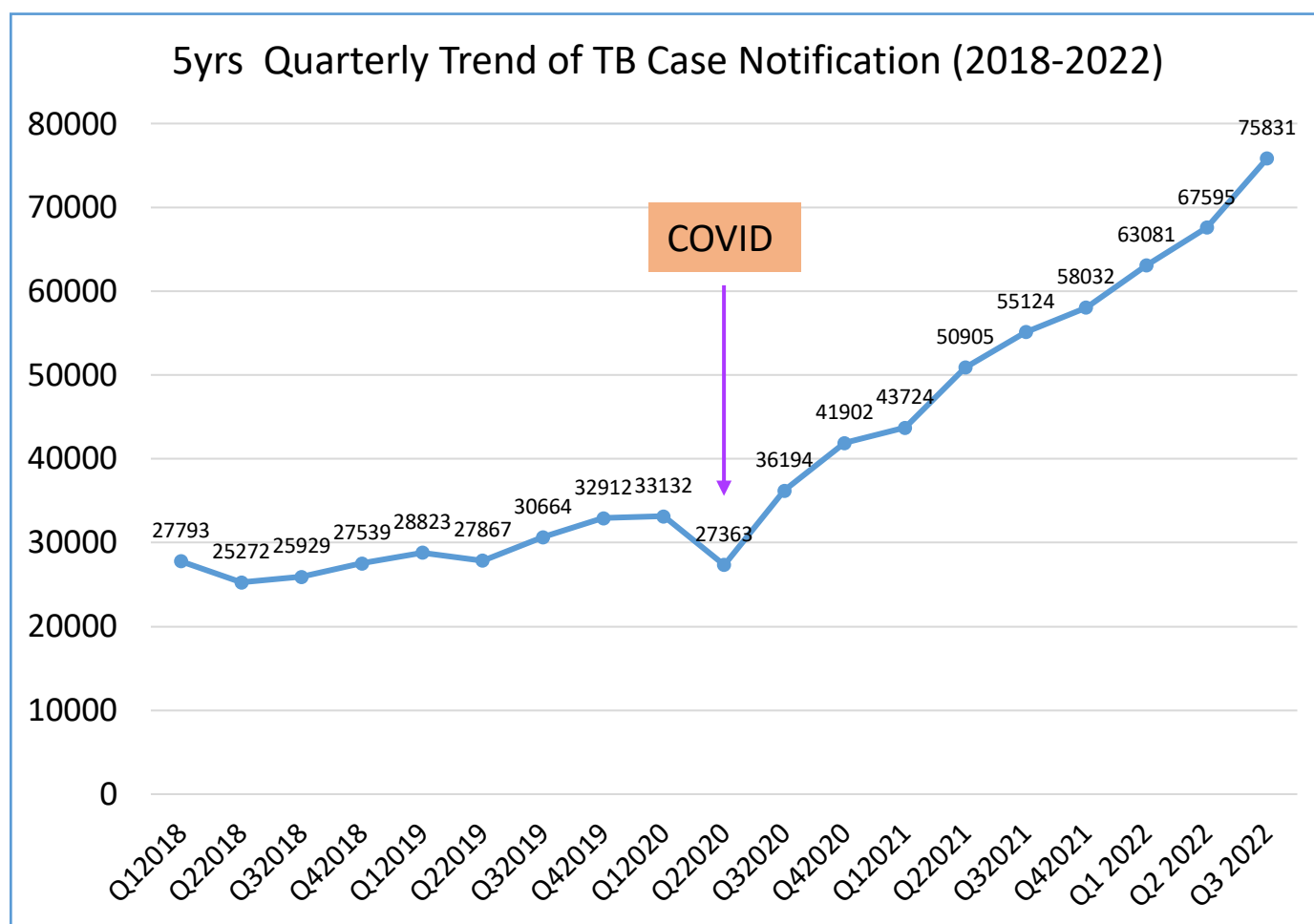
- Distribution of 5 months drugs to the Stores (zonal, state) and the facilities
- Patients given one-month anti TB medicine supply at the lockdown period.
- Use of CBOs to monitor patients at the community.
- Use of CBOs for house-to-house case search.
- Mapping out GeneXpert sites in the whole country for COVID testing
- Integration of TB activities into COVID activities - coordination, Active Case Finding (ACF), bidirectional screening/testing.

The impact of Covid-19 included:

- Onset of stigmatization of TB patients due to similarity of TB symptom to COVID
- Difficulty in distribution of commodities from National to states due to lockdown.
- The ban of Interstate travel led to a step down of most programmatic travel activities such as monitoring, mentorship, technical assistance, and data collation.
- Gap in monitoring quality of our basic management unit
- Lab personnel's phobia for sputum testing due to COVID-19 infectivity caused a drop in tests done.
- Some HCWs were infected, and some DOT sites closed for a while.
- TB treatment facilities were converted to an isolation centre.
- TB presumptive cases had access challenge to the facilities due to the lockdown measures (instituted for some months in Nigeria in March 2020). Presumptive and diagnosed cases had challenges with transportation in accessing the health facility during the lockdown.
- It created further strain on the country's economy and potentially the catastrophic cost on patients.

Despite the Covid-19 pandemic, there was minimal impact of Covid-19 on TB notification in Nigeria in 2020 and 2021. The notification decreased in the second quarter of 2020 but got back on track from the third quarter (Fig 17. Below).

Figure 17: Quarterly trend of TB notification (2018 – 2022)



4. Programme gaps and contributing factors

4.1. SWOT Analysis

A multi-sectoral approach was used to perform a SWOT analysis of the TB programme and to identify root causes of the major weaknesses in programme performance. Stakeholders engaged included people with TB; PLHIV; community-based organizations (CBOs); faith-based organizations (FBOs); technical partners; donors; National Agency for the Control of AIDS (NACA); National AIDS & Sexually Transmitted Infections Programme (NASCP); Ministries, Departments and Agencies (MDAs); Ministries of Labour; Ministry of Women Affairs; The Police; The Nigerian Correctional Services; State TB Programme Managers; Local Government TB and Leprosy Supervisors (LGTBLS); the Country Coordination Mechanism (CCM); WHO; Global Fund Principal Recipients; academia and others. The main findings by the stakeholders are described in detail in the SWOT analysis and root cause analysis as presented in table 13 below. A detailed root cause analysis was performed by the stakeholders as shown in Annex 2.

Table 13: SWOT Analysis of the TB Programme

STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> • Availability of infrastructure and human resources for programme implementation • Dedicated and experienced central unit staff with focal persons for the various TB thematic areas and standardised guidelines for each of the thematic areas • Multi-partner support for TB control including a Nigerian Stop TB Partnership • Regular availability of drugs and materials with good LMIS • Availability of TB services for key populations • Collaboration with CBOs, private sector, and various professional associations • Availability of facilities for management of DR-TB patients • Availability of a training centre for TB programme 	<ul style="list-style-type: none"> • Inadequate government funding of TB services at all levels • Weak TB diagnostic network, low coverage of lab QA and equipment maintenance • Poor integration of TB services with other relevant sectors and appropriate application of relevant policies • High donor dependence • Limited access to TB services • Poor TB/HIV coordination • Low DOTs population coverage • Low consideration for gender and human rights in TB control • No multi-sectoral synergy • Inadequate veterinary TB services

OPPORTUNITIES	THREATS
<ul style="list-style-type: none"> • Existence of NHIS and State Contributory Health Schemes • Existence of BHCPF • Existence TB caucus (House of Representative) • Availability of local and international partner funding • Designation of State First ladies as TB champions and Ambassadors • Existence of a large private health sector • Availability of advanced diagnostic tools (e.g., Ultra, TB-Lamp etc); • High level TB missions to support TB and NCD management. • SOMIL interventions • Presence of organisations with corporate social responsibilities (CSR) • CHIPS & CORPs programme • Ongoing Community interventions by some partners • Existing structures for awareness creation e.g., NOA. 	<ul style="list-style-type: none"> • Donor fatigue and dwindling donor funds • Increasing number of Pre-XDR TB and XDRTB cases • Insecurity in many parts of the country • Natural disaster

4.2. Key Findings from Programme Reviews and Mission Reports

Building on the SWOT analysis, the revision of the NSP is informed by a number of new studies and epidemiological analysis, mid-term review, robust participatory prioritisation process using the people centred framework and multi-sectoral accountability framework. Some of the evidence informing the revision of the NSP are still the same as those that informed the earlier version. However, there are many new studies and review findings that are also listed below.

4.2.2. Key findings from the 2017 KAP Survey

The survey found out that though awareness of TB is generally high in the general population, knowledge about TB is still low. The radio was reported as the commonest source of information on TB. A higher proportion of respondents identified germs and persistent cough (>2weeks) as both the cause and symptom of TB, respectively. Perception of risk of TB among the general population is high though a higher proportion do not know health facilities where TB care can be obtained. Knowledge of causes of TB among TB patient is still poor though

TB patients are well informed of the relationship between TB and HIV infections. Distance to the health facility was major obstacle to their treatment while language barrier and gender discrimination pose some challenges. Among HIV patients, knowledge of TB is very low. With regards to health workers, knowledge of TB causes, symptoms and risk factors is fair. Despite this, their knowledge of TB management is low. Capacity development for health workers on TB-related issues is low and their dissatisfaction with job conditions high.

Though knowledge is good across board, it has reduced significantly from baseline values. Misconceptions about TB declined significantly. Persistent cough remains the most identified symptom of TB among all groups of respondents. Compared with the baseline, more people are now aware of the correct duration of TB treatment and that cough/spit/sputum can aid the spread of TB. Areas for improvement include development of evidenced based, gendered messages on TB that should be aired at prime hours; there is also need for expansion of TB services to more health facilities; and improvement on existing in-service and strengthening of pre-service training on TB related issues for HWs.

4.2.3. Lagos Inventory Study

The primary objective of the inventory study was to determine the magnitude and source of underreporting by the private and public sectors in Lagos state in 2015. The methodology consisted of retrospective analysis of all case-based and aggregated records from the Lagos State TB and Leprosy Control Programme (LSTBLCP) and DSNOs of diagnosed TB cases between 1 January and 31 December 2015.

The findings of the study revealed significant under-reporting of TB cases diagnosed in the state. There were discrepancies in the number of TB patients notified by the LSTBLCP and that notified by DSNOs. As much as 13.3% of TB patients treated in DOTs centers were not recorded in the 25 LGTBLS registers and therefore were not notified to state, national or international agencies. The private health facilities reported less cases than public health facilities. The results of the study showed that 21.5% of the engaged DOTS facilities did not report a single case of TB in 2015. Equally worrying from the study was the finding that there was a 25.6% discrepant information on key variables in the facility and LGA registers on same patients and a lower treatment success in the facility/LGA registers when compared to the total treatment success reported by the state TB program. Further findings from the study showed

that most of the TB patients were diagnosed through AFB microscopy and that treatment outcomes for patients were lower in the private health facilities than in public health facilities.

4.2.4. TB patient catastrophic Survey 2017

The NTBLCP conducted the first national TB patient cost survey in 2017 with the primary objectives of documenting the magnitude and main drivers of different types of costs incurred by TB patients (and their households), determining the baseline percentage of diagnosed TB patients treated in the network of facilities under the NTBLCP and their households, who incur direct and indirect costs beyond a defined threshold of their annual income and assessing cost effectiveness of Tuberculosis diagnosis and treatment in public and private facilities in Nigeria. A total of 1190 TB patients (1095 drug-susceptible and 95 drug-resistant TB) in 40 clusters (LGAs) across 22 states of the federation were enrolled in the study.

Key findings from the Survey

- TB affects all age groups but more among 15-44-year age group.
- More males than females are affected.
- About half of the patients are primary income earners in the households.
- A quarter of the patients are in the poorest wealth category in the survey.
- The proportion of TB patients that suffer catastrophic cost in Nigeria is 71%
- 48.4% of DR-TB and 28.2% of Drug Sensitive TB patients lost jobs due to TB.
- Children in 12.4% of households affected by TB had their education disrupted.
- 44.6% of TB patients suffer food insecurity.
- 27.6% suffer social exclusion (i.e., stigma, rejection, discrimination)
- 10.0 – 36.9% of patients used coping strategies such as loans, sale of assets, farmland, houses, or use of savings

Recommended National actions to mitigate the economic burden of TB

- Enhance TB specific social protection measures.
- Link TB affected households to food security programs.
- Advocate inclusion of TB treatment services in the NHIS coverage.
- NHIS benefit package to include all elements of tuberculosis care.
- Adopt a multi-stakeholder approach to TB programming.
- Develop and implement policies and laws to eliminate discrimination and ensure job security for TB patients.

4.3. Reviews and activities carried out since implementation of NSP 2021-2025

4.3.1. Mid-term review January 2023

A mid-term evaluation of the NSP 2021 – 2025 was conducted in January 2023. The objectives of the mid-term review include:

- Review the overall progress of the national programme, in relation to set national strategic plan 2021-2025 goals, objectives, and targets.
- Assess the epidemiology of TB in the country as it relates to progress and remaining challenges and capacity of national surveillance systems to directly measure the level of and trends in disease burden.
- Review the implementation status of the country's PMDT scale up plan in relation to the set targets.

Table 14: Midterm Review of the NSP 2021-2025

Thematic Areas	Key Achievements:	Key Challenges	Recommendations
1. MAF & Governance & Partnership	Increased government participation and ownership in TB response was observed in the country with key strategic partnerships and alliance between government and donors, implementing partners as well as the private sector. The TB programme is resilient with effective programme leadership at the NTBLP.	<ul style="list-style-type: none"> a. Deficits in funding for TB programme b. Gaps in domestic funding of TB program activities c. Inadequate human resource for health d. Suboptimal engagement, ownership and participation of High-Level policy makers <p>Non-implementation of the 2018 National Council of health resolution on mandatory TB screening and reporting in private health facilities</p>	<ul style="list-style-type: none"> a. Increase domestic funding for TB program b. Implement a multi-sectoral framework for TB response c. Integrate TB services into the National & state health insurance schemes d. Strengthen human resources for health and capacity development e. Facilitate the logistics for TB programme activities f. Ensure implementation of the National Council of Health communique on mandatory reporting of TB activities (2018)
2. TB Case detection, Care, Treatment & TB/HIV	There was marked increase in case notification and a good treatment success rate for drug Sensitive TB patients. The programme has achieved high performance in implementation of TB/HIV activities including provision of ART for co-infected patients	<ul style="list-style-type: none"> a. Nigeria still amongst the top 10 high TB burden countries and there are still missing TB cases in the country b. First in Africa, 6th in the world, high TB/HIV coinfection c. Integration of TB & HIV services e.g. the practice in HIV is to provide ART for up to 3 months while TB provides anti-TB drugs for only 2 weeks d. IPC committees are not functional and there is low capacity of IPC among HCW <p>The use of LF LAM in TB diagnosis among PLHIV is still limited</p>	<ul style="list-style-type: none"> a. Targets towards closing the gap between notification and estimated needs to be monitored closely b. Annual chest X-Ray screening for all HIV positive clients c. Monitor progress towards reaching NSP targets d. A need to review and strengthen the quality of screening at service delivery points (OPD, in-patient care) e. Strengthening the use of LF LAM in the country f. IPC practices at health facility levels needs strengthening g. TB Infection Prevention & Control Trainings and respiratory programs across facilities
3. Childhood & Adolescent TB	The engagement of Childhood TB Focal persons has been initiated with nominations and clear Terms of reference shared in all 36 states and	<ul style="list-style-type: none"> a. Low healthcare worker capacity in childhood TB in line with national guidelines. 	<ul style="list-style-type: none"> a. Utilize free Global Fund transportation fund for chest X-rays in children. b. Strengthen linkages between DOTS clinic and child health services.

	FCT. Active TB case search for childhood TB in orphanage homes and during Immunization Plus Days (IPDs) have contributed to increase in the percentage of childhood TB to the overall TB case notification.	<ul style="list-style-type: none"> b. The low utilization of transportation fund provided for uptake of Chest X ray services and out of pocket expenses for Chest Xray resulted in suboptimal utilization of chest X-ray services thereby resulting in low Childhood TB case finding. In addition, inadequate skills and awareness for stool sample testing and other diagnostic methods, as well as lack of engagement and collaboration with child welfare clinics and reproductive maternal and child health clinics are reasons for low TB cases finding among children. c. Stock-out of paediatric TB medicines and treatment interruptions are due to financial constraints d. Lack of adolescent-friendly services, poor data management hinders accurate adolescent TB determination. 	<ul style="list-style-type: none"> c. Strengthen childhood TB contact investigation and consider champion mothers as support. d. Develop clear action plan for adolescent-specific TB response, revise M&E tool for disaggregated data, and collaborate with Paediatric Association of Nigeria.
4. Programmatic management of Drug resistant Tuberculosis	There is a functional DR-TB structure at both the federal and state levels and timely adoption of new diagnostic tools & treatment regimens for the management of drug-resistant TB. A Steady increase in case notification of DR-TB was observed with the narrowing enrolment gap. There is a high treatment success rate among DR-TB patients (97%; 2020 treatment cohort).	<ul style="list-style-type: none"> a. There is suboptimal patient enrolment leading to poor DRTB case notification b. There is also sub-optimal funding for social support of DRTB cases, contact tracing and ACSM for programmatic management of DRTB. 	a. Funding to expand decentralization of DR-TB services, build health care workers, capacity for psychosocial support for PMDT patients, enhance ACSM, contact tracing & social support and provision of more diagnostic equipment for PMDT
5. TB prevention	The country experienced remarkable increase in TPT uptake across the country by 600% in 2022 relative to 2021. (2021: 17,517 & 2022: 77,083). This was due in part to improved data management on TPT uptake and the	<ul style="list-style-type: none"> a. Low TPT uptake due to cost of cards, consultation fees, duration of treatment and transport cost for monthly refills. The use of TPT for management of contacts of bacteriological TB cases is outrightly rejected by some clinicians 	<ul style="list-style-type: none"> a. Capacity building of health system staff for optimal delivery of TPT services. b. Communication and social mobilisation activities to educate the community on the importance of TPT for improvement in demand for TPT from the community.

	introduction of a shorter regimen: 3HP which showed improved adherence.	<p>e.g., University of Ilorin Teaching Hospital, Ilorin.</p> <p>b. Difficulty of convincing TB contacts to take medicine since they are healthy and the TPT completion rate among those who started the medication is low.</p> <p>c. There is weak mechanisms for contact investigation and enrolment gap between the eligible clients for TPT and those placed on TPT due to refusal</p> <p>d. There is sub- optimal documentation of TPT activities in the health facility</p>	<p>c. Incorporation of CBOs as community drug pick-up agents at TPT points.</p> <p>d. Introduce virtual adherence monitoring and follow-up on clients within the 3-month refill cohort</p>
6. Laboratory services	There is a clear political commitment and strong synergy with other partners working towards laboratory strengthening. Significant progress towards the roll-out of the WHO-recommended rapid diagnostic (WRD) for the diagnosis of TB M/XDR-TB from 2019-2021.	<p>a. There is suboptimal nationwide laboratory network coordination, insufficient lab support supervision and training as well as lack of Laboratory Centre of excellence for TB in the country. including</p> <p>b. The quality of TB laboratory services is also suboptimal at all levels</p>	<p>a. Strengthen implementation of LQMS at all levels of the laboratory network</p> <p>b. Optimize and expand the nation-wide use of molecular WHO Rapid Diagnosis as the initial diagnosis for TB and M/XDR-TB</p> <p>c. Strengthen the laboratory network linkages including support supervision and training. Upgrade one of the TB Reference Laboratories to a Centre of Excellence Laboratory for TB.</p>
7. Community, Rights and Gender & Social protections	The Community Rights and Gender data and action plan are available. The Community Health Volunteers are providing important support for TB diagnosis and care contributing substantially to TB case notification. The TB data is gender disaggregated and used to identify service delivery gaps in the programme. There is notable engagements and partnership with civil society organizations, religious and community leaders in most states. There are a number of best practice examples of engagement and provision of services to Key Vulnerable Populations in the country.	<p>a. Limited considerations for CRG barriers to care undermines TB case finding and management e.g. Transport & food insecurity</p> <p>b. Effective community inclusion & engagement contributes to improved TB Case Notifications but efforts in this direction seems insufficient.</p> <p>c. Meaningful engagement of people affected by TB is currently limited</p>	<p>d. Ensure CRG action plan is nationally resourced & implemented</p> <p>e. Assess all patient basic CRG needs and link to resources for relevant support</p> <p>f. Build on Key Vulnerable Population best practices and extend to all States</p> <p>g. Set standards and targets for community inclusion & engagement</p>

8. Advocacy, Communication and Social Mobilization (ACSM)	<p>There is increasing knowledge of causes of TB and availability of TB test among community members, Nigeria introduced a nationwide multimedia TB campaign aimed at massively increasing awareness and TB test. The national TB testing week has strengthened partnership with other critical stakeholder like the military and paramilitary. There is a strong STOPTB Partnership at National level and establishment of state chapters in some states for domestic resource mobilization. The commemoration of the World TB Day has gone beyond one day advocacy event to a week-long intense communication and active case finding activities during the period.</p>	<ul style="list-style-type: none"> a. Inadequate government support, commitment and funding of the ACSM component of TB programs b. Persistence of TB related stigma and discrimination c. Inadequate Human Resource for Health including poor capacity of few existing ones leading to poor client centered care and unfriendly provider behavior d. Inadequate coverage of media campaign leading to knowledge gaps about TB among some communities due to insufficient fund for media coverage 	<ul style="list-style-type: none"> a. More funding support from government and partners to implement ACSM strategies b. Mitigate stigma and discrimination through a targeted SBC approach at the community and among caregivers including health workers c. Strategic engagement of community leaders and gatekeepers in TB care including use of community dialogues for TB education d. Innovate Community initiated TB campaign, award ceremony/incentivizing best performance
9. Supply chain and logistics	<p>There was continuous availability of quality assured TB commodities in the country with improved government support and budget allocation for TB medicines in the country. The country also maintained a good stock management practice. There is a bi-annual post marketing surveillance of TB medicines at selected health facilities by NAFDAC.</p>	<ul style="list-style-type: none"> a. Inadequate storage space and suboptimal storage condition for TB drugs b. Funding gap for procurement of TB medicines and diagnostics and supply chain activities. c. The inventory management system is still paper based and the NHLMIS is nonfunctional because of lack of subscription for the system. d. There is gap in capacity for quantification and early warning system 	<ul style="list-style-type: none"> a. Expedite the construction of FCMS Oshodi mega store and upgrading of state medical stores b. The government to release funds for TPT (3HP) at the Central Bank and step up the commitment for other TB medicines. Early release of grant cycle 7 TB grant by Global Fund c. Installing and using an Enterprise Resource Planning system for managing stocks across all warehouses in the country. d. Early completion of integration of public health programs medicines and health products supply chain management.
10. Public-Private-Mix	<p>There was increased in the coverage of private facilities engaged in TB control activities from 977 (2017) to 3,759 (2021). This translated to a significant increase in the percentage of TB notification from private sector from 10% (2018) to 28% (2021). The use of</p>	<ul style="list-style-type: none"> a. The TB control in the private sector is largely donor funded limiting TB service expansion. b. TB control services is also yet to be included in benefit package of health insurance and social welfare schemes 	<ul style="list-style-type: none"> a. Funds to sustain innovative projects initiated by partners. b. Aggressive expansion of TB services in private sector c. National multi-sectoral PPM steering committee is essential

	linkage coordinators for sample shipment and screening officers in high volume facilities by means of the Mobile Application TB Screening App is commendable.		<ul style="list-style-type: none"> d. Innovative mechanisms to provide human resources for coordination of private sector TB services. e. Support to develop and include TB in the health insurance benefit package.
11. Cross Border	Some states (Kwara) provided diagnostic and treatment services for TB patients residing in other states/country thereby ensuring the inclusion of migrants in the program without discrimination of any kind. Some supervisory activities were carried out from state to cross border communities. Referral systems were also available within the country but the follow-up activities is limited.	<ul style="list-style-type: none"> a. Guideline for TB control among mobile population are not available and Data on cross border population is also not included in the TB register thereby resulting in difficulty in monitoring the care of migrants throughout the TB care continuum. b. No forum to discuss the cross-border TB related issues with other states and neighboring countries. 	<ul style="list-style-type: none"> a. Develop and implement guidelines and roadmap for TB control among mobile population. b. Set up a technical working group on integration of cross-border TB management in the NSP. c. Integrate indicators on prevention, detection, treatment and monitoring of treatment of migrants/nomads/IDPs and refugees in Nigeria. d. Identify and map relevant migration stakeholders and partners for multisectoral collaboration and partnership for cross-border TB control. e. Integrate TB screening at border settlement in the community engagement and TB outreach programs. f. Facilitate cross-border collaboration with neighboring states/ countries on improved TB care along the mobility continuum. g. Leverage existing digital system to track TB care and prevention.
12. NTBLCP Emergency preparedness: TB Control in Crisis Situation	The NTBLCP developed a preparedness plan for TB control in the NSP. The plan was effective in mitigating the negative effect of the recent flooding experienced in some parts of the country where more than 200,000 homes were destroyed, including TB diagnostic and treatment sites.	The crisis situation in some communities led to disruptions to TB diagnostic and treatment services subsequently resulting to treatment interruption and difficulty in tracking and monitoring health status of affected populations.	<ul style="list-style-type: none"> a. Strengthening emergency preparedness and response plans. b. Maintaining continuity of care for TB patients. c. Improving data management and surveillance systems, coordination among healthcare providers, and building resilience in the healthcare system. d. Increasing public awareness and community engagement
13. TB AND COMORBIDITIES / MULTIMORBIDITIES	The NTBLCP guideline captures nutrition and diabetes care and treatment in persons with TB. There is	c. TB and Nutrition: There is little or no documentation of TB case finding	a. Integrating TB care into general health systems to facilitate screening for TB among patients with DM & other comorbidities.

	<p>an existing multi-sectoral / core planning cell meetings held at the Federal level. The UN High - Level joint Mission on NCDs and TB was held in Nigeria in 2020 with recommendations to strengthen collaborations. The country had an impressive mitigation of Covid-19 impact on TB during the pandemic.</p>	<p>activities at nutritional clinics in states visited</p> <ul style="list-style-type: none"> d. TB and Mental health: Study in Kano in 2020 estimated that 48.6% of people with any form of TB had depression e. TB and Diabetes: No systematic screening of TB in DM clinics in most of the states f. TB and Tobacco: No data on tobacco use is collected during TB follow-up 	<p>b. Patient-centered approach to comprehensive care for TB patients, including comorbidities.</p>
--	---	--	---

4.3.2. TB epidemiological assessment (Epi-analysis) 2023.

As part of the NSP-TB development process, WHO conducted an epidemiological assessment in collaboration with programme staff in January 2023. The major aims of the 2023 epi-analysis were to evaluate the capacity of the surveillance system to correctly measure the magnitude of the TB epidemic (e.g., in terms of incidence and mortality) and to analyse surveillance data to determine the level and trends of TB burden (e.g., in terms of notifications) and possible causes of variation in TB epidemic.

4.3.2.1. Key messages and updates since the last 2020 epi-analysis

4.3.2.1.1. System governance:

- TB programme, as agency responsible for recording and reporting of TB data, has taken the decision to discontinue the use of eTB manager, following an evaluation carried out with TB-DIAH.
- TB programme is taking the logical steps in developing and implementing a new digital platform for TB recording and reporting, with the preference of it being a home-grown system and fully governed by the NTP.

4.3.2.1.2. System coverage:

- Excellent progress has been made in improving case-finding (addressing the issue of under-diagnosis), through various strategies: expansion of DOTS providers, PPM, community outreach, active screening in OPD.
- Continued (or even increased) investment in case-finding will be needed in order to not lose the momentum gained and continue to expand strategies further.
- Important gaps still remain in finding TB cases (under-diagnosis), due to various factors (e.g. barriers in accessing care, incomplete coverage of DOTS)
- Reception of health facility quarterly reports appear to be complete at the national level, but recording of all diagnosed TB cases remains an issue (under-reporting).
- Under-diagnosis (compared to under-reporting) continues to be the larger contributor to sub-optimal treatment coverage.
- New prevalence survey is needed to better understand the burden in the country.

4.3.2.1.3. System use:

- Paper tools are used for recording case-level data and for reporting aggregate data (as well as Excel) along the pathway of prevention and care, with the LGA serving as the BMU.
- eTB manager is still being used at some units, but its use is waning (as expected with the decision to discontinue its use).

4.3.2.1.4. System architecture:

- TB surveillance system is fragmented: DS-TB and DR-TB are recorded and reported separately by paper, with digital tools also recording TB data: eTB manager, SORMAS, CommCare, NHMIS/DHIS2, MATS, EWORS, EPCON.
- Reporting relies on a manual process which is labour-intensive (and prone to errors).
- Plans for the digital system should include the harmonization of systems (as much as possible), aiming for a consolidated dataset, capturing data along the whole pathway of prevention and care from the various service areas (community, lab, facility, etc)

4.3.2.1.5. Data management and quality:

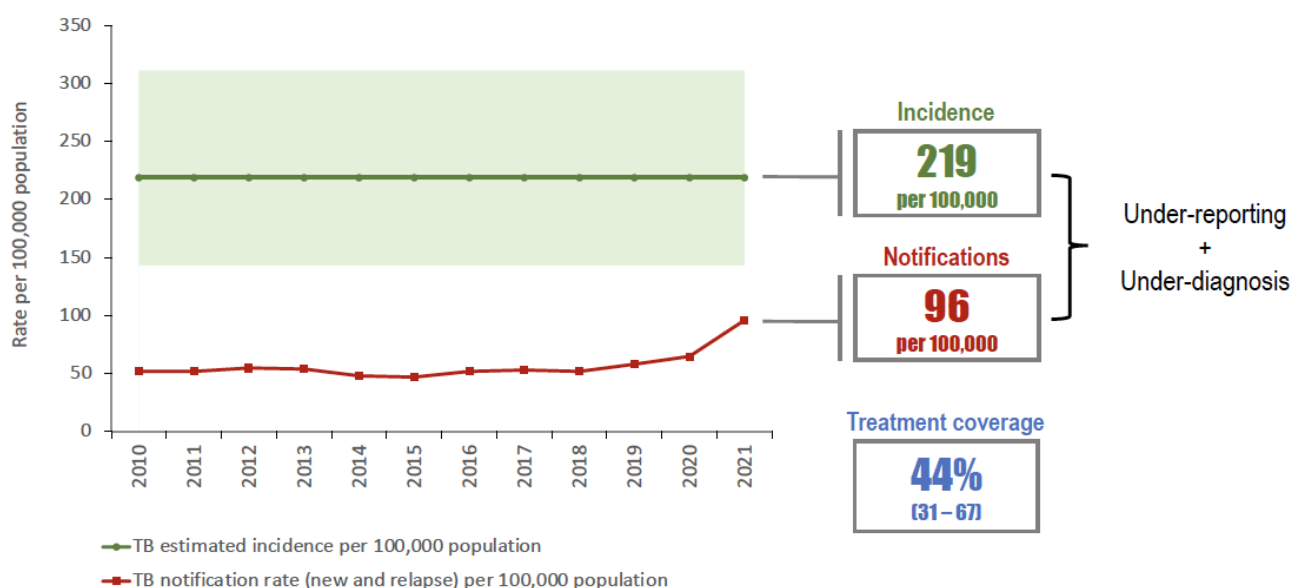
- Facility registers appear relatively well kept, with some gaps in recording GeneXpert results in the presumptive register and treatment outcomes in treatment register, as observed at two separate sites.
- Various efforts to ensure data quality are in place and the Global Fund DQA suggests good quality (with some gaps). A full data quality audit based on nationally representative sample is missing.
- Data are being housed on Excel sheets, which is risky for introducing errors and is vulnerable to loss of data, further highlighting the need for a digital platform. Other methods for safeguarding data in the meantime (e.g. tbhistoric.org) should be strongly considered.

Figure 18: Key findings from 2023 epi-analysis:

Standard	1 st Ed			2 nd Ed
	2014	2017	2020	2023
B1.1 Case definitions are consistent				
B1.2 Minimum set of variables captured				
B1.3 All expected submissions received				
B1.4 Quality of data in paper system				
B1.5 Quality of data in digital system				
B1.6 External consistency of data				
B1.7 Internal consistency of data				
B1.8 All TB cases reported				
B1.9 Good access to health care				
B1.10 High quality and coverage of VR				
B2.1 Surveillance of DR-TB				
B2.2 Surveillance of TB-HIV				
B2.3 Surveillance of childhood TB				
B3.1 M&E of treatment outcomes				
B4.1 M&E of PMTPT				

Key: Met Partially met Not met Not applicable Not assessed

Figure 19: Estimated incidence and case notification



4.3.2.2. Recommendations from the 2023 Epi-analysis

1. Measure population-level burden with a new prevalence survey based on the new methodology using GeneXpert (reducing number of cultures and costs).
2. Transitioning to digital case-based system: Continue with logical approach and planning to develop and implement a digital case-based system for TB recording and reporting:
3. Strengthening data quality, analysis, and use
4. Addressing under-diagnosis: Continue to invest in activities to improve case-detection and scale up wider.
5. Carry forward engagement with NPHCDA to integrate TB services into CHIPS and nutritional campaigns, and to also strengthen case-detection among young children.
6. Vital registration: Consider collaborating with UNICEF to carry out a mortality survey in children and use findings to advocate for increased resources to support childhood TB interventions.
7. Investigate the high rate of MTB+/Rif indeterminate results, which is a systematic finding across all states (12% of MTB+ results are rif indeterminate at the national level in 2021).

8. Showcase programmatic success: The TB programme has made huge progress in case-detection in recent years, remained resilient through the height of COVID, and maintained high treatment success and data quality despite the increased case load.

4.3.3. Regional Green Light (rGLC) Mission 2022

The combined 2022 rGLC and GDF mission to Nigeria aimed to:

- Evaluate programme coordination and management of PMDT as it pertains to the diagnosis, enrolment and treatment of DR-TB cases across the facilities and in the community.
- Assess the implementation status of the new WHO approved BPaLM and BPaL shorter treatment regimen for the management of MDR-TB and Pre XDR-TB respectively.
- Appraise the implementation status of the reference laboratories alongside the Gene Xpert laboratories in preparation to switch into the new WHO recommended all oral MDR-TB treatment regimen.
- Assess all ongoing operational research in relation to all regimen recommended by the WHO to be used under research conditions and give recommendations.
- Evaluate the routine surveillance system including the electronic web based and hard copy data capturing tools.
- Generate strategic priority intervention with specific recommendations to ensure optimal programme performance.

4.3.3.1. Key Finding

- Improved rollout of World Health Organization's (WHO) recommended diagnostic tools (WRD) that had improved case finding
- Expand and strengthen TB case finding and surveillance
- Strong partner support
- Adequate stock levels of first- and second-line TB medicines (FLD and SLD)
- All patients were on all oral short-term regimen including the implementation science BESTREAM regimen.

4.3.3.2. Areas requiring follow up.

- Despite the improved TB and DR-TB case finding and surveillance, there were still significant delays in treatment initiation of diagnosed MDR-TB
- The accumulation of sputum samples awaiting testing by mWRD is AN URGENT finding requiring urgent solution.

- Inadequate nutritional support to patients receiving drug resistant TB treatment.
- Surveillance tools were not available in adequate amounts.
- There is urgent need to develop a plan for further decentralizing of the mWRD

4.3.3.3. Achievements from Previous Combined rGLC and GDF Mission

Reviewing the status of the implementation of the recommendations of the previous rGLC support. A total of 5/10 recommendations were fully implemented, 4/10 were work in progress and 1/10 was still to be implemented.

Table 15: Recommendations of rGLC mission

	Recommendation	Status
1	Strengthen capacity for intensive case finding through improving coverage of Gene Xpert technology and community screening during contact tracing	
2	Expedite the process of training TBLS in all states to improve case holding	
3	Further decentralize laboratories that can support with baseline tests	
4	Further decentralize Gene Xpert machines to at least one per LGA	
5	Expedite the dissemination of new policy and guideline documents to states and LGA	
6	Expedite training of health care workers on new DR-TB treatment guidelines	
7	Laboratory network analysis to be done and develop more capacity for SL DST especially for the new drugs	
8	Assess feasibility of point of care diagnosis for DR-TB that is more stable in hot temperatures in Nigeria	
9	Enrol patients on DR-TB treatment even before the line probe assay (LPA) results are available	
10	Develop a proper and clear anti-TB medicines forecasting and quantification.	

5. TB Programme risks, new strategic direction, and enablers

5.1. Risk Analysis and Mitigation Plan for the NSP

The NTBLCP has identified various strategic interventions that will ensure that the identified programme goals and objectives as outlined in the 2021 – 2026 NSP are realized. Certain key threats which could contribute to low or non-achievement of the targets include:

- a. Lack of demonstrable increase in government funding and release at federal, state, and local government levels, including non-fulfilling of Global Fund counterpart funding requirements for TB
- b. Frequent and prolonged industrial strike actions
- c. Widespread insecurity and civil unrest
- d. Weak health and community systems, especially at PHC level

Mitigating measures which can cushion the effects of the identified risks have also been laid out in the NSP and include the following:

- a. Strengthened and coordinated advocacy, including specific CBO advocacy capacity building aimed at influencing policy and decision makers at all levels to allocate enough resources to TB control.
- b. Linkage with the DPRS to ensure tracking of TB budgets and financing at all levels which will be implemented through the National Health Account, with support of the Global Fund.
- c. Increased resource allocation for health and community system strengthening, by pooling funds from government, private sector, and donor funding. Targeted advocacy and policy shift in the NHIS are also planned to promote the inclusion of TB services for financing by the NHIS.
- d. Strengthening of the existing community systems as well as scale up of community TB activities to provide access to TB services for people that live in hard-to-reach areas, difficult terrains and internally displaced persons arising from insecurity and civil unrest.
- e. Identification of alternative health service delivery mechanisms that will ensure continued provision of TB services across all the LGAs in Nigeria during periods of

industrial strike actions. These include private health facilities and community pharmacies.

- f. Collaboration with NPHCDA, as well as the HIV and Malaria Programmes to institute health system strengthening measures at all levels, especially in geographical areas with high disease burden, with special focus on the PHC level, where most TB patients access services. These measures include capacity building of service providers to diagnose and manage TB, provision of adequate infrastructure and human resources, strengthening the supply chain management to ensure availability of required drugs and commodities in an integrated manner as well as increased investment and harmonisation of the data management system for effective reporting promptly and effectively.

5.2. Community, Rights and Gender

The percentage of community contribution to notified cases increased from 19% in 2018 to 43% in 2022. Hence, the need to strengthen community and its structures to be responsive to implementing and monitoring TB services. Nigeria is one of the few countries that have successfully completed three key Community Rights and Gender (CRG) assessments namely Nigeria Legal Environment Assessment, TB Gender Assessment in Nigeria, TB KP prioritization and rapid assessment report. The findings of this assessment have led to the development of a CRG costed Action Plan the “Human Rights and Gender Action Plan for Tuberculosis Care and Prevention in Nigeria 2021-2025”. There is an ongoing stigma study that will further inform the CRG policy in the country. The midterm review of the CRG recognized these important first steps in terms of documenting the CRG context in Nigeria. However, noted that the existing comprehensive knowledge of a CRG approach to TB has yet to extend to managers and implementers.

This TB NSP 2022-2026 is aligned to the Human Rights and Gender Action Plan for Tuberculosis Care and Prevention in Nigeria 2021 – 2025 and takes note of the factors related to Human rights and Gender that disproportionately hinder the effectiveness, accessibility and sustainability of TB programmes and services in the country.³¹ These factors shall be considered in the design, development and implementation of the TB programme applying the Human Right and gender lens. This will strengthen a human rights-based TB response and enhances the traditional approaches to combatting the disease. The approach focuses on social

³¹ Nigeria Population 2020 (Demographics, Maps, Graphs)
[Http://Worldpopulationreview.Com/Countries/Nigeria-Population](http://Worldpopulationreview.Com/Countries/Nigeria-Population)

and economic drivers, combatting TB-related stigma and discrimination, protecting privacy and confidentiality, and ensuring good-quality testing and treatment for TB is available and accessible without discrimination³², also ensuring a process of receiving complaints and providing feedback from the beneficiary of the TB services.

5.3. TB Stigma Assessment

There is increasing recognition that TB stigma continues to be a major barrier for TB patients, families, caregivers, and communities. TB stigma can delay diagnosis and hindering successful treatment, hence reducing stigma in the TB program is a priority for the NTBLCP.

To appropriately measure TB stigma and discrimination and to identify how it affect TB care and management, an assessment of stigma related to TB was conducted in 2023, the purpose of this study was to assess the extent to which TB stigma acts as a barrier to both accessing and providing services, and to support the development of recommendations and an action plan to address and ultimately end TB-related stigma in Nigeria. Results revealed high levels of self-stigma among People with Tuberculosis (PWTB), especially relating to disclosure of TB status, feeling alone, feeling hurt and feeling guilty for themselves. Respondents from south east (62%) north west (55%) regions reported higher levels of self-stigma than the other regions. TB stigma reduced with increasing age, education level and marital status. Most family members also expressed secondary stigmatization. Also there seems to be a gender play with females more likely to be stigmatized at home. Stigma was experienced the most at community level and Healthcare workers also expressed high levels of stigma towards PWTB and had experienced themselves stigma from attending to patients³³.

The key recommendations of the assessment include:

- Prevalence of TB stigma is high in Nigerian and occurs at various settings which will require multifaceted evidence-based approaches to mitigate.
- TB Stigma affects all components of the TB service cascade; from recognition of symptoms to completion of treatment and thus demands urgent interventions if Nigeria must achieve significant improvements in TB case findings as well as TB treatment completion rates.
- TB stigma is highest at the community level suggesting that behaviour change communication interventions must be targeted and sustained within the community to reduce it and its impact of TB service cascade.

³² Department of Public Health National Tuberculosis, Leprosy and Buruli Ulcer Control Programme Human Rights and Gender Action Plan for Tuberculosis Care and Prevention in Nigeria 2021 – 2025

³³ NTBLCP, 2023. Research Report: An Assessment Of Stigma Related To Tuberculosis For The National Tuberculosis And Leprosy Control Programme

- The burden of TB stigma is high among family members and support systems must be instituted to empower them to manage and address experienced and anticipated stigma given their role as treatment supporters to PWTB.

The TB stigma study informed the packaging of this NSP with the aim of preventing and mitigating TB stigma in the country. In addition, the CRG interventions also aligns with the Human Rights and Gender Action Plan for Tuberculosis Care and Prevention in Nigeria 2021-2025

In line with the above and the recommendations of the MTR NSP 2021-2025, the TB NSP will address human rights, gender, and stigma by:

- Designing targeted behavioural change interventions as part of the TB service delivery package to address the high level of TB stigma at community, family, and among health care workers.
- Promoting and advancing community systems strengthening (CSS), human rights, and gender and integration into the TB response at all levels of the Nigeria health systems.
- Ensuring that the communities and civil society are meaningfully engaged in the design, implementation, and monitoring of TB programs and interventions.
- Ensuring that technically sound interventions supporting human rights, gender equality, and CSS are implemented by building the capacity of TB stakeholders at all levels on the importance of applying gender, human right and inequality lens in all aspects of their programming.
- Laying emphasis on engagement of key population that are most affected by TB including. Children, Migrants and Refugees, Internally Displaced Persons (IDPs), People working in poorly ventilated and crowded environments, slum dwellers, people who use drugs, people who use alcohol, involuntary isolation, and women as identified in the Human Rights and Gender Action Plan for Tuberculosis Care and Prevention in Nigeria 2021 – 2025.
- Forming strategic partnership with identified stakeholders in driving the gender and human right agenda in the country by providing technical support, resource mobilization, monitoring and oversight of the process of implementation.

5.4. Advocacy, Communication and Social Mobilization (ACSM)

ACSM activities has a role to play in addressing stigma and discrimination against TB patients. With a high level of TB stigma reported in the TB stigma assessment, it is critical for ACSM activities to be optimised and targeted to getting high impact results in implementing TB control activities in the country. Many successes had been reported; there is increasing knowledge of causes of TB and availability of TB test among community members; Nigeria introduced a nationwide multimedia TB campaign aimed at massively increasing awareness

and TB test. Furthermore, the national TB testing week has strengthened partnership with other critical stakeholder like the military and paramilitary and there is a strong STOPTB Partnership at National level and establishment of state chapters in some states for domestic resource mobilization. The ACSM also leverages health days including the commemoration of the World TB Day to organise a week-long event of intense communication and active case finding activities during the period.

5.5. Supply chain management and logistics

The mid-term review of the NSP reported that adequate Anti-TB drugs were regularly available during the period of the current NSP. There was also an improved government support and budget allocation for TB medicines in the country. A bi-annual post marketing surveillance of TB medicines at selected health facilities by NAFDAC has been established and functional. Issues of SCM and logistics is key to implementing the NSP.

5.6. TB cross border issues

Nigeria shares land borders with Cameroon, Chad, Niger, Benin republic and as an ECOWAS country with free movement among member states. The country is dealing with a mixed migration profile of IDPs, nomads, refugees, documented and undocumented immigrants, emigrants. Migration is recognized as a social determinant of health³⁴ there are several vulnerabilities associated with migration including access to health services, condition of migration, health information and communication, living condition of mobile population, cultural practices, appropriateness of available health service to migrants' health needs³⁵.

Lagos State borders with Benin and a business hub currently reports 65% missing TB cases and 22% new bacteriologically confirmed cases were loss to follow-up in quarter three of 2022. During the COVID-19 pandemic, IOM's Displacement Tracking Matrix (DMT) and WHO, assessed cross-border movements across the Borno State in north-east Nigeria and Cameroon. This assessment profiled migration pattern, with equal proportion of male and female, indicating over about 75% chose either seasonal or family visit as the main reasons for movement. Majority crossed border using motorcycle (41%) and foot (35%), while only 4% crossed by using cars. Almost 1 out of 4 people screened at the entry points had sought medical

³⁴ Health of migrants: the way forward: report of a global consultation, Madrid, Spain, 3–5 March 2010. Geneva: World Health Organization; 2011:3–5 (<https://apps.who.int/iris/handle/10665/44336>, accessed 7 April 2022).

³⁵ World report on the health of refugees and migrants. Geneva: World Health Organization; 2022. Licence: CC BY-NC-SA 3.0 IGO.

care in any health facilities within the last 14 days of crossing borders. These calls for a need to have a coherent response to the cross border related issues.

The MTR of the current NSP reviewed the cross-border issues, acknowledged the ongoing interventions across the country. However, made the following recommendations³⁶:

- Develop and implement guidelines and roadmap for TB control among mobile population.
- Set up a technical working group on integration of cross-border TB management in the NSP.
- Integrate indicators on prevention, detection, treatment and monitoring of treatment of migrants/nomads/IDPs and refugees in Nigeria.
- Identify and map relevant migration stakeholders and partners for multisectoral collaboration and partnership for cross-border TB control.
- Integrate TB screening at border settlement in the community engagement and TB outreach programs.
- Facilitate cross-border collaboration with neighbouring states/ countries on improved TB care along the mobility continuum.
- Leverage existing digital system to track TB care and prevention.
- Implement periodic screening exercise along the border settlements in Nigeria.

In addressing the recommendations:

- The NTBLCP will carry out the mapping of migratory stakeholders and partners for multisectoral collaboration and partnership for cross-border TB control.
- The NTBLCP, states and LGAs along the border states will establish a cross-border technical working group on integration of cross-border TB management. This will be done in collaboration with ECOWAS.
- In collaboration with stakeholders, the NTBLCP and states and LGAs will organize targeted periodic screening exercises, especially at the high movement volume seasons.
- The NTBLCP and stakeholders will identify and initiate studies to provide evidence around TB cross-border issues to inform interventions.

³⁶ Mid-term Review (MTR) of TB NSP 2022-2025

5.7. TB control in crisis situation

The NTBLCP developed a standard operating procedure for the implementation of TB control in crisis situations in 2016. Since then, the advent of COVID-19 and the flood situation in 2022 have emphasized the importance of the inclusion of the TB control in crisis situations as an integral part of the national emergency and disaster preparedness and response plan. This TB NSP 2022-2026 is aligned with the National Humanitarian Development Peace Framework 2021-2025 of the Federal ministry of Humanitarian Affairs, Disaster Management and Social Development. This ministry is responsible for ensuring the coordination of the prevention, preparation, response, and mitigation of national pandemic/disaster. This is done with other government ministries and agencies and non-governmental agencies in a coordinated manner.

Nigeria has an ongoing humanitarian disaster that led to the problem of internally displaced individuals. In the North-East region, the number of people in need of humanitarian assistance in north-east Nigeria rose from 7.9 million at the beginning of 2020 to 10.6 million. According to IOM's Displacement Tracking Matrix (DTM) Round 33, dated August 2020, the total number of internally displaced persons (IDPs) has increased to over 2.1 million ³⁷. The COVID-19 pandemic has further aggravated the already dire living conditions. It is the responsibility of the TB programme to ensure that people who are receiving treatment for TB disease can continue their treatment, even if they are displaced temporarily or permanently by an emergency or disaster.

The NTBLCP should Update the 2016 Standard Operating Procedures³⁸ for implementing TB control in crisis situations to guide implementation. This updated document will include the following:

- Define clear objectives and roles of the NTBLCP, State, LGA and partners; governance.
- Key intervention that will take place in different settings (displaced or not displaced) and phases of disaster interventions (Acute, protracted etc.)
- Identify procedures to follow in different settings and situations
- Identify opportunities for collaboration with existing disaster or emergency management programmes

³⁷ IOM, 2021. Nigeria Crisis Response Plan 2021

³⁸ NTBLCP, 2016. Standard Operating Procedures for implementing TB control in crisis situations

The guideline will take into consideration specific objectives of TB control in crisis to:

- Facilitate integration of TB control services into the emergency health services during crisis.
- Ensure uninterrupted TB control services during crisis situation
- Provide step by step guide to government and stakeholders at all levels for the provision of TB control services in crisis situation
- Harness resources for emergency intervention during crisis
- Mitigate the impact of crisis on provision of TB services in affected population and overall TB control effort.

The immediate priority response following a disaster, is to save lives, protect property, and meet basic human needs have precedence over recovery and mitigation¹. However, the NTBLCP will work together with other stakeholders to identify TB services integration opportunities within the national preparedness and response plan to facilitate the mitigation of the impact of the disaster on TB programme.

This will be done in collaboration with the stakeholders and in alignment with the National Humanitarian Development Peace Framework 2021-2025.

6. The National Strategic Plan for Tuberculosis 2021-2026

6.1. New strategic directions

In line with the programme implementation experience, routine data analysis, results of the review and studies, the following strategic directions were identified:

1. Domestic resource mobilization with in-country funding of TB budget
2. TB case finding (including key populations)
3. Comprehensive engagement of all private care providers
4. TB laboratory services
5. Community system strengthening (including key populations)
6. Human rights and gender
7. TB treatment and care (including comorbidities: HIV and non-communicable diseases – NCDs and people-centred social support services for TB patients) with high treatment success rate
8. TB prevention and infection control
9. Childhood TB
10. Programmatic management of drug-resistant TB (PMDT)
11. Supply chain and logistics
12. Strategic information and research

6.1.1. Domestic resource mobilisation for funding of TB budget

Domestic funding for TB control in Nigeria is very low currently. Only 8% of the TB funding is funded locally while 32% is funded by international donors. This leaves a gap of 60% of required funding for TB programme. Lack of targeted and effective advocacy to relevant government authorities and corporate organisations has been given as a major reason for the low domestic funding of TB activities. In the 2021 – 2026 NSP, the programme plans to strengthen domestic resource mobilisation with in-country funding for TB budget from 8% in 2019 to 50% by 2026.

Multi-sectoral collaboration and leveraging on programmes like the Save One Million Lives (SOMIL), the BHCPF and the NHIS will be employed by the programme to garner funding for TB control activities. Other resources that will be leveraged upon to increase domestic funding for TB are the first Lady of Nigeria and the First Ladies of the various states who are Ambassadors for TB in Nigeria. The Nigerian StopTB partnership has been very active in efforts to mobilise domestic funding for the programme through high level advocacy to

governmental authorities and in organising TB Conferences in the country. There also exist many organizations in the country that embark on several corporate social responsibilities (CSR). All the above structures will be utilised by the programme to improve domestic funding for TB in the country.

Outcome Targets

Indicator	Baseline (2020)	Target (2026)
Domestic resource mobilisation for funding of TB budget	8%	50%

6.1.2. TB case finding (including key populations)

Nigeria with an estimated 467,000 incident TB cases (incident rate of 219/100,000 population)³⁹ notified 285,561 (60%) of the estimated incident TB cases in 2022, leaving a gap of 181,439 undetected cases. WHO estimates that Nigeria is among five countries that accounted for more than half of the global gap in TB case notification in 2019⁴⁰. The 2023 epi-analysis results and the main findings of the mid-term review show that under-diagnosis and under-reporting were mainly responsible for the low TB case notification in the country. In the 2021 – 2026 NSP, the programme plans to increase TB case notification rate for all forms of TB from 60 per 100,000 population in 2019 to 164 per 100,000 population in 2026. Interventions planned by the NTBLCP to increase TB case finding include strengthening and scaling up TB diagnosis in the laboratories, establishment of TB policy in workplace that will ensure that persons with presumptive TB are identified early enough and strengthening and scaling up OPD screening for TB. TB case finding among key populations (HIV infected individuals, Contacts of active TB cases, Nomads, Migrants and IDPs, Prisoners, Slum dwellers, Children, Miners, Inmates of Police Cells, Diabetes Mellitus) will be intensified in the new NSP. The programme will also collaborate with the veterinary health services to improve the diagnosis of TB, especially extra-pulmonary TB. In line with the Universal Health Coverage (UHC), TB services will be scaled up so that every facility should be able to implement at least one TB service. The programme will review and update the guidance on TB activities during emergency situations, and this will be employed in the NSP. Equally, TB in lung health will be promoted and capacity building carried out for this.

³⁹ Nigeria Profile, WHO GTB Report 2022

⁴⁰ 2020 WHO Global TB Report

Outcome Targets

Indicator	Baseline (2019)	Target (2026)
Case notification (all forms)	120,266	401,829

6.1.3. Private sector involvement

In the last NSP, remarkable progress was made in the engagement of the private sector in the implementation of TB control services. As of December 2019, 4,945 Private health facilities had been engaged in the TB programme. Private sector contribution to TB case finding was 14% in 2019. This increased to 4,038 private facilities and 24% contribution of the private sector to the TB program in 2022. The improvement in proportion of TB notification from the private sector was enhanced by implementation of the National PPM guidelines and incentivised support to the private sector. The PPM Action Plan 2022-2025 was developed.

In the 2021 – 2026 NSP, the programme plans to improve access to quality TB care through comprehensive engagement of all private care providers with the sector accounting for 35% of notified TB cases by 2026. Interventions designed to achieve the target include enhancing the capacity of private health facilities to diagnose and treat TB cases and to ensure systematic screening of all OPD attendees in engaged private facilities. The programme also plans to strengthen linkage systems between first points-of contact in communities (PPMV, CP, traditional healers, traditional and religious leaders) and PPM referral facilities. More PMVs and CPS will be engaged by the programme. In the new NSP, more stand-alone private laboratories will be provided with Xpert MTB/Rif machines and other advanced diagnostic tools to diagnose TB. There will be scale-up of on-going quality improvement initiatives to cover more private health facilities. There will be an enforcement of the memo on mandatory reporting of TB in the private sector, and the electronic notification and reporting to all private health care providers will be scaled-up.

Outcome Targets

Indicator	Baseline (2019)	Target (2026)
Proportion of TB Case notifications by the private sector	14%	35%
Proportion of private sector providers engaged to provide comprehensive TB services	34%	80%

6.1.4. TB laboratory services

Laboratory services are crucial to the diagnosis of TB. In 2016, the country adopted Xpert MTB/Rif assay as the primary diagnostic tool for TB. AFB microscopy is however still performed for diagnosis in locations where Xpert MTB/Rif assay is not feasible. In addition to the low coverage of Xpert MTB/Rif assay, the greatest challenge to Xpert MTB/Rif assay is poor power supply in the laboratories and frequent modular failures. Stock out of GeneXpert cartridges and other diagnostic reagents and consumables and weak sample referral network were other challenges that impeded optimal performance of laboratory services. Quite recently, new TB diagnostic technologies like the TB LAMP and LF LAM were approved by WHO prompting the NTBLCP to adopt them for TB diagnosis in Nigeria in 2019. In the 2021 – 2026 NSP, the programme plans to increase the number of GeneXpert sites from 398 in 2019 to 654 sites by 2026 and increase the number of microscopy centers from 3,220 to 3,727 by 2026.

Interventions planned by the NTBLCP to improve the capacity of the laboratories to diagnose TB include increasing access to rapid TB Laboratory diagnosis in the public and private sector. Specimen referral system will be strengthened as well as the laboratory Quality Management System (LQMS) at all levels of the network. The programme will also strengthen the laboratory biosafety and biosecurity infrastructure to meet internationally acceptable standards. Invest in constant supply of power at the GeneXpert sites.

Outcome Targets

Indicator	Baseline (2019)	Target (2026)
Number of sites/facilities offering Xpert MTB/Rif assay TB diagnostic services	398	654

6.1.5. Community system strengthening (including key populations)

Community engagement has been one of the interventions of the NTBLCP since the inception of the programme. Despite this, the awareness of community members regarding TB is low. The findings of the 2017 TB knowledge, Attitude and Practice (KAP) survey shown that only 27% of community knew that TB is caused by germs. In the 2015 – 2020 NSP, the programme envisaged proportion of suspects identified by a CV/CBO to increase from 22% to 35% and the proportion of LGAs with formal community TB care services to be more than >25%. Reasons for the low awareness of TB and the sub-optimal yield from community engagement

include weak community ownership, non-engagement of ward developing committees (WDCs) and community development committees (CDCs) in TB control and the persistence of myths and misconceptions towards TB by community members.

In the 2021 – 2026 NSP, the NTBLCP will strengthen community systems and structures for effective participation in TB response. Following successful TB REACH interventions in implementing TB services in hard-to-reach and high-risk areas, the NTBLCP will sustain these activities and scale them up to other areas. Targeted multi-channelled social and behaviour change for TB using media and other communication channels will be deployed to reach community leaders, community members and health care providers. The ACSM strategies will be reviewed to be more responsive to the need at the community level.

Outcome Targets

Indicator	Baseline (2019)	Target (2026)
Proportion of TB cases referred from the community	22%	45%
Proportion of community member with correct knowledge of TB	27% (2017)	75%

6.1.6. Human rights and gender consideration in provision of quality TB services

Human rights and gender considerations have not received adequate attention in the programme. In the 2021 – 2026 NSP, the programme plans to protect and promote human rights and genders related factors in provision of quality TB services. To carry out this, the NTBLCP will conduct human rights and gender analysis to identify gaps for TB implementation. Policies will then be developed to address the gaps identified from the analysis. Gender specific activities for workplaces and leisure areas will also be developed. The NTBLCP will also provide training for TB treatment providers on the implementation of the Patient Charter as a component of patients’ pre-treatment counselling. The programme will also engage more TB survivors, patients, and other key populations actively in human right-based community mobilisation. TB treatment and care (including comorbidities: HIV and non-communicable diseases – NCDs and people-centred social support services for TB patients) with high treatment success rate.

6.1.7. TB treatment and care

TB treatment success rate has been consistently high in the country in the past 10 years. Despite this high percentage, the achievement is still less than the national target of 90% treatment success. The programme, though having a high percentage of documented HIV status among TB patients with HIV infection, has a weak collaboration with the HIV programme. Despite the established relationship between TB and Diabetes Mellitus (DM), the programme is yet to develop a guideline for the management of TB-DM co-morbidity.

In the country, there are no insurance provisions that cover loss of income due to TB and there is no nutritional support for drug-sensitive TB patients on treatment. Equally, there are no financial and psychosocial support available for drug sensitive TB patients on treatment. The findings of the 2017 catastrophic survey revealed that 44.6% of TB patients in the country suffer food insecurity with 48.4% of DR-TB and 28.2% of Drug Sensitive TB patients respectively losing jobs due to TB. In addition, 27.6% of the patients suffer stigma, rejection, and discrimination. These findings have been shown to hamper the completion of TB treatment by patients. These factors, if not addressed can present challenges in reaching the targets of the UNHLM. The recommendations of the 2023 MTR of the NSP 2021 – 2025 also highlighted the need for provision of social protection for TB patients.

In the 2021 – 2026 NSP, the programme aims to achieve and sustain a TB treatment success rate of 92% by 2026. It also hopes to increase the percentage of TB patients with documented HIV status from 97% in 2019 to 100% in 2026.

The interventions planned to maintain a high level of TB treatment and care is dependent on ensuring that the health facilities have the capacity to manage the anticipated increase in TB case notifications during the period of the NSP. This will entail provision of social support to reduce financial barriers to accessing care for child TB and building the capacity of STBLCPM, LGA PHC coordinators, State programme staff, LGA TBLS and other health care workers on patient care including contact investigations, TPT and recording and reporting. The programme will also undertake high level advocacy visit to ensure the inclusion of TB services in the NHIS package. Case finding for DM patients at endocrinology and Geriatrics clinics will be intensified. With regards to TB/HIV collaboration, the programme plans to strengthen the coordination mechanisms for delivering integrated TB and HIV services at the national, state and health facilities. This will also strengthen the implementation of interventions aimed at

reducing the burden of TB in people living with HIV and the burden of HIV in patients with presumptive and diagnosed TB. Issues of community rights and gender (CRG) will be prioritised. Standards and targets for community inclusion & engagement will be set as well as introduce the concept of community led monitoring (CLM). The NSP 2021-2026 will ensure CRG action plan is nationally implemented, assess all patient basic CRG needs and link to resources for relevant support and build on Key Vulnerable Population best practices and extend to all States.

Outcome Targets

Indicator	Baseline (2019)	Target (2026)
Treatment success rate	87%	92%
Paediatric cases as a proportion of total notifications	8%	13%
Proportion of TB patients with documented HIV status	97%	100%
Proportion of HIV-positive registered TB patients on CPT	92%	100%
Proportion of HIV-positive registered TB patients on ART	91%	100%

6.1.8. TB prevention and infection control

6.1.8.1. TB Preventive Therapy

As at December 2019, 88% of identified under-five children were screened for TB, 76% of those screened were eligible for TPT and 92% of the under-five contacts eligible were placed on TPT. In the 2021 – 2026 NSP, the program aims to rapidly scale up TB preventive services with the number of contacts receiving TPT increasing annually from 10,788 in 2018 to 702,076 by 2026. The programme will strengthen Contact Investigation and TB Preventive Therapy in children/adolescents. The emphasis on TPT will include not only under-five children but also include all contacts of TB patients irrespective of their age through capacity building of health system staff for optimal delivery of TPT services, communication,, and social mobilisation activities to educate the community on the importance of TPT for improvement in demand for TPT from the community. incorporation of CBOs as community drug pick-up agents at TPT points and introduce virtual adherence monitoring and follow-up on clients within the 3-month refill cohort. The programme will also address lack of R&R materials and documentation.

6.1.8.2. TB infection Control

The findings of the 2020 End Term review of the 2015 – 2020 NSP show that there are weak infection control principles and practices in both public and private health facilities. The NSP 2021-2026 aims to strengthen the implementation of infection control practices in health facilities as well as ensuring uninterrupted supply of commodities for TB Infection Control (TBIC).

Outcome Targets

Indicator	Baseline (2019)	Target (2026)
Number of Contacts placed on TPT (under 5 and above 5)	10,788	702,076

6.1.9. Childhood TB

The proportion of children among total notified cases has remained lower than the target set by the NTBLCP. In 2019, 8% of notified all forms of TB were children as against the target of 12% set by the 2015 – 2020 NSP target. Findings from the MTR show that case finding for childhood TB is still grossly inadequate, with persistent limited capacity of HCWs to diagnose TB in peripheral facilities. Other factors that affected childhood TB case finding during the years that the NSP has been implemented included: suboptimal utilization of chest X-ray services, inadequate skills and awareness for stool sample testing and other diagnostic methods, out-of-pocket expenses for chest X-rays, lack of engagement and collaboration with child welfare clinics and reproductive maternal and child health clinics, stock-out of paediatric TB medicines and treatment interruptions due to financial constraints, low transportation utilization, lack of adolescent-friendly services and poor data management. There is also low target include weak integration of the TB programme with RMNCAH + N services. In the 2021 – 2026 NSP, the NTBLCP aims to increase the proportion of childhood TB from 8% in 2019 to 13% in 2026. To achieve this, the programme will strengthen the referral system for childhood TB, promote school health services and strengthen the engagement of professional bodies and international bodies in promoting childhood TB services. Efforts will be made to provide children with presumptive TB with free X-rays.

Outcome Targets

Indicator	Baseline (2019)	Target (2026)
Paediatric cases as a proportion of total notifications	8%	13%

6.1,10. Programmatic management of drug-resistant TB (PMDT)

The WHO estimated incident MDR/RR-TB cases were reviewed downwards from 21,000 in 2021 to 15,000 in 2022. Similarly, the estimates of proportion of MDR/RR-TB were reduced for new TB patients from 4.3% in 2020 to 2.5% in 2021 and 19% among previously treated TB cases. Major challenges affecting PMDT implementation is the long turnaround time of getting lab results (DST results), the high delay/gap in enrolment of DR-TB patients for treatment. Nigeria is using a mixed model of DR-TB care (centralized and decentralized). There is also a weak implementation of active drug safety monitoring and management.

In the 2021 – 2026 NSP, the programme plans to increase the proportion of estimated MDR/RR-TB cases notified from 11% in 2019 to 75% by 2026 and to increase the proportion of notified DR-TB patients enrolled on treatment from 83% in 2019 to 100% in 2026. Equally, it aims to increase the treatment success rate from 77% in the 2017 cohort to 80% in 2026. Interventions to be rolled out by the NTBLCP to achieve the targets include: 1) Increase DR-TB case finding; 2) Strengthen Coordination of DR-TB activities by creating a platform for routine meetings at the National and state Programme level; 3) Scale-up of novel oral DR-TB regimen and new drugs; 4) To improve the quality management of DR-TB patients, the Nigeria TB Qual will be expanded to all DR-TB treatment centers and DRTB GOPDs; 5) Further decentralisation of baseline investigations for newly diagnosed DR-TB patients will be carried out; 6) Strengthening active drug safety monitoring and management; 7) the engagement of the community and patient peer groups in ensuring treatment adherence of DR-TB patients; 8) capacity building of TBLS and 8) increased access to baseline investigations. A key component is to expand decentralization of DR-TB services, build health care workers, capacity for psychosocial support for PMDT patients, enhance ACSM, contact tracing and social support and provision of more diagnostic equipment for PMDT.

Outcome Targets

Indicator	Baseline (2019)	Target (2026)
DR-TB: percentage of TB cases tested with DST	58%	80%

DR-TB: Number of cases diagnosed per year (RR- and MDR-TB)	2,384	12,304
Proportion of confirmed DR-TB (RR- and MDR-TB) patients enrolled on treatment	83%	100%
DR-TB: treatment success rate (final treatment outcome)	77%	83%

6.1.11. Supply chain and logistics

There was general availability of medicines across different levels of the supply chain in the country and a functional logistic management system in the period of the last NSP. Proportion of DOTS facilities reporting no stock out of first line anti-TB drugs on the last day of the quarter was 95% in 2019. The MTR of the NSP 2021-2025 identified inadequate storage space and suboptimal storage condition, Funding gap for procurement of TB medicines and diagnostics and supply chain activities, and gap in capacity in quantification and early warning system as the factors impeding progress of implementation.

In the 2021 – 2026 NSP, the programmes will strengthen the supply chain and logistic system to ensure regular availability of drugs and other logistics, and their proper management. This will be achieved through advocating for the construction of FCMS Oshodi mega store and upgrading of state medical stores, conducting regular PSM TWG meetings, onsite LMIS Data Validation and expanding the scope of NHLMIS to capture the state and zonal reports. In the new NSP, a robust system for PV and aDSM in-country will be developed and geospatial monitoring tools to track 3PL deliveries, across all levels will be developed. All the M&E and LMIS tools would be updated to capture all essential information on logistic management.

6.1.12. Strategic information and research

The 2021-2026 NSP will strengthen institutional framework and coordination for HIS at all levels, strengthen capacity to generate, transmit, analyse, and utilise routine health data, from all health facilities, including private health facilities and Improve integration of existing surveillance systems and diseases registries into the overall health information system.

6.2. Programme management and capacity

There has been an overall improvement in programme management and capacity in the NTBLCP since the last NSP. The national programme has strong leadership at the center with

relatively good coordination of activities with engagement of key stakeholders, communities & partners at the state level. All the thematic areas of the programme have focal persons which coordinate the activities of their areas. There are also functioning steering committees of the various thematic areas.

Notably among the improvement in programme management is the roll out of the national electronic TB information management system (NETIMS) which commenced in 2015 with DR-TB reporting and covered DSTB reporting and is operational in all the 36 States and FCT. Challenges with the implementation of this system has meant that the NTBLCP, in partnership with the USAID-funded TB-DIAH is transitioning to a more robust electronic TB information management system. The gradual shift from paper-based to electronic reporting by the programme is commendable. Quarterly harmonization of all programme data from all the States and FCT has resulted in improved data completeness and accuracy.

Major challenges still faced by the NTBLCP in programme management include stock-out of recording tools for both DSTB and DR-TB, inadequate HR capacity at state and facility level to translate data into informed decision and limited capacity for conducting Operational Research at national and state level.

To strengthen programme management and capacity at all levels for the achievement of the NSP target in the 2021 – 2026 NSP, the programme will build the capacity of programme officers at all levels on data management and TB cascade reporting. The NTBLCP will set a mechanism to ensure continuous availability of R&R tools. A new national electronic TB information management system will be developed to improve data reporting and case management. The capacity of programme officers in operational research will be built and some specific surveys and studies will be conducted. Most especially, the country plans to conduct another national TB prevalence survey.

6.3. Performance targets

Stakeholders that participated in the development of the NSP-TB were unanimous in their desire to see the NTBLCP set ambitious targets for the 2021 – 2026 period, given the many opportunities they see to catalyse radical changes in programme performance. The new national targets for TB are presented in Table 16 below

Table 16: National TB control 2019 baseline and 2026 targets for key indicators

Key Indicators	2019 performances	2026 target
Case notification (all forms)	120,266	401,829
Treatment coverage rate	27% (2019)	75%
Treatment success rate	87%	92%
Paediatric cases as a proportion of total notifications	8%	13%
Number of Contacts placed on TPT (under 5 and above 5)	10,788	702,076
Proportion of TB patients with documented HIV status	97%	100%
Proportion of HIV-positive registered TB patients on CPT	92%	100%
Proportion of HIV-positive registered TB patients on ART	91%	100%
DR-TB: percentage of TB cases tested with DST	58%	80%
DR-TB: Number of MDR/RR-TB cases diagnosed	2,384	12,304
Proportion of confirmed DR-TB (RR- and MDR-TB) patients enrolled on treatment	83%	100%
DR-TB: treatment success rate (final treatment outcome)	77%	83%
Proportion of community member with correct knowledge of TB	27% (2017)	75%
Proportion of TB patients affected by Catastrophic cost due to TB	71% (2017)	0%
Proportion of TB budget funded by Domestic Resources	8%	50%

6.4. NSP goal, objectives, and strategic interventions

This NSP-TB is set within the overall framework of the NTBLCP's vision and mission for TB control in Nigeria as presented below. This NSP describes in detail the steps that the NTBLCP and all its partners must take within the next five years to address urgent challenges in TB control and to move Nigeria closer to the ultimate aim of the programme, namely a Nigeria free of TB. It is the explicit intention of the NTBLCP to reach or exceed global targets for TB

control as quickly and expediently as possible, recognising that some targets are achievable within the scope of this five-year plan, while others will require longer-term efforts to bring Nigeria up to international standards.

Vision of the NTBLCP's TB efforts

A Nigeria free of TB

Mission of the NTBLCP for TB

Nigeria free of TB, expressed as, “zero death, disease and suffering due to TB”.

Goal of the NTBLCP

End TB epidemic in Nigeria

Goal of the current NSP

The overall goal of the NTBLCP Strategic Plan 2021–2026 is to accelerate efforts at ending TB epidemic in Nigeria by ensuring access to comprehensive and high-quality patient centered and community-owned TB services for all Nigerians

The NTBLCP and its partners will achieve the goal of providing universal access through a coordinated and client-centered approach that establishes systems and interventions that best serve people with TB. Accordingly, the NTBLCP and partners are committed to the objectives and strategic interventions presented in table 15 below, which are further elaborated into activities in the operational and technical assistance plan.

Table 17: NSP goals, objectives, interventions and key indicators and targets

Goal	To accelerate efforts at ending TB epidemic in Nigeria by ensuring access to comprehensive and high-quality patient-centred and community-owned TB services for all Nigerians
Impact Indicator and Target	<ul style="list-style-type: none"> * TB mortality rate decrease by 75% relative to 2016 level * To reduce catastrophic cost to 0% by 2026
Objective 1	To increase TB case notification rate for all forms of TB from 60 per 100,000 population in 2019 to 164 per 100,000 population in 2026 through universal scale up of patient-centered quality TB services addressing the need of all populations
Key Indicators and Targets:	<ul style="list-style-type: none"> 1. Case notification rate of all forms of TB increases from 60/100,000 in 2019 to 164/100,000 in 2026. 2. Number of all forms of TB cases notified annually increases from 120,266 (2019) to 401,829 in (2026). 1. Treatment coverage rate increases from 27% in 2018 to 75% in 2026

	2. Percentage of TB patients tested using WHO rapid test at the time of diagnosis increases from 58% in 2019 to at least 80% in 2026	
Strategic Interventions for Objective 1	Strategic Interventions	Activities
	Improved human resource and capacity development of TB laboratory personnel at all levels of laboratory services	<ol style="list-style-type: none"> 1. Review policy on human resource acquisition and retention 2. Develop TB laboratory training, materials, programmes, plans and manuals/SOPs for all facilities 3. Develop a national TB diagnostic Manual of operation 4. Conduct annual training and retraining of TB laboratory personnel on diagnostics and management at all levels
	Strengthen and scale up TB diagnosis at all levels	<ol style="list-style-type: none"> 1. Increase on the number of Gx sites from 398 in 2020 to 654 sites by 2026 2. Increase the number of microscopy centers from 3,106 to 3,727 by 2024 3. Hire the services of 2 maintenance Engineers biannually 4. Increase the number of functional TB Reference laboratories from 10 to 15 by year 2023 5. Increase LPA sites for both first- and second-line DST 6. Increase capacity for culture (solid & liquid) and DST among all TB culture labs 7. Review of TB diagnostic algorithm to accommodate new innovations 8. Sensitisation and awareness of all stakeholders on TB diagnostic network services 9. TB laboratory network assessment (mid and end term reviews) 10. Development and monitoring of key performance indicators at all levels of TB laboratory network. 11. Mapping service point areas including sample referral in six geo-political zones to reduce diagnostic delays due to lack of equipment or breakdown 12. Develop and distribute manual for sample transport system and M&E framework to track key indicators 13. Review existing QA guidelines, plans, and training materials for Laboratory Quality Management System (LQMS) twice in the NSP period 14. Expand and maintain infrastructure and biosafety for TB culture and DST 15. Establish performance-based incentives such as recognising best performing labs, certificates, personnel recognition within the laboratory 16. Training of clinicians on the clinical and programmatic management of TB for public and private practitioners. 17. Scale up free chest X-ray services for children and adults to Secondary and Tertiary Health Facilities
	Strengthening TB laboratory Quality Management System (LQMS) at all levels of the network	<ol style="list-style-type: none"> 1. Training of laboratory personnel on basic QMS activities

	National TB reference laboratories accreditation programme	1. Enrol the National TB Reference laboratories in accreditation programmes.
	Scale up of novel oral DRTB regimen	1. Increase capacity of diagnostic laboratory using the WHO rapid molecular tools- culture (solid and liquid) and DST among all TB culture labs
	Establishment of TB policy in workplace	Engagement of authorities of Ministries of Labour & Interior to adopt and implement TB services in workplace
	Improve active case finding among key populations (HIV infected individuals Contacts to active TB cases, Nomads, Migrants and IDPs, Prisoners, Slum dwellers, Children, Miners, Inmates of Police Cells, Diabetes Mellitus)	<ol style="list-style-type: none"> 1. Conduct active contact tracing and screening regularly 2. Targeted active case finding among Nomadic/Migrant population 3. Establishment and implementation of TB services in IDP camps 4. Regular screening of inmates of Nigerian Correctional Service Centres/Police cells for TB 5. Adoption and implementation of WHO TB/DM Guidelines 6. Targeted active TB case finding among Miners like Quarries
	Integrate one health approach (zoonotic TB)	1. Adoption and implementation of the one health strategic plan 2019-2023
	Strengthen and scale up OPD screening for TB	Scale up screening of clients at all SDP and TB cascade recording/reporting in high volume health facility settings.
	Scale up TB services to all health facilities	Expansion of TB service to all Health facilities without TB services at all levels (both Private and Public)
	TB in Emergency/ Crisis	<ol style="list-style-type: none"> 1. Review, print and disseminate the national SOP on managing TB during emergency/crisis situation 2. Establish linkage with relevant emergency management agencies and other stakeholders (SEMA, MoH, state NLC/TUC, UN-HCR, WHO, UNICEF, Red Cross, MSF, State Disaster Management Committee, etc.) 3. Provide supervisory supports to the camp clinic/platform
	TB in Lung Health	<ol style="list-style-type: none"> 1. Develop technical and operational guidelines on PAL 2. Establish a national working group (NWG) to assess the epidemiological situation of respiratory diseases 3. Establish intra- and inter-organisational coordination bodies for the PAL strategy
Objective 2	To achieve and sustain TB treatment success rate of 92% by 2026	
Key Indicators and Targets	Treatment success rate for new drug-susceptible TB increases from 87% (2019) to 92% (2026). Proportion of annual LTFU not more than 5%	
Strategic Interventions	Strategic Interventions	Activities
	Ensure TSR among TB patients supported by TS is $\geq 90\%$	<ol style="list-style-type: none"> 1. Provision of social support to patients as motivation for treatment completion 2. Advocacy to the state, LGA and community stakeholders
	Care and Support for TB Patients	1. Inclusion of TB Treatment and Care in Social Welfare Packages

Objective 3	To enhance childhood TB detection and treatment through innovative provision of integrated services towards achieving childhood TB proportion of 16% among all forms of TB cases.	
Key Indicators and Targets	1. Proportion of total cases notified represented by paediatric TB cases increases from 8% (2018) to 13% (2026).	
Strategic Interventions	Strategic Interventions	Activities
	Align treatment capacity scale-up with increased diagnostic capacity to reach a treatment success rate of 95% in children by 2025	1. Provision of social support to reduce financial barriers to accessing care for child TB 2. Build capacity of STBLCPM, LGA PHC coordinators, State programme staff, LGA TBLS and other health care workers on child TB including contact investigations, TPT and recording and reporting
	Strengthen the referral system between the peripheral facilities and tertiary/secondary institutions to improve case management of complications and more severe forms of TB in children	Linking of peripheral facilities to one tertiary/secondary hospital using the spoke and hub system
	Increase awareness of child TB among children through promotion of school health services	1. Sensitisation/orientation of school children on TB
Objective 4	To increase proportion of estimated MDR/RR-TB cases notified from 11% in 2019 to 75% by 2026	
Key Indicators and Targets	DR-TB cases notified annually increases from 2,384 in 2019 to 12,304 in 2026	
Strategic Interventions	Strategic Interventions	Activities
	Strategically improve access to DR-TB diagnosis	Universal Access of DR-TB patients to LPA /Culture and DST.
	Strategically implement active case finding for DR-TB	Contact tracing and chest-xray for Presumptive TB cases
Objective 5	To increase the proportion of enrolled DR-TB patients from 83% in 2019 to 100% in 2025	
Key Indicators and Targets	Proportion of notified DR-TB patients enrolled on treatment increases from 83% in 2019 to 100% in 2026. Treatment success rate increases from 77% in the 2017 cohort to 83% in 2026.	
Strategic Interventions	Strategic Interventions	Activities
	To strategically scale up treatment for DR-TB in Nigeria	1. To Strengthen Coordination of DR-TB activities by creating a platform for routine meetings at the National and State Programme level 2. Establish DR-TB treatment centers in the remaining 9 states of the federation without a Treatment center
	Scale of novel oral DR-TB regimen	1. Capacity building of health care workers to implement the new oral MDR-TB regimen
	Scale up of quality improvement (QI) systems: Nigeria TB Qual to all DR-TB treatment centers and DRTB GOPDS.	Setting up of Quality improvement teams in Health facilities
	Reducing time of enrolment of DR-TB patients.	1. Provision of portable ECG machines to every OPD site in each state to ensure prompt clinical decision-making
Objective 6	To rapidly scale up TB preventive services with the number of persons receiving TPT increasing annually from 121,784 in 2019 to 702,076 by 2026	

Key Indicators and Targets		
Strategic Interventions	Strategic Interventions	Activities
	Strengthen Contact Investigation and TB Preventive Therapy in children/adolescent	Scale up contact investigation among children of bacteriologically positive TB cases
	Infection Prevention and Control	1. Strengthen infection control committees and plan in all facilities.
Objective 7	To improve access to quality TB care through comprehensive engagement of all private care providers with the sector accounting for 35% of notified TB cases by 2026.	
Key Indicators and Targets	Proportion of case notification contribution by private sector increase from 14% in 2019 to 35% in 2026.	
	Strategic Interventions	Activities
	Enforcement of the memo on mandatory reporting of TB in the private sector.	<ol style="list-style-type: none"> 1. Advocacy to each state private health facility regulatory body to enforce the NCH memo on compulsory TB reporting. 2. Advocacy and sensitisation to professional regulatory bodies e.g., Medical and Dental council of Nigeria (MDCM), Pharmaceutical Council of Nigeria (PCN), Medical Lab Science Council of Nigeria (MLSCN), Nursing and Midwifery Council 3. Sensitisation meetings with private providers' associations 4. Sensitisation of LGA Medical Officer of Health on mandatory TB case notification by private facilities 5. Development, printing, and dissemination of SBC materials on mandatory reporting of TB 6. TBLS to get the update on TB data notification from private facilities from the MOH during quarterly supervisory visits 7. Subject to availability of funds and government support for sustainability, provision of incentives/enablers for non-engaged PPM facilities reporting TB cases
	Enhance the capacity of private facilities to diagnose and treat childhood TB	<ol style="list-style-type: none"> 1. Regular capacity building sessions on diagnosis and treatment of childhood TB 2. Facilitate access to clinical diagnosis for childhood TB through free chest X-ray and linkages with radiologists 3. Regular on-site mentoring of private providers by paediatricians on diagnosis of childhood TB 4. Continuous medical education of private providers on policy changes in management of childhood TB
	Systematic screening of OPD attendees for TB	<ol style="list-style-type: none"> 1. Sensitise management of private facilities and providers' association on the benefits of OPD screening 2. Provide R&R tools to enhance effective OPD screening 3. Monitor the processes and yield from OPD screening
	Inclusion of TB prevention, diagnosis (GX, DST) and treatment (1st and 2nd line) services, according to national guidelines, in the NHIS scheme	<ol style="list-style-type: none"> 1. High level advocacy visits to Executive secretary, NHIS to include TB services in the scheme 2. Facilitate actuarial analysis to determine the cost of including TB services in NHIS (in collaboration with the NHIS)

Strategic Interventions		3. Inclusion of National TB control team in the development of the new guideline for NHIS
	Expand engagement of private sector in TB service delivery	<ol style="list-style-type: none"> 1. Mapping of all private health facilities (PPMVs, CPs, Labs, nursing homes, maternity, and hospitals) 2. Rapid assessment of unengaged private facilities to determine potential for yielding TB cases 3. Selection of private facilities for training and engagement 4. Signing of MOU 5. Training of private care providers 6. Capacity building for implementers 7. Provision of working tools for PPM TB services 8. Empower more stand-alone laboratories with GeneXpert machines and other advanced diagnostic tools to diagnose TB 9. Regular monitoring and supportive supervision in the private sector 10. Incentives for the private sector to report 11. Engagement of Linkage Coordinators for the private sector 12. Scale up the use of TB notification app to non-engaged private providers to enable notification of all TB cases 13. Scale up electronic notification and reporting to all private healthcare providers 14. Expand procurement and supply chain network to include all engaged private facilities and labs
	Strengthen linkage systems between first points-of contact in communities (PPMV, CP, traditional healers, traditional and religious leaders) and PPM referral facilities	<ol style="list-style-type: none"> 1. Advocacy to CAN, NAFSAT, other leadership of large denominational religious groups, association of traditional healers and rulers (where they exist) at sub-national level 2. Sub-national TB control programme to facilitate bi-annual meetings between the first points-of-contact for health care in the communities and the PPM treatment facilities 3. Directory of nearest PPM referral facilities to be disseminated to all first points-of-contact
	Engage professional bodies and academic institutions to support training, task shifting and/or other RSSH activities	<ol style="list-style-type: none"> 1. Orientation of professional bodies on TB control 2. Inclusion of umbrella bodies of private facilities in TB control activities (e.g., TWG) and support for attendance of implementers at annual scientific conferences of professional bodies 3. Provide incentives and enablers e.g., support CME/CPD (Continuous professional development) activities, provision of tax holidays for engaged private TB service providers
	Improve implementation in accordance with the PPM guideline	<ol style="list-style-type: none"> 1. Print and disseminate PPM guidelines at sub-national, district and facility levels 2. Hold quarterly meetings of the PPM steering committee at the national level and communicate the meeting outcome to sub-national and district levels

		3. Incorporate the PPM content of TB control strategy into existing TB/HIV TWG at sub-national levels (where they exist)
	Improve Infection control practices at most private health facilities	1. Orientation of health workers on appropriate infection control practices for TB 2. Regular meetings on Infection Control at all referral PPM facilities and support them with available infection control materials
	Improve integration of TB/HIV services	1. Set up one-stop shop for TB/HIV services in the private sector 2. Include private sector in TB/HIV TWG at national and sub-national levels
	Scale-up of quality improvement initiatives from 12 states to 36 states	1. National stakeholder engagement meeting 2. Engagement of State Ministries of Health, State TB control programs and Site leadership 3. Administration of baseline assessment tools 4. Trainings on quality improvement 5. Granular site management 6. Distribution of NigQual TB guideline 7. Support implementation, monitoring and evaluation of site-based QI projects 8. Implementation of an Improvement collaborative 9. Patient-centered care to improve health outcome
Objective 8	To strengthen provision of integrated services for all co-infected with TB and HIV, Patient with Diabetes, and other co-morbidities	
Key Indicators and Targets:	1. Percentage of TB patients with documented HIV status increases from 97% in 2019 to 100% in 2026. 2. Percentage of co-infected TB patients placed on ART to increase from 91% in 2019 to 100% in 2026	
Strategic Interventions	Strategic Interventions	Activities
	Reduce the burden of TB in people living with HIV and initiate early antiretroviral treatment (the Three I's for HIV/TB)	1. Intensify TB screening of all eligible persons during HIV testing and for all PLHIVs at every encounter. 2. Leverage on HIV community testing/outreaches (HIV surge states) to screen for TB. 3. Intensify clinical screening using chest X-ray for all new HIV positive clients and presumptive PLHIVs with high index of suspicion with negative Xpert MTB/RIF result. 4. Introduce 3 months of weekly isoniazid and rifampentine, (3-HP) as TPT. 5. Continuous engagement of tertiary and secondary facilities on need for TPT among all PLHIVs including positive pregnant women (PPW). 6. Institutionalize one stop shop (OSS) for TB/HIV services at all PMTCT sites and OSS centers for key populations. 7. Referral services for all newly diagnosed HIV patients 8. Provide close supervision to HCWs/adhoc staff at all levels to ensure complete documentation in paper based and electronic tools. 9. Operationalise revised guidelines on management of latent TB infection (LTBI)

		10. Commence and strengthen triage (FAST strategy) of presumptive TB cases at ART sites in all facilities. 11. Strengthen infection control committees and plan in all facilities. 12. Institutionalise annual X-ray testing of all HCWs in all facilities.
	Reduce the burden of HIV in patients with presumptive and diagnosed TB	1. Provision of rapid test kits (RTKs) in all DOT centres and Stand-Alone Labs (SALs) 2. Strengthen referral services for all newly diagnosed HIV patients in low performing states. 3. Strengthen monitoring of co-infected patients
	Intensify case finding for Diabetic mellitus (DM) patients at endocrinology and Geriatrics clinics	1. Introduce TB screening on clinic days at endocrinology and Geriatrics clinics and sample collection from presumptive cases. 2. Improve TB diagnosis among DM patients
Objective 9	To strengthen domestic resource mobilisation with in-country funding of TB budget increasing from 8% in 2019 to 50% by 2026.	
Key Indicators and Targets	Domestic funding for TB control increases from 8% in 2019 to 50% in 2026 TB is included in major national health strategies and initiatives, including the national health insurance scheme	
Strategic Interventions	Strategic Interventions	Activities
	Strengthened Targeted High-Level Advocacy	1. Conduct Stakeholders analysis using influence and power criteria 2. Develop and produce targeted advocacy materials for all identified levels of stakeholders 3. Advocacy to stakeholders at national and state levels 4. Conduct TB media chat (electronic, print, social media), share briefs 5. Conduct advocacy visits 6. Engage corporate bodies and philanthropists for domestic resource mobilisation for in-country financing of TB programs and services 7. Finalise and harmonise the existing ACSM/CTBC strategy/policy documents 8. Establish/strengthen coordination of ACSM/CTBC Core Group in the States 9. Quarterly meeting of ACSM /CTBC subcommittee members at national levels 10. Build capacity of State TB ACSM/CTBC Focal Persons. 11. Form strong/expanded AIDS, TB, and Malaria (ATM) Resource Mobilisation Group (using harmonised advocacy tool kits and Facts-sheets)
	Strengthening Community Systems and Structures for effective participation in TB response	1. Identify, create, and update database of all administrative structures in communities 2. Strengthen capacity of CBOs for effective engagement with community and religious leaders, key population groups and organisations in TB decision making and response 3. Engage Community Health Influencers, Promoters and Services (CHIPS) Program in TB referral

		4. Engage traditional media in dissemination of appropriate TB messages in communities. 5. Support CBOs on community TB implementation 6. Support CSO Networks on community TB Coordination and implementation
	Strengthen World TB Day Campaigns	Constitute Committee and plan for World TB Day
Objective 10	To strengthen community involvement in provision of quality TB care with the community contribution to TB case notification increasing from 22% in 2019 to 45% by 2026	
Key Indicators and Targets	1. Proportion of TB patients referred from community increases from 22% in 2019 to 45% in 2026	
Strategic Interventions	Strategic Interventions	Activities
	Community driven intervention in hard-to reach and high-risk areas	1. Advocacy to stakeholders in the community 2. Mapping of the communities to reach out 3. Selection and orientation of community members 4. Chest camps for TB screening including sputum movement 5. Implement output based (OBA) approach in TB case finding 6. Engagement of security services during the exercise
	Targeted Multi-Channelled Social and Behaviour Change for TB using Media	1. Develop and disseminate Social and Behavioural Change (SBC) materials using promotional materials (Billboards, Posters, Handbills, T-Shirts, Fez- Caps, etc). 2. Develop and disseminate harmonised TB documentary/jingles/messages in local languages 3. Produce feature articles on TB program and services in print media.
	Engagement of the community in TB case finding	1. Advocacy to the state, LGA and community stakeholders
Objective 11	To protect and promote human rights and genders related factors in provision of quality TB services	
Key Indicators and Targets	Establish Baseline	
Strategic Interventions	Strategic Interventions	Activities
	Improved access to TB services with Human Rights and Gender considerations.	1. Conduct human rights and gender analysis to identify gaps for TB implementation 2. Stakeholders’ orientation on human right and gender 3. Patient support to DRTB patients 4. Develop targeted gender specific operational guideline for workplaces and leisure areas 5. Training of DOT providers on the implementation of the Patient Charter as component of patients' pre-treatment counselling. 6. Engage TB survivors, patients, and other key populations actively in human right-based community mobilisation, awareness creation and contact tracing of index cases.
Objective 12	Strengthen programme management and capacity at all levels for the achievement of the NSP target	
Key Indicators and Targets		
	Strategic Interventions	Activities

Strategic Interventions	Strengthen reporting across service delivery points.	1. Joint national annual mop-up of data across all states.
	Capacity building on programme management across all levels of TBLCF.	<ol style="list-style-type: none"> 1. Strengthen Human resource needs of the M&E unit of the NTBLCP CU 2. Strengthen Human resource needs of state TBLCF M&E officers. 3. Strengthen Human resource needs at LGA and Facility level 4. Joint integrated supportive supervision 5. Retraining of GHWs in TB treatment centers across the country.
	Strengthen data quality at all levels.	<ol style="list-style-type: none"> 1. Provide mentoring and onsite data validation visit to the States, LGAs and facilities to ensure quality assurance, improve performance and establish supportive supervisory systems 2. Develop and dissemination of quarterly and annual National and State programme reports. 3. Availability of R&R tools
	Optimize NETIMS (etb-manager, Gx alert/GxAspect, and MATS app)	<ol style="list-style-type: none"> 1. Procure Tablets and Android phones for LGAs and facilities. 2. Scale up e-TB manager to capture community TB activities 3. Establish and maintain a central data bank system for the NTBLCP 4. Recruit 2 IT Specialists to manage NETIMS
	Unlinked facilities report to the NTBLCP	1. Expand TB notification App to unlinked facilities
	Improve data analysis at all levels	<ol style="list-style-type: none"> 1. Procure Statistical and Data visualisation software (SPSS, STATA, Tableau, 2Epi Info, Arc GIS). 2. Programme review at all levels 3. Capacity building on data analysis and visualisation for national M&E staff. 4. Produce and disseminate fact sheets, score cards and annual reports
	Strengthen M&E systems at all levels	<ol style="list-style-type: none"> 1. Conduct National quarterly M&E Technical working group meeting. 2. Quarterly data validation and harmonisation 3. Develop National and State Strategic and operational plans 4. Provide adequate equipment for M&E operations 5. Support data visualisation at National level
	Include Operational Research session in NSP	1. Support operational research
	Conduct specific TB surveys and studies	<ol style="list-style-type: none"> 1. Conduct TB Catastrophic survey 2. Conduct KAP Survey 3. Conduct an assessment of NETIMS 4. Drug resistant survey 5. Conduct TB prevalence survey. 6. Mid Term review NSP 2021-2025. 7. End Term review NSP 2021-2025 8. Conduct patient pathway study.

Strengthen coordination mechanisms for delivering integrated TB and HIV services at the national, state and health facilities.	<ol style="list-style-type: none"> 1. Biannual TB-HIV Technical Working Group meetings 2. Joint supportive supervision to 6 states annually. 3. Quarterly State TB-HIV Technical Working Group meeting 4. Joint supportive supervision to health facilities quarterly. 5. Enhance TB-HIV collaboration in all facilities. 6. Incentivise and recognise facilities that meet and sustain NSP target for TB-HIV indicators.
Development of geospatial monitoring tools to track 3PL deliveries, across all levels	<ol style="list-style-type: none"> 1. Procure a service provider for this activity 2. Roll-out of this service to cover all locations for LMDs
Upgrade of facilities with minimum requirements for good storage	<ol style="list-style-type: none"> 1. Provision of temperature regulating and monitoring devices, cooling systems shelves and pallets for all Federal, Zonal and State stores 2. Develop storage SOPs for DOT facilities that are less dependent on electronic devices 3. Advocacy to State governments to upgrade and insure storage facilities in their States. 4. Relocation of TB commodities to the State CMS; where applicable 5. Provision of funding for the insurance for FCMS
Expansion of the scope of NHLMIS to capture the state and zonal reports.	<ol style="list-style-type: none"> 1. Engage NPSCMP based on the outcome of the stakeholders meeting on the expansion of the NHLMIS platform 2. Quarterly NHLMIS TB data entry meeting (Zones Pharmacists and State team- SLO, M&E, DRTB FP and QAO) 3. Roll out of the expanded NHLMIS across the relevant levels
Develop a robust system for PV and aDSM in-country	<ol style="list-style-type: none"> 1. Use of electronic reporting platforms that allows for instantaneous reporting and sharing of reports (Electronic Pharmacovigilance Monitoring System). Setup of TB expert aDSM committee to conduct causality assessment and signal detections. Setup of TB expert aDSM committee to conduct causality assessment and signal detections. 2. Provision of tablets/devices for reporting on the electronic platforms 3. Quarterly meeting to conduct causality assessment and signal detection on the ADR reported 4. Designation of a Pharmacovigilance officer at the NTBLCP to drive and monitor reporting. 5. Support aDSM and pharmacovigilance committees in the states and facilities 6. Capacity building of FPs at the facilities on PV and aDSM reporting on the electronic platforms
Central level support for the retrieval and destruction of expired medicines across all levels	<ol style="list-style-type: none"> 1. Collection of data of expired and unusable TB medicines and commodities from all Stores and SDPs in accordance with the national waste disposal policy

		2. Transportation and destruction of all expired commodities at Zonal Destruction sites in collaboration with NAFDAC.
	Ensuring availability of good quality TB medicines, laboratory commodities and consumables in the pipeline	<ol style="list-style-type: none"> 1. Provision of packaging/kitting materials for DRTB medicines 2. Monitoring and supervising patient-specific kitting of DRTB medicines at CMS Oshodi 3. Orientation of samplers 4. Sample collection 5. Testing of collected samples 6. Report writing and dissemination 7. Procurement of laboratory equipment, reagents and Consumables for Xpert MTB/RIF, Microscopy, LPA, Culture, C/DST, new molecular tools etc.
	Advocacy to the government to include key PSM activities in the budget and release requisite funds	1. Deploy advocacy tools to facilitate FG, SG and LG buy-in to support PSM activities within their scope. (e.g., HR support)
	Advocacy to government and partners to ensure prompt release of budgeted funds for procurement of TB medicines/commodities.	<ol style="list-style-type: none"> 1. Engage the ACSM team to provide TA on the package to use for advocacy to government and partner 2. Regular communication with key FMOH staff and partners and ensure their involvement in relevant national PSM activities
	Funding Support to hold regular PSM TWG meetings & Onsite LMIS Data Validation	<ol style="list-style-type: none"> 1. Quarterly PSM TWG meetings 2. Quarterly 3PL performance monitoring (facilities-To the last mile) 3. Quarterly LMIS validation meeting (FCMS, Zonal, State stores and treatment centers)
	Partner coordination for laboratory activities at sub-national level	<ol style="list-style-type: none"> 1. Quarterly CGAT meetings in collaboration with partners and stakeholders 2. Quarterly TB laboratory technical working group meetings in collaboration with partners and stakeholders 3. Quarterly state Quality Assurance (QA) officers coordination meeting
	Improved human resource and capacity development of TB laboratory personnel at all levels of laboratory services	<ol style="list-style-type: none"> 1. Review policy on human resource acquisition and retention 2. Develop TB laboratory training, materials, programmes, plans, and manuals/SOPs for all facilities 3. Develop a national TB diagnostic manual of operation 4. Conduct annual training and retraining of TB laboratory personnel on diagnostics and management at all levels 5. Laboratory Information System
	Develop operational research capacity	Evaluate use of good quality data to determine TB burden (DS-TB, DR-TB, and TB-HIV), result delivery, client satisfaction, and laboratory performance indicators
	Strengthen operational Research for Childhood TB	<ol style="list-style-type: none"> 1. Institute operational research on incidence and prevalence of child TB 2. Institute operational research on assessing different diagnostic options for child TB 3. Institute operational research on accessing the outcome of TB treatment in children

		4. Institute operational research on assessing the impact of task shifting and different models of child TB integration
	Strengthen Coordination and Governance of Child TB Control	<ol style="list-style-type: none"> 1. Strengthen Coordination of Child TB Control in Nigeria 2. Ensure provision of guidelines and SOPs on child TB 3. Strengthen collaboration with Paediatric associations and other professional bodies 4. Strengthen the capacity of the NTBLCP in child TB control
	Integrate child TB care into RMNCAH + N as well as HIV Service	1. Strengthen collaboration with Child health and nutrition stakeholders
	Strengthen DR-TB surveillance	<ol style="list-style-type: none"> 1. Update Recording and reporting tools for DR-TB 2. Quarterly supervision of DR-TB programme management at all levels 3. Conduct National Drug Resistant Tuberculosis Survey. 4. Review National PMDT guideline scale-up plans and training documents and manuals.
	Pre-service curriculum updated to include current TB control strategies	<ol style="list-style-type: none"> 1. Engagement of umbrella bodies of healthcare professionals e.g., MDCN and other bodies for the introduction of TB into their training curriculum 2. Advocacy to the school of Medicine, Nursing and Health tech for the inclusion of TB in the training curriculum
	Medicines, Vaccines, and other Health Technologies & Supplies	1. Procurement of laboratory equipment, reagents and Consumables for Xpert MTB/RIF, Microscopy, LPA, Culture, C/DST, new molecular tools etc.

7. The monitoring and evaluation plan

7.1. Purpose

The purpose of the M&E Plan for the NSP-TB 2021 – 2026 is to describe how, and by what metrics the programme will evaluate the effect of the strategies and interventions described in the Core Plan on the TB epidemic in Nigeria and monitor progress on implementation of the activities described in the Operational Plan to meet the NSP's goals and objectives. It also briefly describes the current recording and reporting as well as data management systems, summarises the findings of the recent epidemiological analysis conducted by WHO and presents the recommendations of that review. The NTBLCP will endeavour to address those recommendations as an integral part of this NSP-TB.

The objectives of the NTBLCP M&E Plan 2021 - 2026 are to:

1. Track progress and monitor the outcomes and outputs of the NSP-TB 2021 - 2026
2. Build upon the requisite infrastructure for monitoring and evaluation in Nigeria
3. Strengthen the required human resource capacity at all levels from federal, state, LGA and facility level
4. Ensure standardisation of TB indicators and harmonise recording and reporting tools for use by all entities within the NTBLCP
5. Define clear roles and responsibilities in monitoring and evaluation across different levels of the system
6. Facilitate efficient data transmission and feedback flow
7. Facilitate processes for ensuring good data quality and availability at all levels of the health system
8. Promote the use of information and M&E products for policy decision-making and improving quality of service
9. Strengthen mechanisms to ensure dissemination of critical information to all stakeholders
10. Coordinate and strengthen surveys and operations research
11. Mobilise adequate financial and material resources to support full operationalisation of the M&E plan.

7.2. Data management system

The NTBLCP M&E system encompasses the central unit of the NTBLCP, the States and the LGA and focuses on three main aspects: programme monitoring, supportive supervision, and evaluation. Programme monitoring entails the routine tracking of key elements of programme's activities and interventions through careful record keeping and regular reporting at all levels using standardised NTBLCP tools. Supportive supervision encompasses a range of measures to ensure that healthcare workers carry out their activities effectively and become more competent at their work. It involves observing and guiding staff when carrying out their assigned tasks with the purpose of improving their performance against agreed standards. Evaluation is the periodic assessment of programme performance with focus on the effectiveness of interventions, efficiency in resource utilisation and the level of impact achieved. The type of evaluation conducted by NTBLCP system include Mid-term and End-term evaluation of the Strategic plan.

To ensure effectiveness of programme implementation, the NTBLCP has put in place several programme review exercises to help provide periodic evaluation and objective assessment of programme progress against intended objectives. These are quarterly programme review meetings at all levels (Planning cell meeting at the national level, Programme zonal and State level review meetings) with the singular purpose of providing periodic opportunity to review all planned programme activities, its progress towards set targets and use the result to inform key programme decisions where necessary. Data from these various review meetings are also important sources of information to aid improvement in programme management.

The programme also conducts surveillance to collect epidemiological data (i.e., disease outcomes) to track trends in disease incidence or prevalence over time. Routine surveillance is in place to collect routine data from all health facilities in the country providing DOTS services. Special surveys like national TB prevalence surveys are conducted every 10years while national DR-TB surveys are conducted every 5 years.

7.3. Recording and reporting

The NTBLCP Monitoring & Evaluation system starts from the community and peripheral health facility units to the Central Unit of the programme. The process involves the following:

- Data recording and reporting at the facility level by the health worker using the NTBLCP tools.

- Data collation by the LGA TBLs from all the health facilities using the LGA registers and summary tools.
- Quarterly data collation, analysis, and feedback at the state level
- Quarterly data collation, analysis, and feedback at the zonal level
- Quarterly data harmonisation at the national level.

The data collection and collation are done using both paper-based and electronic system. The electronic system of NTBLCP is referred to as National Electronic TB information management System (NETIMS). Presently, NETIMS comprises of the GX alert, etb manager, MATS app and DHIS 2.

7.4. E-TB Manager

The e-TB Manager is an electronic data management information system for TB case management. It is a web-based system, available on the internet. It needs an operational browser and can be accessed using this URL/website link (www.etbmanager.gov.ng). There is also an offline version of the e-TB manager called the eTB mobile. The e-TB manger comprises of the Dashboard and the following modules:

- Registration module
- Laboratory module
- Medicine module
- Management module
- Administration module

Quarterly reports are generated from the e-TB manager through the management module and made available for programme use at all levels. Health workers and all LGA TBLs are to ensure timely recording and the correctness of the information entered in the e-TB manager. As part of its efforts to optimize its electronic data management system, the programme carried out an assessment of the NETIMS in 2022. The outcome of the assessment revealed that there is need to upgrade the e-TB Manager to a more robust system that will be efficient for patient management. The report of the assessment also recommended the need to integrate all systems in the NETIMS. This upgrade and integration will be prioritized during the NSP 2021 – 2026 period.

7.5. Innovations in Data Management

The programme will deploy some innovation in the management of TB data during the NSP period. Some of these new innovations are outlined below.

7.5.1. Xmap

The Xmap is for monitoring the implementation of mobile digital X-rays and instituting a data visualization dashboard for all digital X-ray results to showcase screening across the country. The digital x-ray utilizes artificial intelligence in identifying presumptive TB cases which will be linked to the Xmap to show real-time geographic distribution of the x-rays conducted and the results.

7.5.2. Interactive Voice Response (IVR) for Treatment Adherence

To strengthen case holding and improve treatment outcomes, NTBLCP will deploy an Automated Appointment Reminder (AAR) system in selected states. The AARs will use the Interactive Voice Response (IVR) channel (pre-recorded audio messages) to send reminders to clients' mobile phones a day before their scheduled visits, reminding them of their appointment for follow up tests. The advantage of this technology is that it is not internet- dependent and does not require the procurement of additional devices. It can also be delivered in multiple Nigerian languages like Pidgin English, Yoruba, Hausa, and Igbo in addition to English. Therefore, the AARs transcend geographical, financial, literacy and language barriers faced by most TB patients.

7.5.3. Digital Training

The use of mobile technology for building the capacity of health care workers is one of the innovation the programme will deploy during the lifetime of this NSP. This digital training involves the deployment of training contents through IVR in five Nigerian languages of English, Pidgin English, Yoruba, Hausa, and Igbo using a mobile phone. The technology involves creating an audio training curriculum that consists of individual lessons and both a baseline and end-line survey so we can measure knowledge change because of the course. In addition, a “pull” option is added as a targeted Infoline to complement the digital training, allowing the trainees to re-listen to lessons or listen to any missed lessons at a time that suits them.

7.5.4. Aspect reporter

The Aspect reporter will connect all molecular diagnostic platforms for real-time reporting.

7.6. Community Led Monitoring (CLM) Tool

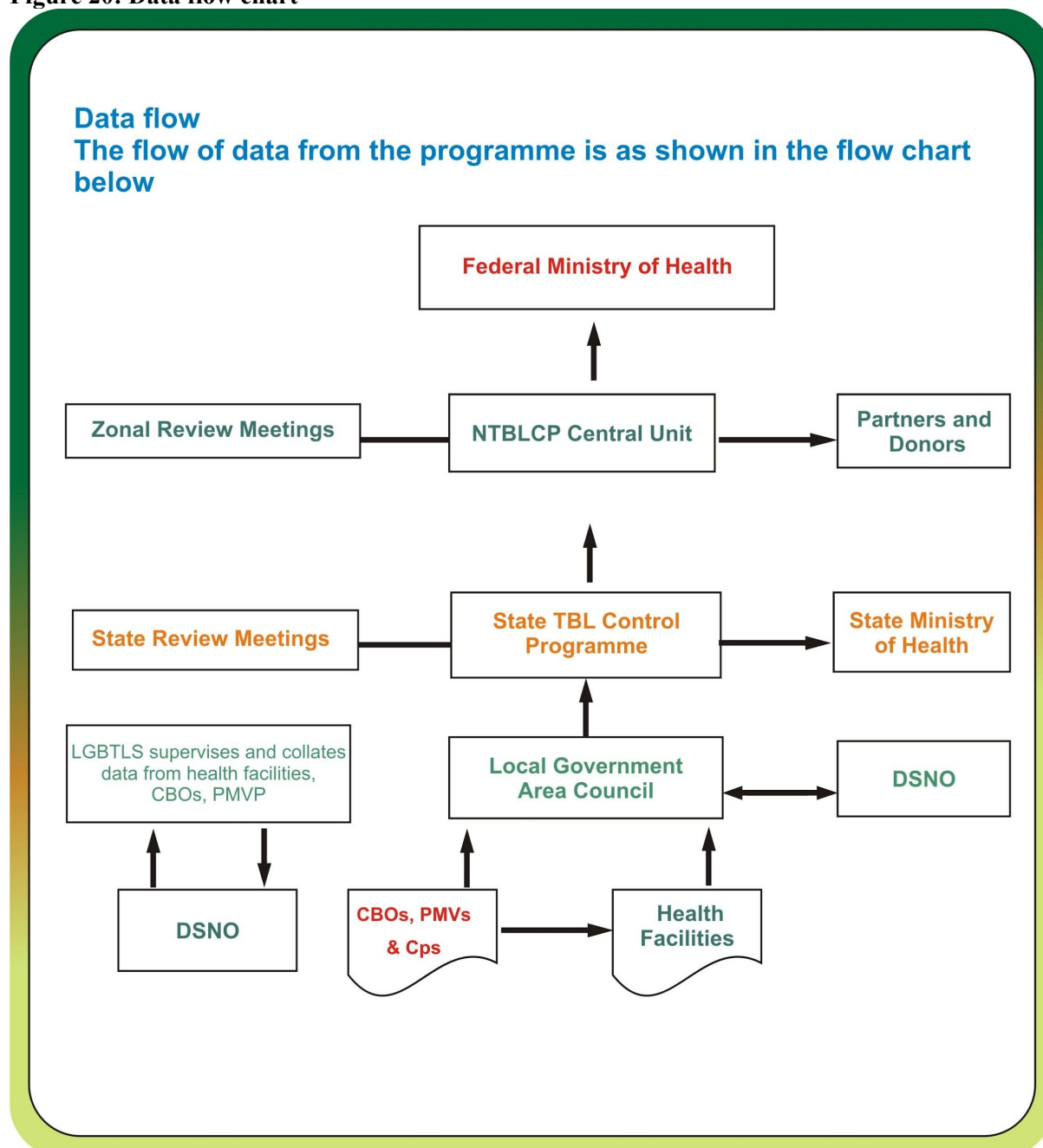
The Community Led Monitoring (CLM) tool has proven to be an empowerment tool for communities. This tool will be deployed during this NSP period. The CLM provides evidence (data) that strengthens advocacy, feedback, and impacts on decision making for improved programming and participation. It also provides opportunity for experience sharing at national and global platforms.

7.7. Flow of information

The NTBLCP recording and reporting tools used at all levels are as in the figure below. It is the responsibility of the designated officers to ensure that the tools are completely and correctly filled. Reporting of TBL and BU data is on a quarterly basis. The timeline for data reporting and management is outlined below:

1. LGA quarterly reports should be ready by the end of the 1st week of every new quarter.
2. State quarterly reports should be ready by the end of the 2nd week of every new quarter.
3. The M&E unit of the central unit should provide data quality feedback to all State programmes at least one week after submission of State data but not later than the end of the 3rd week of every new quarter.
4. Consequently, the M&E unit of the central unit on behalf of the National coordinator of the NTBLCP, should ensure that the national TBL and BU quarterly reports are available for dissemination (including DHIS) by the end of the 4th week of every new quarter.

Figure 20: Data flow chart



A traditional, paper-based system is used in Nigeria, starting from the primary data collection point at health facilities within each LGA (public, some private and some FBO), using standard NTBLCP recording and reporting forms. The health worker at the health facility has the primary responsibility of ensuring that all components of these forms are completed accurately. DOTS services are implemented in most government health facilities especially primary health care centres, secondary health facilities, ART comprehensive centres, FBOs/Mission hospitals, private and prison facilities. GHCWs who are heads of the DOTS clinics in these facilities are responsible for screening individuals who are presumed to have TB, case-finding, infection control and treatment of TB, as well as HIV testing services for TB patients. To effectively

perform these tasks, they receive technical and logistical support from the LGA TBL Supervisors and the State TBL team. Support includes regular supportive supervision, capacity-building through training, technical assistance, and supply of drugs, recording and reporting (R&R) tools and other commodities.

Table 19: TB recording and reporting tools used by the NTBLCP

S/N	M&E formats	Data requirement	Site of use	Freq. of entry
NTBLCP	NTBLCP Recording tools for Drug Susceptible TB activities			
TB 01	Presumptive PTB case Register for DS-TB & DR-TB	Records of patients presenting with symptoms of TB.	DOTS facility/OPD clinics/PMVs/Pharmacies/Outreach/Stand-alone laboratories	Every time clients present themselves for exams.
TB 02A	Specimen Examination Request Form for TB	Request for GeneXpert MTB/RIF assay, AFB smear microscopy and Culture/LPA investigations for patients	DOTS facility/OPD clinics/PMVs/Pharmacies/Outreach/Stand-alone laboratories	Each time specimens are sent to the laboratory for examinations.
TB 02B	Specimen Examination Result Form for TB	Results of AFB smear microscopy, GeneXpert MTB/RIF, and culture/LPA	Laboratory	Every time results of examinations are done at the laboratory
TB 03	TB specimen Dispatch/Shipment Form (Used for both DS-TB & DR-TB)	Movement status of specimen	DOTS facility/ Laboratory/anywhere sputum is being moved from	When moving samples
TB 04	Laboratory register for smear microscopy and Xpert MTB/RIF	Results of AFB smear microscopy and Xpert MTB/RIF	Laboratory	Each time specimen is sent for examinations at the AFB/Xpert lab.
TB 05	TB Patient Treatment Card	Patients primary information, treatment records and progress	DOTS facility	Each time a DS-TB Case is initiated on treatment.
TB 06	TB Patient Treatment Appointment Card	Patient's treatment appointment records	DOTS facility	Each time a DS-TB Case is initiated on treatment.

TB 07	TB Patient Treatment Supporter (TS) card	Patient's daily treatment records at home or at the community level	Home/Community	Each time a TS is engaged for a DS-TB Case.
TB 08	TB LGA/Facility Register--	Patients' primary information, treatment records and progress	DOTS facility/LGA	Each time a DS-TB Case is initiated on treatment.
TB 09	Facility TB Contact Management Register	Daily records and progress of TPT in-take	DOTS facility	Each time a client is placed on TPT.
TB 10	TB Index patient contact investigation form	Contacts of index patient information	DOT facility	Each time a contact of an index TB case is traced and investigated for TB.
TB 11	TB Preventive Treatment (TPT) Card	Daily records and progress of TPT in-take	DOTS facility	Each time a client is placed on TPT.
TB 12	TB Referral form for community and facility	Records of presumptive TB Cases referred from the community/ Patient's up-to-date treatment status	Community	Each time a presumptive TB Case is identified in the community/ Each time a client needs to be referred or transferred to another service point.
TB 13	TB Referral Register for community	Records of presumptive TB Cases referred from the community	Community	Each time a presumptive TB Case is referred for examination.
TB 14	Treatment Interruption Tracing Form	Records of actions taken to retrieve TB Patients who interrupt treatment	DOTS facility	Each time a DS-TB Case interrupts treatment.
TB 21	Facility Outpatient Department (OPD) Screening Tool	Record of all OPD attendees clinically screened for TB	OPDs of facilities	Each time a patient visits any OPD unit in a facility
TB 22	TB Symptomatic (Clinical) Screening Tool for Correctional Facilities	Record of all inmates is clinically screened for TB	Correctional Facilities	Each time an inmate is screened for TB

NTBLCP Recording tools for Drug Resistant TB activities

DR-TB 01	Laboratory register for AFB smear microscopy/culture and drug susceptibility testing (DST)	Results of smear/Culture and DST	Laboratory	Each time specimen is sent for exams at the AFB/Culture & DST lab.
DR-TB 02	DR-TB Patient Referral/Transfer Form	Details of patient. Details of facility referring, and facility discharged to	DOTS facility/ DR-TB Treatment centre	Each time a DR-TB patient is being referred or transferred from one service point to another.
DR-TB 03	DR-TB Patient Treatment Card	Patients' primary information, treatment records and progress	DOTS facility/ DR-TB treatment centre	Each time a DR-TB Case is being enrolled for treatment.
DR-TB 04	DR-TB Patient appointment/Hand Card	Patients' details of daily intake of drugs, follow-up lab results, details of referring sites	LGA/DOTS facility/DR-TB treatment centre	Each time a DR-TB Case is being enrolled for treatment.
DR-TB 05	DR-TB Treatment Register	Patients' primary information, treatment records and progress	DOTS facility/DR-TB treatment centre	Each time a DR-TB Case is being enrolled for treatment.
DR-TB 06	Discharge form (from DR-TB Treatment centre to DOTS Facility)	Patients' treatment and referral details.	DR-TB treatment centre	Each time a DR-TB patient is being discharged from the treatment centre.
DR-TB 07	Laboratory Tracking Logbook for Samples sent for Culture and DST for Reference Laboratory	Movement status of specimen	DOTS facility/ Laboratory/anywhere sputum is being moved from	When moving samples

NTBLCP Recording tools for LMIS activities

LMIS 01	Delivery Voucher	Evidence and details of delivery of Drugs or Commodities	National, Zonal and State Levels	Each time delivery of Drugs or Commodities are being carried out.
LMIS 02	Stock Card	Details of transaction of Drugs or commodities	All levels (Facility/Lab/LGA/State store/Zonal Store/CMS	Each time a transaction is being executed.

LMIS 03	Record for Returning/Transferring (RT) form	Details of Returning or Transferring of Drugs or commodities	Facility Levels	Each time Drugs or Commodities are being Returned or Transferred.
LMIS 04	QRRIF for LAB	Details of Quarterly Facility, LGA or State lab consumables utilisation and request	All Levels	At the end of every quarter or when an emergency order is executed.
LMIS 05	QRRIF for DRUGS	Details of Quarterly Facility, LGA or State Drugs /Commodities utilisation and request	All Levels	At the end of every quarter or when an emergency order is executed.
LMIS 06	QRRIF for R&R TOOLS	Details of Quarterly Facility, LGA or State R&R tools utilisation and request	All Levels	At the end of every quarter or when an emergency order is executed.
LMIS 07	Adverse Drug Reaction (ADR) form	Details of symptoms and signs of adverse drug reactions	Facility/LGA Levels	Each time there is an adverse reaction to anti-TB medicines.
LMIS 08	Active Drug Safety and Monitoring Form	Details of adverse events/adverse drug reactions from new TB medicines/ new regimens	OPD Doctors/Facility	Each time there is an adverse reaction to new anti-TB medicines.
LMIS 09	Laboratory Stock card	Summary of the workload in the laboratory	Laboratory	At the end of every workday.
LMIS 10	Facility Issue Voucher	Details of the quantity of commodities that move from the facility pharmacy/store to the nursing bay/ward (intra-facility logistics transaction tool).	Facility	At the end of every week

E-tb manager (Electronic register): Update on a daily and weekly basis

S/N	M&E formats	Data requirement	Site of use	Freq. of entry
NTBLCP	NTBLCP Reporting tools for Drug Susceptible TB activities			
TB 15a	Quarterly Summary form for presumptive TB cases & TB cases - case finding by LGA/Facility	Report on Presumptive and TB cases detected in the quarter under review by category	LGA/State/ Zonal/ National	Quarterly, Annually
TB 15b	LGA Quarterly Report on TB Case Finding Form	Report on TB cases detected in a quarter by category	LGA/State/ Zonal/ National	Quarterly, Annually
TB 16	Quarterly Sputum Conversion Report form	Report on treatment outcome of TB cases started on treatment 3-6 months earlier	LGA/State/ Zonal/ National	Quarterly, Annually
TB 17	Quarterly TB Cohort Report Form	Report on treatment outcome of TB cases started on treatment 9-12 months earlier	LGA/State/ Zonal/ National	Quarterly, Annually
TB 18	Quarterly report form for newly established DOTS & Microscopy centres	Report of all newly established DOTS and Microscopy centres in the quarter under review	LGA/State/ Zonal/ National	Quarterly, Annually
TB 19	Quarterly quality assurance report form	Report on EQA activities in the quarter under review	State/Zonal/ National	Quarterly, Annually
TB 20	Quarterly GeneXpert Summary form	Details of Laboratory activities using Xpert machine	State/Zonal/ National	Quarterly
NTBLCP Reporting tools for Drug Resistant TB activities				
DRTB 08	DRTB Quarterly Line listing	Details of all DRTB cases diagnosed and enrolled in a quarter	LGA/State	Quarterly
DR-TB 09	Quarterly Report on DR-TB Cases Enrolment report	Details of DR-TB Case Notification	LGA/State/ Zonal/ National	Quarterly

DR-TB 10	DRTB Interim Outcome Assessment	Details of patient culture & DST result after intensive phase of treatment	LGA/State/ Zonal/ National	Quarterly
DR-TB 11	DRTB Treatment Outcome of patients on second line treatment	Details of patient treatment outcome at end of treatment	LGA/State/ Zonal/ National	Annually
DR-TB 12	Treatment Centre Trackers	Summary of all referrals and enrolments at treatment centres	Treatment Centres only	Quarterly
DR-TB 13	DRTB Medicine Tracker	Monitors the daily issues of medicines to patients at the DOT centre	Facility/Treatment supporter	Daily

7.8. Data storage

NTBLCP has a backup policy to safeguard NTBLCP data, prevent the loss of data in the case of accidental deletion or corruption of data, system failure or disaster and to permit timely restoration of information in case such events should occur. The policy stipulates that data from NTBLCP, STBLCP and LGA TBLS are stored in waterproof and fireproof locations as well as on dedicated desktop computers designed for this purpose. Currently, data storage and back-up is done on personal computers at the zonal level (WHO NPOs) and the national level (NTBLCP). There is currently no server for shared TB data management and storage.

Waterproof files: Records of patients on treatment, as well as patients who have completed treatment should be stored in individual folders and where possible, waterproof files and folders to ensure easy retrieval and protection from rains or flooding. In line with the Federal Government of Nigeria policy of document archival, all project and patient medical records must be kept safe for at least 5 years after the expiration of the project.

Fireproof/security shelf: This will be used to store paper-based recording and reporting tools like treatment cards, registers, and forms. The storage facilities will be provided and ensure utilisation at all levels of data generation within the health system from National, State, LGA to health facility as well as community level.

External backup/ hard drives: All electronic data from state to national level should be systematically backed up using an external hard drive. External backup/ hard drives that are

used for storage/ backup must be stored securely in a locked safe and at a sufficient distance away from the original data to ensure both the original and backup copies are not compromised.

The computer server: The use of a relational, open-source database will allow data to be backed up on a server which will give users equal rights over the internet, sharing of files and storage of files produced by each user. The method provides a network for all users to access the server. This will enable all data generated by each user from service delivery points to be saved on the server. At intervals, the server will automatically backup all the data on all the workstations connected to the network at a scheduled period. Consequently, a unified server system will be established at NTBLCP to allow for effective coordination and management of programme data and information systems. Where this is not possible, NTBLCP M&E team in collaboration with the IT unit will seek for suitable alternatives within the country e.g., GALAXY Backbone.

7.9. Data Access

The NTBLCP is the sole custodian of all TBL & BU data in the country. However, the NTBLCP has put in place a system which guarantees access to data for programme planning, decision making and research purposes at all times. The current NTBLCP data management system captures patient level information, which must be managed in line with the principle of confidentiality. Individuals or groups who intend to access TBL & BU data from the NTBLCP should follow the standardised NTBLCP data accessing process which entails that a formal request is submitted to the National coordinator. Furthermore, the dashboards of the NETIMS (e-TB manager, Gx Alert etc.) are linked to the NTBLCP website <http://ntblcp.gov.ng/> for open access.

7.10. Data products, dissemination, and use

7.10.1. NTBLCP annual report

The annual report provides a brief description of activities implemented during the year and evaluates progress on the objectives of the National Tuberculosis, Leprosy and Buruli Ulcer Control Programme. It also provides information on the country progress towards the achievement of global targets for TB control. The annual report is distributed to stakeholders, partners, state TBL control programmes, CSOs, relevant government ministries, departments and parastatals and donors in hard copy or electronically.

7.10.2. NTBLCP website

As part of this NSP, NTBLCP will upgrade its website to provide relevant TB data to public users.

7.10.3. NTBLCP fact sheet

As part of this NSP, NTBLCP will produce a fact sheet on quarterly and annual basis to showcase progress and achievements in meeting the set goals and objectives of the NSP.

7.11. Data quality assurance

Data quality is a measure of the fitness of data for decision making. Data quality involves ensuring the accuracy, timeliness, completeness, and consistency of data used for decision making. Good quality data depends not only on the availability of the tools but also on the appropriate, complete, and accurate documentation of data in relevant tools.

7.12. Zonal and state review meetings

The NTBLCP conducts two (state and zonal) quarterly review meetings which are used for data verification and validation. Identified inconsistencies are reconciled where feasible; where not feasible, feedback is provided to the lower levels to reconcile the data using primary source documents. Zonal and state TBL review meetings improve the timeliness of reporting to the national programme. The state meetings usually take place within two weeks of the beginning of a new quarter, while the zonal meetings usually take place between the third and fourth week of a new quarter. During the meetings, state or zonal-level data are compiled and a data audit performed.

7.13. Onsite data validation exercises

This is a routine M&E activity designed to improve the quality of reported data across all relevant levels; from the health facility to LGA and the state. The exercise allows for the audit of data by comparing what has been reported to what is obtainable at the source of reporting. This exercise acts as a cross-check for the correctness, completeness and validity of data while checking against over-reporting or under-reporting that may have been caused by human or system error. The NTBLCP regularly conducts OSDV to states on a quarterly basis with the support of partners. States noted to have consistent data quality issues are visited and supported

most frequently. Similarly, those observed not to have problems are visited to verify the authenticity of the reports.

7.14. Data Quality Assessments

Data Quality Assessments are carried out bi-annually with the aim of providing technical assistance to enhance the existing quality assurance system. The aim of the DQA is to assess data that have been reported over a longer period and assess the M&E system of the reporting structures at the LGA and states level. This exercise is usually participatory in nature and involves multiple stakeholders and partners of NTBLCP. A report is presented to document the findings of the stakeholders and recommendations are expected to be implemented at LGA, state and national level.

7.15. Supportive supervision

This activity involves visit to states and health facilities to provide mentorship and support for all the components of the TB control programme. This includes advocacy visit to canvass for political commitment for the TB control programme at state and LGA level. It also extends to supervising the management of the TBLCP, including the procurement and supply management of commodities, drugs and R&R tools and data management. Supportive supervision is done quarterly. States identified as challenged states based on some set criteria are prioritised by NTBLCP for supportive supervision using the appropriate revised supervisory checklists. A one-day supervisory meeting is held to collate outcomes and identify follow-up actions.

7.16. M&E coordination

The M&E Technical Working Group (TWG) was inaugurated in November 2011 by the National Coordinator, NTBLCP with membership drawn from NTBLCP, TBCARE, WHO, ARFH, CIHP, FHI360, MSH, IHVN, NASCP, MEASURE Evaluation and ILEP organizations (TLMN, GLRA, NLR and DFB). The main goal of the M&E TWG is to support strengthening of the M&E systems at all levels, facilitate effective utilisation of health information and promote linkages between NTBLCP and other stakeholders. The M&E TWG is scheduled to meet quarterly, however, lack of budget to do so has prevented the TWG from functioning effectively. The terms of reference of the TWG include:

1. Foster the coordination of all M&E activities among different partners, especially TB/HIV implementing partners

2. Provide technical guidance to partners in addressing M&E issues
3. Engender the promotion of best practices around TB/HIV M&E
4. Strengthen linkages between the M&E, laboratory, and logistics systems within the programme
5. Develop SOPs for management of data discrepancies at all levels of the programme
6. Develop data feedback/dissemination mechanism for the programme at all levels
7. Undertake periodic review of the NTBLCP M&E Plan.

7.17. Technical Assistance from WHO

The WHO country team and global staff play a vital role in strengthening the coordination and managerial role of the NTBLCP. This includes technical assistance across the different components of programme management, survey coordination, proposal development, evaluation and assessment/review activities, policy development and strategic plan development. The WHO National Programme Officers also facilitate coordination and regular review of quarterly statistical data generated by the states at zonal and national level. This review includes analysis and recommendations for programme management.

7.18. Special assessments and surveys

In addition to routine monitoring and evaluation activities, the NTBLCP will plan and implement some special assessments and surveys during the NSP period.

7.19. Joint International Monitoring Mission

The National Tuberculosis and Leprosy Control Programme assess its programme, implementation of strategies and follow-up of previous assessments through a Joint International Monitoring Mission (JIMM) every two years. Participants include a team of national and international experts, major partners, federal and state ministries of health, representatives of civil society organisations, the media, and staff of the NTBLCP. Following the conclusion of the mission, recommendations will be made to strengthen the national TB control efforts towards reaching the set objectives and targets. The terms of reference include:

1. Review progress in implementation of the NSP
2. Assess the implementation of the previous JIMM recommendations
3. Assess the implementation of Global Fund grants and make recommendations

7.20. Operations research

Operations research is one of the key components of the Stop TB strategy. NTBLCP in 2010 reconstituted the National Operations Research Committee with the following terms of reference:

1. Review all research carried out in the programme and maintain a research database
2. Provide technical support to programme managers who are currently carrying out operations research
3. Provide technical support to programme managers to publish completed research projects in peer reviewed journals
4. Support capacity-building of programme managers on research
5. Identify and deploy resources for research and support the national programme to participate in conferences
6. Provide support to the development of a national TB newsletter
7. Coordinate and link up with other organisations on TB-related research in the country
8. Provide technical advice to the national programme on changes to national TB policy and guidelines based on findings from local research

8. MONITORING AND EVALUATION OF NSP-TB 2021 – 2026

Monitoring and evaluation of the NSP-TB will continue to follow the practices above and will be aligned with the definitions and guidance provided in the TB & Leprosy Indicator Reference Book. The logical framework presented in figure 21 shows the chain of expected inputs, processes, outputs, outcomes, and impact that the objectives of the NSP-TB comprise. The M&E plan will focus heavily on results—some key outputs and all outcomes associated with the NSP-TB objectives. Routine monitoring of progress on activity and sub-activity implementation will be achieved through the operational plan, which will be reviewed and updated on both a quarterly and annual basis. Interim outcome data analysis will be used to identify implementation challenges at an early stage and correct them to support progress toward the targets. If necessary, activities and approaches will be changed, halted, or added in response to the evidence provided to achieve the desired outcomes.

The overall goal of the NTBLCP is to achieve a 75% treatment coverage rate and 75% reduction in the TB mortality (excludes HIV-related TB) rate in Nigeria by 2026. This translates to increasing case notification rate from a baseline of 53/100,000 population to 142/100,000 population in 2026. While overall impact is important, new data to support evaluation of progress on these impact indicators (in the form of another prevalence survey or improved vital registry data) are not likely to be available during the period of the NSP. In addition to tracking WHO modelled estimates of these indicators, NTBLCP will rely on rapid changes in case notification and sustained treatment success to demonstrate progress.

8.1. M&E Framework for the National Strategic Plan for Tuberculosis, 2021 – 2026

The M&E framework for the NSP-TB with the key indicators and targets is presented in Table 19 below, linked with specific objectives and strategic interventions of the NSP-TB.

Figure 21: M&E Logical framework for the NSP-TB

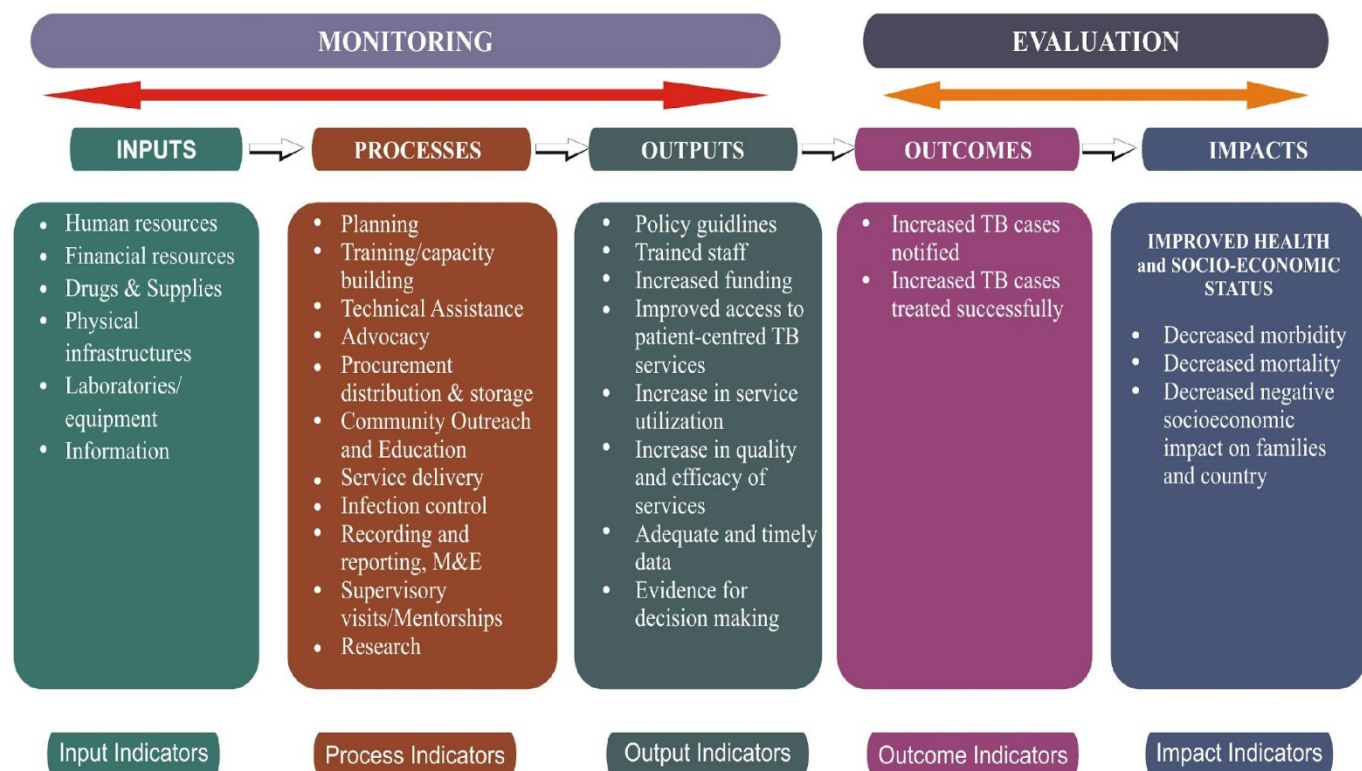


Table 20: M&E Framework for the National Strategic Plan for Tuberculosis, 2021 – 2026

Objective 1: To increase TB case notification rate for all forms of TB from 60 per 100,000 pop in 2019 to 164 per 100,000 population in 2026 through universal scale-up of patient-centred quality TB services addressing the need of all populations										
Ind. No	Indicator	Baseline		Performance target						Data source & frequency
		Year	Value	2021	2022	2023	2024	2025	2026	
Impact Indicators										
1.1	TB incidence rate per 100,000 population	2019	219	217	216	217	218	218	217	WHO Global TB report
1.2	RR-TB and/or MDR-TB prevalence among new TB patients: Proportions of new TB cases with RR-TB and/or MDR-TB	2019	4.3	4.2	4.1	2.4	2.4	2.3	2.2	WHO Global TB report/National Drug Resistance survey
1.3	TB mortality rate per 100,000 population	2019	63	61	59	57	55	53	51	WHO Global TB report
Outcome Indicators										
1.4	Case notification rate per 100,000	2019	60	77	99	142	149	158	164	NTBLCP annual report
1.5	Number of cases notified	2019	120,266	163,098	215,632	320,283	344,547	375,139	401,829	NTBLCP annual report
1.6	Percentage of new and relapse TB patients tested using WHO rapid test at the time of diagnosis	2019	58	65	70	75	80	80	80	NTBLCP quarterly report
1.7	TB Treatment coverage	2019	27%	35%	45%	65%	68%	72%	75%	Global TB Report/ NTBLCP annual report
1.8	Number of all forms of TB notified among nomads	2019	2705	4,234	4,354	4,435	4,788	4,924	5,224	NTBLCP quarterly report

1.9	Number of all forms of TB notified from Correctional centers	2019	546	710	745	887	958	985	1045	NTBLCP quarterly report
1.10	Number of all forms of TB notified among Internally Displaced Persons (IDP)	2019	N/A			5913	6384	6565	6965	NTBLCP quarterly report
Output Indicators										
1.11	Number of facilities (both Private and Public) trained on providing TB treatment services	2019	12,606	22,311	27,311	32,311	36,175	36,175	36,175	NTBLCP annual report
1.12	Number of facilities providing scheme 1 TB services (both Private and Public, TB identification and referral)			5,000	5,942	5,942	5,942	5,942	5,942	NTBLCP annual report
1.13	Number of clinicians trained on the clinical and programmatic management of TB for public and private practitioners	2019		8,207	8,207	4,105				NTBLCP annual report
1.14	Number of new microscopy sites whose personnel were trained on diagnosis of TB	2019	250	100	56	50	50			NTBLCP annual report
1.15	Number of new GeneXpert sites whose personnel were trained on diagnosis of TB	2019	0	100	56	50	50			NTBLCP annual report
1.16	Number of GeneXpert sites renovated and upgraded	2019	0	100	56	50	50			NTBLCP annual report
1.17	Number of established TB Reference Laboratories	2019	10	12	13	15				NTBLCP annual report
1.18	Number of LPA sites	2019	9	11	12	14				NTBLCP annual report
1.19	Number of high-capacity solar power system (inverters, panels, batteries, air-conditioners, fridges) procured and installed	2019	14	200	200	200				NTBLCP annual report

1.2	Manual for sample transport system developed and printed	2019		1,807			1,807			NTBLCP annual report
1.21	Printing and distribution of national biosafety manual	2019		3,377						NTBLCP annual report
1.22	Number of TB LAMP machines procured	2019	5	222	111					NTBLCP annual report
1.23	Number of LF LAM test kits procured	2019								NTBLCP annual report
1.24	Number of Truant machines procured	2019	0	111	74	74				NTBLCP annual report
1.25	Number of above 5 contacts tested for latent TB (Quantiferon Gold TB IGRA, TST)	2019	0	352,292	465,765	585,379	711,389	787,792		NTBLCP annual report
1.26	Proportion of GeneXpert sites performing optimally (testing at least 720 samples every quarter)	2019	4%	30%	50%	60%	70%	80%	80%	NTBLCP annual report
1.27	Number of free chest X-ray performed for adults	2019		560,000	560,000	560,000	560,000	560,000	560,000	NTBLCP quarterly report
1.28	Number of free chest X-ray performed for children	2019		224,000	224,000	224,000	224,000	224,000	224,000	NTBLCP quarterly report
1.29	Number of Under 5 provided with transport voucher for X-ray	2019		159,040	159,040	159,040	159,040	159,040	159,040	NTBLCP quarterly report
1.3	Number of digital Chest X-rays with CAD4 TB procured and installed in the 36 States+1	2019		111	111	111	111	111	111	NTBLCP annual report
1.31	TB workplace policies adopted by the Ministries of Labour and Interior	2019		1						NTBLCP annual report
1.32	Number of chest camps/community outreaches and school outreaches conducted	2019		774	774	1548	1548	1548		NTBLCP annual report

1.33	Proportion of notified bacteriologically positive TB cases that had their contacts investigated for TB	2019		60%	70%	80%	90%	95%	95%	NTBLCP quarterly report
1.34	Contact Investigation coverage	2019		90%	90%	90%	95%	95%	95%	NTBLCP quarterly report
1.35	Outreach in nomadic settlements in the 12 states conducted for screening nomads for TB.	2019		48	48	48	48	48	48	NTBLCP annual report
1.36	Number of radio jingles on Tuberculosis in relevant local languages (Hausa and Fulani) targeting nomads produced	2019		24						NTBLCP annual report
1.37	Number of radio jingles aired in each State (12 states)	2019		144	144	144	144	144	144	NTBLCP annual report
1.38	Quarterly outreaches in 328 IDP camps	2019		1,312	1,312	1,312	1,312	1,312	1,312	NTBLCP annual report
1.39	Number of staff of correctional service centres/police divisions (1733) oriented on TB screening among inmates	2019		15,770	6,759					NTBLCP annual report
1.4	Number of States in which miners were oriented and sensitised on TB identification and referral (active TB case finding) in mining communities	2019		6	6	6	6	6	6	NTBLCP annual report
1.41	Number of States in which at least one Veterinary officer participated in the State quarterly TB review meeting	2019	N/A	37	37	37	37	37	37	NTBLCP quarterly report
1.42	Proportion of laboratories showing adequate performance for smear microscopy	2019		95%	95%	95%	95%	95%	95%	NTBLCP annual report

1.43	Proportion of laboratories showing adequate performance for Xpert MTB/Rif assay	2019		>80%	>80%	>80%	>80%	>80%	>80%	NTBLCP annual report
1.44	Proportion of laboratories showing adequate performance for LPA	2019		100%	100%	100%	100%	100%	100%	NTBLCP annual report
1.45	Number of laboratories showing adequate performance for culture/DST	2019		95%	95%	95%	95%	95%	95%	NTBLCP annual report
Objective 2: To achieve and sustain TB treatment success rate of 92% by 2026										
Ind. No	Indicator	Baseline		Performance target						Data source & frequency
		Year	Value	2021	2022	2023	2024	2025	2026	
Outcome Indicators										
2.1	TB treatment success rate for all forms DSTB	2018	87%	90%	90%	91%	91%	91.5%	92%	NTBLCP quarterly report
2.2	Percentage of DSTB cases LTFU	2019	6%	<5%	<5%	<5%	<5%	<5%	<5%	NTBLCP quarterly report
2.3	Percentage of TB patients and their household experiencing catastrophic cost due to TB	2017	71%	50%	30%	20%	10%	0%	0%	Catastrophic cost survey
Output Indicators										
2.4	Number of patients provided with monthly support	2019	120,266	163,098	215,632	320,283	344,547	375,139	401,829	NTBLCP quarterly report
2.5	Total no. of patient-selected TS linked to CBOs	2019	120,266	163,098	215,632	320,283	344,547	375,139	401,829	NTBLCP quarterly report
2.5	Total no. of CBO staff trained on TB treatment monitoring	2019		1770						NTBLCP quarterly report
	Total no. of monitoring visits of TB patients in the community (PMDT)	2019		43,978	58,143	73,075	88,805	98,343		NTBLCP quarterly report
2.6	Treatment coverage new TB drugs	2019								
Objective 3: To enhance child hood TB detection and treatment through innovative provision of integrated services towards achieving childhood TB proportion of 16% among all forms of TB cases.										
	Indicator	Baseline		Performance target						Data source & frequency

Ind. No		Year	Value	2021	2022	2023	2024	2025	2026	
Outcome Indicators										
3.1	Proportion (%) of children with TB notified	2019	8%	10%	12%	14% (PF 8%)	15% (PF 10%)	16% (PF 11%)	16% (PF 13%)	NTBLCP quarterly report
3.2	Number of children diagnosed with TB	2019	9540	34,111	37,951	44,840 (PF 23,652)	51,682 (PF 31,921)	60,022 (PF 36,107)	64,293 (PF 45,273)	NTBLCP quarterly report
3.3	Proportion of children diagnosed as new TB cases who were successfully treated among those started on treatment	2019	92%	93%	94%	94%	95%	95%	95%	NTBLCP quarterly report
Output Indicators										
3.4	Child TB Annual operational plan developed			1						NTBLCP annual report
3.5	Number quarterly meeting of the National Child TB Steering Committee held			4	4	4	4	4	4	NTBLCP quarterly report
3.6	SOPs on child friendly medicines for DS TB printed			1						NTBLCP annual report
3.7	SOPs on child friendly medicines for DR TB printed			1						NTBLCP annual report
3.8	SOPs on gastric aspiration/lavage printed			1						NTBLCP annual report
3.9	Guidelines on Latent TB Infection Management printed			1						NTBLCP annual report
3.10	No of MCH staff orientated on identification of presumptive child TB			120						NTBLCP annual report
3.11	No of nutrition service providers trained on identification & referral of child TB in high burden secondary facilities across the country			740						NTBLCP annual report

3.12	No of nurses trained on effective gastric washing for child TB diagnosis			740						NTBLCP annual report
3.13	Total no. of C-DOT FP paid monthly			266,549	282,526	299,193	321,037	343,878		NTBLCP quarterly report
3.14	Total no. of printed CTBC training manuals			1,702						NTBLCP annual report
Objective 4: To increase proportion of estimated MDR/RR-TB cases notified from 11% in 2019 to 75% by 2026										
Ind. No	Indicator	Baseline		Performance target						Data source & frequency
		Year	Value	2021	2022	2023	2024	2025	2026	
Outcome Indicators										
4.1	Number of DR-TB cases notified (RR-TB and/or MDR-TB)	2019	2,384	10,115	12,004	9,592	10,319	11,235	12,304	NTBLCP quarterly report
4.2	Proportion of estimated DR-TB cases notified (RR-TB and/or MDR-TB)	2019	11%	35%	45%	65%	68%	72%	75%	NTBLCP quarterly report
4.3	Number of diagnosed cases of XDR TB	2019								
4.4	Number of cases of XDR TB enrolled on treatment	2019								
4.5	Percentage of TB patients with DST results for at least Rifampicin among the total number of notified cases in the same year	2019	58%	75%	75%	80%	80%	80%	80%	NTBLCP quarterly report
Output Indicators										
4.6	Print and distribute PMDT guidelines			1800						NTBLCP annual report
4.7	Percentage of confirmed RR/MDR-TB cases tested for resistance to second-line drugs			100%	100%	100%	100%	100%	100%	NTBLCP quarterly report
4.8	Number of DRTB patients whose contacts were traced			7,330	9,690					NTBLCP quarterly report

4.9	Number of DR-TB supervisions to the States			37	37	37	37	37	37	NTBLCP quarterly report
Objective 5: To enrol 100% of diagnosed DR-TB cases on treatment in accordance with global standard of care										
Ind. No	Indicator	Baseline		Performance target						Data source & frequency
		Year	Value	2021	2022	2023	2024	2025	2026	
Outcome Indicators										
5.1	Number of diagnosed DR-TB (RR-TB and/or MDR-TB) cases started on treatment	2019	1,975	7,330	9,690	9,592	10,319	11,235	12,304	NTBLCP quarterly report
5.2	Proportion of notified DR-TB patients enrolled on treatment increases	2019	83%	100%	100%	100%	100%	100%	100%	NTBLCP quarterly report
5.3	Proportion of diagnosed DRTB with RR started on treatment	2019		100%	100%	100%	100%	100%	100%	NTBLCP quarterly report
5.4	Proportion of diagnosed DRTB with MDR-TB cases started on treatment	2019		100%	100%	100%	100%	100%	100%	NTBLCP quarterly report
5.5a	Proportion of diagnosed DRTB (RR-TB and/or MDR-TB) cases started on treatment stratified by gender (male)	2019		100%	100%	100%	100%	100%	100%	NTBLCP quarterly report
5.5b	Proportion of diagnosed DRTB (RR-TB and/or MDR-TB) cases started on treatment stratified by gender (female)	2019		100%	100%	100%	100%	100%	100%	NTBLCP quarterly report
5.6	Proportion of diagnosed DRTB (RR-TB and/or MDR-TB) cases started on treatment at the DR-TB treatment centre	2018	41%	30%	25%	20%	15%	10%	10%	NTBLCP quarterly report
5.7	Proportion of diagnosed DRTB (RR-TB and/or MDR-TB) cases started on treatment in the community	2018	59%	70%	75%	80%	85%	90%	90%	NTBLCP quarterly report

5.8	Proportion of culture-positive MDR-TB cases who have a negative culture at the end of intensive phase of treatment	2017	81%	85%	85%	85%	85%	85%	85%	NTBLCP quarterly report
5.9	Treatment success rate of RR TB and/or MDR-TB: Percentage of cases with RR and/or MDR-TB successfully treated	2017	77%	80%	80%	83%	83%	83%	83%	NTBLCP quarterly report
5.10	Proportion of DR-TB cases who were cured at end of the treatment – preliminary treatment outcome	2017		70%	70%	70%	70%	70%	70%	NTBLCP quarterly report
5.11	Proportion of DR-TB cases who failed treatment at end of the treatment – preliminary treatment outcome	2017		7%	7%	7%	7%	7%	7%	NTBLCP quarterly report
5.12	Proportion of DR-TB cases who died at end of the treatment – preliminary treatment outcome	2017		8%	8%	8%	8%	8%	8%	NTBLCP quarterly report
5.13	Proportion of DR-TB cases who were lost to follow-up at end of the treatment- treatment outcome	2017		5%	5%	5%	5%	5%	5%	NTBLCP quarterly report
Output Indicators										
5.14	Quarterly National DR-TB committee meeting	2019	0	4	4	4	4	4	4	NTBLCP quarterly report
5.15	Number of health care workers (states team, GOPD doctors, TBL supervisor, DOTS officers and Community health care workers) trained on the implementation of the new oral DR-TB drugs)	2019		2,592	2,592	2,592	2,592	2,592	2,592	NTBLCP quarterly report

5.16	Number of clinical expert team meetings conducted in each state for the Treatment centers and OPD doctors	2019	148	148	148	148	148	148	148	NTBLCP quarterly report
5.17	Number of supervision visits to states by NTBLCP	2019	24	37	37	37	37	37	37	NTBLCP quarterly report
5.18	Number of supervision visits to states by STBLCP to LGAs	2019	20	20	20	20	20	20	20	NTBLCP quarterly report
5.19	Total number of DR-TB treatment centers	2019	28	30	32	34	36	37	37	NTBLCP quarterly report
5.2	Number of new states with scale-up of quality	2019	12	6	6	6	6	1		NTBLCP quarterly report
5.21	Number of clinical mortality review in Treatment centers and DRTB GOPD sites with reports of high mortality	2019	2	2	2	2	2	2	2	NTBLCP quarterly report
5.22	Number of portable ECG machines provided to existing DRTB GOPDs	2019	110	74	74	74	74	74	74	NTBLCP quarterly report
Objective 6: To rapidly scale up TB preventive services with the number of persons receiving TPT increasing annually from 121,784 in 2018 to 702,076 by 2026										
Ind. No	Indicator	Baseline		Performance target					2026	Data source & frequency
		Year	Value	2021	2022	2023	2024	2025		
Outcome Indicators										
6.1	Number of U5 eligible for TPT	2019	10,522	109,210	144,387	238,291	256,343	279,103	298,961	NTBLCP quarterly report
6.2	Number of U5 placed for TPT	2019	9,772	93,944	124,204	190,632	205,074	223,283	239,169	NTBLCP quarterly report
6.3	Number of >5 eligible for TPT	2019	1,860	220,926	276,899	614,943	661,530	720,267	771,512	NTBLCP quarterly report
6.4	Number of >5 placed for TPT	2019	1,016	169,100	223,567	368,966	396,918	432,160	462,907	NTBLCP quarterly report
6.5	Proportion of children placed on TPT who successfully complete prophylaxis	2018	91%	93%	95%	97%	100%	100%	100%	NTBLCP quarterly report
Output Indicators										

6.6	Guidelines on integration of TB care into RMNCAH+N developed and printed	2019		1						NTBLCP annual report
6.7	SOP document for contact tracing & TPT in children developed	2019	0	1						NTBLCP quarterly report
6.8	Number of tertiary and secondary facilities with designated infection control focal person	2019		170 (Tertiary) 5478 (Secondary)						NTBLCP annual report
6.9	Number of 2 monthly infection control meetings conducted in the facilities	2019		30	30	30	30	30	30	NTBLCP quarterly report
6.10	Number of health workers provided orientation on infection control	2019		18,652 (Clinicians) 8809	(OICs of PHCs) 32,600 (Nurses/CHEWS)					NTBLCP annual report
Objective 7: To improve access to quality TB care through comprehensively engagement of all private care providers with the sector accounting for 35% of notified TB cases by 2026.										
Ind. No	Indicator	Baseline		Performance target						Data source & frequency
		Year	Value	2021	2022	2023	2024	2025	2026	
Outcome Indicators										
7.1	Number of diagnosed TB cases by private sector	2019	17,250	47,327	57,927	83,274	96,473	112,542	140,640	NTBLCP quarterly report
7.2	Proportion of diagnosed TB cases by private sector	2019	14%	17%	18%	26%	28%	30%	35%	NTBLCP quarterly report
7.3	Treatment success rate in the private sector	2018	N/A	90%	90%	93%	93%	93%	93%	NTBLCP quarterly report
7.4	Proportion of private sector providers engaged to provide comprehensive TB services	2019	34%	50%	55%	60%	65%	75%	80%	NTBLCP quarterly report
Output Indicators										

7.5	Number of States in which at least one advocacy visit was conducted to each state private health facility regulatory body to enforce the NCH memo on compulsory TB reporting.			37	37	37	37	37	37	NTBLCP annual report
7.6	Number of States in which at least one advocacy and sensitization visit was conducted to each state professional regulatory bodies e.g MDCM, PCN, MLSCN, Nursing and Midwifery Council			37	37	37	37	37	37	NTBLCP annual report
7.7	SBC materials on mandatory reporting of TB produced and disseminated			1						Stock cards
7.8	Number of capacity building sessions on diagnosis and treatment of childhood TB for private practitioners			12	12	12	12	12	12	NTBLCP annual report
Objective 8: To strengthen provision of integrated services for all co-infected with TB and HIV, Patient with Diabetes and other co-morbidities										
Ind. No	Indicator	Baseline		Performance target						Data source & frequency
		Year	Value	2021	2022	2023	2024	2025	2026	
Outcome Indicators										
8.1	Proportion (%) of TB cases with a documented HIV status	2019	97%	100%	100%	100%	100%	100%	100%	NTBLCP quarterly report
8.2	Percentage of notified TB cases who are HIV-positive (TB-HIV co-infection rate)	2019	11%			6%	6%	6%	6%	NTBLCP quarterly report
8.3	Proportion (%) of TB-HIV co-infected cases on co-trimoxazole preventive therapy (CPT) during TB treatment	2019	92%	100%	100%	100%	100%	100%	100%	NTBLCP quarterly report

8.4	Proportion (%) of TB-HIV co-infected cases on ART during TB treatment	2019	91%	100%	100%	100%	100%	100%	100%	NTBLCP quarterly report
Output Indicators										
8.5	Percentage of people in HIV care who were clinically screened for TB in HIV care and treatment centres	2019				90%	95%	95%	95%	NTBLCP quarterly report
8.6	Number of PLHIV with presumptive TB that are tested using a WHO rapid test at the time of diagnosis	2019	N/A	100%	100%	100%	100%	100%	100%	NTBLCP quarterly report
8.7	Number of One-Stop Shop (OSS) for TB/HIV services at all PMTCT sites and OSS centers for key populations introduced.	2019		185						NTBLCP quarterly report
8.8	Number of infection control focal persons in all facilities trained and deployed for routine monitoring of TB-HIV collaboration	2019		5,648						NTBLCP quarterly report
Objective 9: To strengthen domestic resource mobilization with in-country funding of TB budget increasing from 8% in 2019 to 50% by 2026.										
Ind. No	Indicator	Baseline		Performance target						Data source & frequency
		Year	Value	2021	2022	2023	2024	2025	2026	
Outcome Indicators										
9.1	Amount of domestic support from government	2019								NTBLCP annual report
9.2	Proportion of domestic support in relation to NSP budget	2019	8%	15%	25%	35%	45%	50%	50%	NTBLCP annual report
9.3	Proportion of Ministries engaged for TB control	2019	N/A	50%	75%	100%	100%	100%	100%	NTBLCP annual report
Output Indicators										
9.4	Number of fact sheets and advocacy materials developed and printed for all levels of Stakeholders	2019		760		760		760		NTBLCP annual report

9.5	Number of States that have included TB services as part of their BHC PF	2019		37	37	37	37	37	37	NTBLCP annual report
9.6	Number of States that have included TB services as part of their health insurance package	2019		37	37	37	37	37	37	NTBLCP annual report
9.7	No of advocacy visits conducted to media houses to discuss TB and solicit for publicity support	2019		4	4	4	4	4	4	NTBLCP quarterly report
9.8	No of Media charts on TB messages	2019		12	12	12	12	12	12	NTBLCP quarterly report
9.9	No of advocacy visits conducted to Governor's wives to support TB program	2019		36		36		36		NTBLCP quarterly report
9.10	No of Corporate bodies providing support for TB Program	2019		25	25	25	25	25	25	NTBLCP annual report
9.11	No of breakfast meetings held with Corporate bodies and philanthropists on TB	2019		5	5	5	5	5	5	NTBLCP quarterly report
9.12	ACSM/CTBC Guidelines finalized and printed	2019		2000						NTBLCP annual report
9.13	Number quarterly national ACSM/CTBC Sub-Committee meetings held	2019		4	4	4	4	4	4	NTBLCP quarterly report
9.14	No of CBOs personnel trained on community stakeholders' engagement, decision-making and TB response	2019		555						NTBLCP annual report
9.15	No of CHIPS members identified and Trained on TB referrals	2019		2500						NTBLCP annual report
9.16	World TB day celebrated at National level	2019		1	1	1	1	1	1	NTBLCP annual report
9.17	World TB day celebrated at State level	2019		37	37	37	37	37	37	NTBLCP annual report

Objective 10: To strengthen community involvement in provision of quality TB care with the community contribution to TB case notification increasing from 22% in 2019 to 45% by 2026										
Ind. No	Indicator	Baseline		Performance target						Data source & frequency
		Year	Value	2021	2022	2023	2024	2025	2026	
Outcome Indicators										
10.1	Number of TB cases referred from the community	2019	26,226	71,064	82,228	144,127	155,046	168,813	180,823	NTBLCP quarterly report
10.2	Proportion of TB cases referred from the community	2019	22%	25%	26%	45%	45%	45%	45%	NTBLCP quarterly report
10.3	Proportion of TB patients managed by treatment supporters	2019	86%	90%	90%	90%	90%	90%	90%	NTBLCP quarterly report
Output Indicators										
10.4	Number of advocacy visits to stakeholders - State, LGA and Community	2019		12,384	12,384	12,384	12,384	12,384	12,384	NTBLCP quarterly report
10.5	No of TBLS trained on TB identification, referral, specimen collection and transport, and patient linkage to treatment	2019		130						NTBLCP annual report
10.6	No of Chest Camps organized by CBOs to key target populations	2019		32	32	32	32	32	32	NTBLCP quarterly report
10.7	Harmonised SBC materials produced and disseminated	2019		1						NTBLCP annual report
10.8	No of Social media platforms sharing and receiving feedback on TB messages	2019		56	56	56	56	56	56	NTBLCP quarterly report
Objective 11: To protect and promote human rights and genders related factors in provision of quality TB services										
Ind. No	Indicator	Baseline		Performance target						Data source & frequency
		Year	Value	2021	2022	2023	2024	2025	2026	
Outcome Indicators										

11.1	Percentage of people diagnosed with TB who experienced self-stigma that inhibited them from seeking and accessing TB services.	2019	N/A	-	50.5%	-	40.5%	-	25.5%	Stigma Assessment Report, surveys, IBBS, TB prevalence studies
11.2	Percentage of people diagnosed with TB who report stigma in health care settings that inhibited them from seeking and accessing TB services.	2019	N/A	-	25.3%	-	15.3%	-	5.3%	Stigma Assessment Report, surveys, IBBS, TB prevalence studies
11.3	Percentage of people diagnosed with TB who report stigma in community settings that inhibited them from seeking and accessing TB services.	2019	N/A	-	53.4%	-	43.4%	-	23.4%	Stigma Assessment Report, surveys, IBBS, TB prevalence studies
Output Indicators										
11.4	Report of TB Human Rights and Gender Analysis conducted	2019	0	1	-	-	-	1		Mapping and analysis report
11.5	Policy document developed to address gender-based TB issues	2019	N/A	1						NTBLCP annual report
11.6	Gender-specific operational guidelines developed	2019	N/A	1						NTBLCP annual report
11.7	Awareness creation for persons at workplaces and leisure areas	2019	N/A	2,510	2,510	2,510	2,510	2,510	2,510	NTBLCP annual report
11.8	Number of DOT providers trained on the implementation on Patient Charter	2019	N/A							NTBLCP annual report
11.9	Number of patients reporting zero stigma to access	2019	N/A							Stigma Assessment Report, surveys, IBBS, TB prevalence studies
11.10	Awareness creation for persons in police cells and correctional centers	2019	N/A							NTBLCP annual report
11.11	Number of TB Campaigns by TB Support Groups for a human right-based TB response.	2019	N/A							NTBLCP annual report

Objective 12: Strengthen programme management and capacity at all level for the achievement of the NSP target										
Ind. No	Indicator	Baseline		Performance target						Data source & frequency
		Year	Value	2021	2022	2023	2024	2025	2026	
Output Indicators										
12.1	Number of states with annual work plans developed	2019	N/A	37	37	37	37	37	37	NTBLCP annual report
12.2	Number of states with State Strategic Plans developed	2019	N/A	15	30	37				NTBLCP annual report
12.3	Number of supervisory visits from national to state level per year	2019	N/A	6	6	6	6	6	6	NTBLCP quarterly report
12.4	Number of supervisory visits from Zonal to state level per year	2019	N/A	37	37	37	37	37	37	NTBLCP quarterly report
12.5	Number of supervisory visits from state to LGA level per year	2019	N/A	744	744	744	744	744	744	NTBLCP quarterly report
12.6	Number of supervisory visits from LGA to facility level per year	2019	N/A	148	148	148	148	148	148	NTBLCP quarterly report
12.7	Number of supervisory visits to national and zonal reference laboratories	2019	N/A	4	4	4	4	4	4	NTBLCP quarterly report
12.8	Number of DQA from National to state level per year	2019	N/A	4	4	4	4	4	4	NTBLCP quarterly report
12.9	Number of OSDV from state to LGA level per year	2019	N/A	148	148	148	148	148	148	NTBLCP quarterly report
12.10	Number of quarterly review meetings held at national level	2019	N/A	4	4	4	4	4	4	NTBLCP quarterly report
12.11	Number of quarterly review meetings held at zonal level	2019	N/A	24	24	24	24	24	24	NTBLCP quarterly report
12.12	Number of quarterly review meetings held at state level	2019	N/A	148	148	148	148	148	148	NTBLCP quarterly report
12.13	Number of annual review meetings held at national level	2019	N/A	1	1	1	1	1	1	NTBLCP quarterly report

12.14	Number of joint international monitoring missions	2019	N/A		1		1		1	Report of joint international monitoring mission
12.15	Number of national M&E TWG meetings conducted annually	2019	N/A	4	4	4	4	4	4	NTBLCP annual report
12.16	National Drug Resistance Survey	2019	N/A		1					Drug resistance survey report
12.17	Mid-term review of NSP	2019	N/A				1			Report of mid-term review of the NSP
12.18	End-term review of NSP	2019	N/A						1	Report of end-term review of the NSP
12.19	Development of National Strategic plan	2019	N/A						1	National Strategic Plan/ NTBLCP annual report
12.2	Number of high volume health facilities screening at all OPD and recording/reporting TB cascade	2019	N/A	6,528	6,528	6,528	6,528	6,528	6,528	NTBLCP quarterly report
12.21	Number of data mop-up in 36 States + FCT	2019	N/A	37	37	37	37	37	37	NTBLCP annual report
12.22	Number of trainings for CU NTBLCP, State level and Partners on advanced data management skills using relevant statistical softwares	2019	N/A		1	1				NTBLCP quarterly report
12.23	Number of National Staff sent for training on Program management and Supervisors course at NTBLTC Zaria	2019	N/A	1	1	1	1	1	1	NTBLCP quarterly report
12.24	Number of State M&E officers who attended training course at NTBLTC Zaria	2019	N/A	10	10	10	10	10	10	NTBLCP quarterly report
12.25	Number of STBLCP staffed trained at NTBLCP training center, Zaria	2019	N/A	10	10	10	10	10	10	NTBLCP quarterly report
12.26	Number LGATBLS & Assistants trained on basic data management	2019	N/A	1,548	1,548		1,548		1,548	NTBLCP annual report

12.27	Number of new LGATBLS trained on management and control of TB, TB/HIV	2019	N/A	60	60	60	60	60	60	NTBLCP annual report
12.28	Number of GHCW retrained on TB service delivery each year.	2019	N/A	3,462	3,462	3,462	3,462	3,462	3,462	NTBLCP annual report
12.29	Number of quarterly supervisory reports placed on the NTBLCP website	2019	N/A	4	4	4	4	4	4	NTBLCP quarterly report
12.3	State score cards and annual TBL report, printed and distributed	2019	N/A	1	1	1	1	1	1	NTBLCP annual report
12.31	National and state annual reports uploaded on the NTBLCP website	2019	N/A	1	1	1	1	1	1	NTBLCP quarterly report
12.32	Number of GxAlert installed on newly procured machines	2019	N/A							NTBLCP annual report
12.33	e-TB Manager integrated with DHIS	2019	N/A	1						NTBLCP annual report
12.34	Gx Alert integrated with DHIS	2019	N/A	1						NTBLCP annual report
12.35	Number of IT Specialist recruited to manage NETIMS	2019	N/A	2						NTBLCP annual report
12.36	Number of new and non-NTP facilities linked to TB notification App	2019	N/A	5,000	5,942	5,942	5,942	5,942	5,942	NTBLCP annual report
12.37	Number of National quarterly data harmonization meeting held	2019	N/A	4	4	4	4	4	4	NTBLCP quarterly report
12.38	Number of quarterly data harmonization meeting that held at LGA level	2019	N/A	774	774	774	774	774	774	NTBLCP quarterly report
12.39	Number of Laptops procured for National M&E officers, State Program managers and State M&E Officers	2019	N/A	150						NTBLCP quarterly report
12.40	Number of hard drives procured for NTBLCP and STBLCP	2019	N/A	38						NTBLCP quarterly report

12.41	Number of smart devices procured for NETIMS at the LGA and facility level	2019	N/A	100	100	100	100	100	100	NTBLCP annual report
12.42	Number of staff recruited for the operation research unit of the central unit	2019	N/A	3						NTBLCP quarterly report
12.43	Number of quarterly OR task force meeting	2019	N/A	4	4	4	4	4	4	NTBLCP quarterly report
12.44	Number of TB Catastrophic survey conducted	2019	N/A		1					Catastrophic survey report
12.45	Number of KAP survey conducted	2019	N/A	1						KAP Survey report
12.46	Number of TB prevalence survey conducted	2019	N/A	1						TB Prevalence report
12.47	Number of national TB-HIV TWG meeting conducted annually	2019	N/A	4	4	4	4	4	4	NTBLCP annual report
12.48	Number of national TB-HIV MSV conducted annually	2019	N/A	6	6	6	6	6	6	NTBLCP annual report
12.49	Number of operational research held.	2019	N/A	4	4	4	4	4	4	Operational research reports
12.5	Number of PSM TWG meetings held	2019	N/A	4	4	4	4	4	4	NTBLCP quarterly report
12.51	Number of quarterly NHLMIS TB data entry meetings conducted	2019	N/A	4	4	4	4	4	4	NTBLCP quarterly report
12.52	Number of times reverse logistics (of expired commodities) occurred in the grant PSM	2019	N/A	1	1	1	1	1	1	NTBLCP quarterly report
12.53	Number of copies of National TB guidelines printed and distributed	2019	N/A	300,000						NTBLCP annual report
12.54	Number of copies of Child TB desk guide printed and distributed	2019	N/A	30,000						NTBLCP annual report

12.55	Number of copies of SOP on child-friendly medicines for drug susceptible TB printed and distributed	2019	N/A	5,000						NTBLCP quarterly report
12.56	Number of copies of guidelines on Latent TB Infection Management printed and distributed	2019	N/A	20,000						NTBLCP quarterly report
12.57	Number of nutrition service providers trained in high burden facilities on identification and referral of presumptive child TB	2019	N/A	120						NTBLCP quarterly report
12.58	Number of RMNCH+N facilities providing TB services	2019	N/A							
12.59	Geospatial monitoring tool to track delivery of TBL commodities developed	2019	N/A	1						NTBLCP annual report
12.6	Proportion of TB stores (state, zonal and FMS) with minimum requirement for storage	2019	N/A	50%	60%	75%	85%	100%	100%	NTBLCP annual report
12.61	Number of health facilities trained on TB pharmacovigilance and aDSM	2019	N/A	250	250	258				NTBLCP annual report
12.62	Proportion of trained health facilities reporting routinely on TB pharmacovigilance and aDSM	2019	N/A	100%	100%	100%	100%	100%	100%	NTBLCP quarterly report
12.63	Proportion of DOTS facilities reporting no stock out of lab reagents on the last day of the quarter	2019	95%	95%	97%	97%	98%	98%	98%	NTBLCP quarterly report
12.64	Proportion of DOTS facilities reporting no stock out of first line anti-TB drugs on the last day of the quarter	2019	96.50%	97%	97%	98%	98%	98%	98%	NTBLCP quarterly report

12.65	Proportion of DOTS facilities reporting no stock out of R&R tools on the last day of the quarter	2019	85%	87%	90%	96%	96%	97%	97%	NTBLCP quarterly report
12.66	Proportion of DOTS facilities participating in Drug Quality Assurance testing	2019	50%	50%	50%	50%	50%	50%	50%	NTBLCP quarterly report
12.67	Proportion of DOTS facilities reporting timely (DHIS/e-TBM)									NTBLCP quarterly report
12.68	Proportion of State TBLC programmes submitting quarterly LMIS reports timely (paper-based/Navision/PnP)	2019	N/A	90%	95%	95%	100%	100%	100%	NTBLCP quarterly report
12.69	Proportion of State TBLC programmes submitting quarterly reports timely (paper-based/DHIS/e-TBM)	2019	N/A	90%	95%	95%	100%	100%	100%	NTBLCP quarterly report
12.70	Number of state quarterly laboratory EQA meetings conducted	2019	N/A	148	148	148	148	148	148	NTBLCP quarterly report
12.71	Number of quarterly CGAT meetings held each year	2019	N/A	4	4	4	4	4	4	NTBLCP annual report
12.72	Number of quarterly laboratories TWG meetings held each year	2019	N/A	4	4	4	4	4	4	NTBLCP annual report
12.73	Number of national TB diagnostic operations manual developed and printed	2019	N/A	5500						NTBLCP annual report
12.74	Number of TB laboratory policy manual developed and printed	2019	N/A	5500						NTBLCP annual report
12.75	Number of reviewed PMDT guideline printed	2019	N/A	1800						NTBLCP annual report
12.76	Number of new GeneXpert machines procured and installed	2019	N/A	100	56	50	50			NTBLCP annual report

12.77	Number of GeneXpert and cartridges (particularly ULTRA) procured	2019	N/A	742,096	1,056,596	1,422,795	1,844,342	2,042,425		NTBLCP annual report
12.78	Number of umbrella bodies of health care professionals with curriculum updated to include current TB control strategies	2019	N/A	10						NTBLCP annual report
12.79	Number of training institutions implementing curriculum updated to include current TB control strategies	2019	N/A		155	310	465	465		NTBLCP annual report

9. The budget plan

9.1. Introduction

The NSP operational and technical assistance plan describes all activities and sub-activities articulated by NTBLCP and stakeholders to achieve the goal of universal access to high-quality TB prevention, diagnosis, and treatment services by 2026. The efforts required to do so are massive and include a rapid expansion of services to reach far more of the people who are at risk of TB in Nigeria than are being reached through the current predominantly passive case-finding approach and to address the growing problem of drug-resistant TB. The overall cost of reaching the ambitious goal of universal access to TB services by 2026 is estimated at US\$ 2,356,750,000

9.2. Budget for NSP-TB 2021-2026

The detailed budget for the NSP is provided in an excel file, which does not form part of this document. Budgets are provided for each objective, by activity and sub-activity and tied to the NSP descriptions. The first tab for each objective provides the summary budget, broken down in two ways: by cost category and by intervention, according to the WHO planning and budgeting tool categories. The second tab provides the operational plan text with which the budget is associated. The third tab provides a detailed budget broken down by activity costs per year. The fourth tab provides assumptions on the unit costs of each activity and subsequent tabs provide the cost basis for consumables, equipment, and other standard items. This detailed budget is summarized by objectives (Table 21).

Table 21: Summary NSP budget (2021 – 2026)

By Module - Intervention	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Total	%
Case detection and diagnosis	198,629	114,988,101	115,620,208	116,341,530	116,285,097	117,628,979	581,062,544	23.8%
Treatment (TB care and prevention)	288,911	208,052,365	213,983,480	220,004,112	233,628,855	236,328,854	1,112,286,577	45.0%
Engaging all care providers (TB care and prevention)	5,940	1,782,107	1,719,511	838,450	824,329	833,856	6,004,193	0.3%
Other TB care and prevention intervention(s)	2,303	1,470,264	1,796,453	1,419,866	1,435,848	1,452,442	7,577,176	0.3%
Other program management intervention(s)	52,222	34,509,551	33,993,132	33,338,287	33,701,745	34,091,229	169,686,166	7.0%
Policy, planning, coordination and management of national disease control programs	0	0	29,962	29,398	0	0	59,360	0.0%
Treatment: MDR-TB	374,425,145	3,442,113	3,379,682	3,668,766	3,884,941	3,929,838	392,730,485	20.0%
Grant management	30	19,984	19,669	19,299	19,516	19,742	98,240	0.0%
Key populations (TB care and prevention) - Others	24,006	15,893,655	15,643,309	15,348,853	15,521,614	15,700,994	78,132,431	3.2%
Key populations (TB care and prevention) - Prisoners	999	661,199	650,785	638,535	645,722	653,184	3,250,424	0.1%
Case detection and diagnosis: MDR-TB	492	332,501	334,010	333,819	344,029	348,005	1,692,856	0.1%
Community MDR-TB care delivery	30	19,587	19,278	18,916	19,128	19,349	96,288	0.0%
Other MDR-TB intervention(s)	0	0	0	0	0	0	0	
Prevention (TB care and prevention)	1,257	828,572	815,521	800,171	809,177	818,528	4,073,226	0.2%
Routine reporting	35	0			0	0	35	0.0%
Total	375,000,000.00	382,000,000.00	388,005,000.00	392,800,000.00	407,120,000.00	411,825,000.00	2,356,750,000.00	1

9.3. Funding sources for the NSP-TB 2021 – 2026

Funding for TB control in Nigeria comes from the Government of Nigeria and donors (international and local) including the private sector. Funding of TB control activities is heavily dependent on external funders, particularly the Global Fund and USAID. Stop TB Partnership through the TB REACH also funds several projects in different parts of the country. External donors have contributed most of the funding available to the programme.

9.4. Funding strategy for NSP-TB 2021-2026

Far more funding is needed than is currently available from all sources to implement the ambitious activities described in the NSP. Without additional funds, NSP targets cannot be met. This shortfall translates to real human suffering as well as economic losses at family, community and national levels as people fall ill with TB, stop working and some of them die needlessly in the most productive years of their lives.

The NTBLCP will aggressively pursue additional sources of funds to implement essential TB activities. One objective of the NSP is to mobilise significantly more domestic resources for TB, so that domestic funds represent at least half of the funding available for TB control in Nigeria. This will be done through an intensive advocacy campaign to mobilise resources at federal, state, and local levels, in collaboration with civil society organisations that are best placed to demand and monitor the financial commitments of the government to the health and welfare of its citizens. In addition, NTBLCP will reach out to the business sector to identify opportunities for TB integration within corporate social responsibility initiatives for mutual benefit. It will actively pursue integration of TB within federal social insurance schemes and policies aimed at reducing the burden of TB-related costs on individuals seeking care. It will integrate TB services into other general health activities to provide access to basic services at the lowest possible cost.

At the same time, NTBLCP will continue to work with donors to access funds, including Global Fund, USAID, TB REACH, ILEP partners, the World Bank, and others. It will build its internal capacity to manage finances to make the best possible use of available resources. On a yearly

basis, NTBLCP will reassess its available funding with respect to the NSP budget and will adjust activities and targets as needed to achieve the maximum impact possible, coupled with strong advocacy for additional funds.

10. Operational and technical assistance plan

Purpose

The purpose of the Operational and Technical Assistance Plan is to define the specific activities that will be implemented to achieve the targets of the NSP. The template provides for the details of what activities will be implemented, when and by whom, as well as the funding source that will support each activity. The Operational and Technical Assistance Plan will serve as a roadmap for the NTBLCP and its partners to prepare annual work plans based on agreed activities and to monitor progress toward reaching the expected outputs and outcomes described in the M&E Plan. Such annual work plans will define specifics in terms of whom, when and where the activities will be implemented and the funding sources.

It also indicates, as an integral part of the document, areas in which the NTBLCP requires technical assistance, particularly in laboratory expansion, PMDT scale-up, TB/HIV integration, HMIS strengthening, PSM strengthening, CSS, advocacy, financial management and programme management. As part of its annual planning process, NTBLCP will identify technical assistance providers (drawing from in-country resources as well as external experts) and opportunities for staff skills-building through training courses and exchange visits.

This document is meant to be a working document that guides the activities of the NTBLCP and its partners. It will be revisited and revised on a regular basis to consider changes in the situation on the ground, including changes in donors, funding, implementing partners, the political landscape, and the security situation among others. Those changes will be reflected in the annual work plans of the NTBLCP and its partners.

The framework of operational and technical assistance plan is in Annex 3 for annual updates that is informed by the funding and partnership landscape.

11. Annexure

Annex 1: The relationship of the NSHDP II (2018 – 2022) and the NSP-TB Response

Strategic Pillar	NSHDP priority	NSP-TB response
DOMESTIC RESOURCE MOBILISATION WITH IN-COUNTRY FUNDING OF TB BUDGET		
Strategic Pillar One - Enabled Environment for Attainment of Sector Outcomes	Priority Area 1: Leadership and Governance	Objectives 9
	<ul style="list-style-type: none"> Strengthen voice and accountability, including community participation and engagement with civil society organisations (CSOs). 	<ul style="list-style-type: none"> Strengthened Targeted High-Level Advocacy Strengthening Community Systems and Structures for effective participation in TB response Advocacy to government and partners to ensure prompt release of budgeted funds for procurement of TB medicines/commodities Advocacy to the government to include key PSM activities in the budget and release requisite funds
Strategic Pillar Five – Predictable Financing and Risk Protection	Priority Area 15: Health Financing	Objective 9, 11
	<ul style="list-style-type: none"> Advocate for increase in government annual budget and spending on health Strengthen technical capacity of health personnel on health insurance and contributory schemes 	<ul style="list-style-type: none"> Strengthened Targeted High-Level Advocacy Inclusion of TB prevention, diagnosis (GX, DST) and treatment (1st and 2nd line) services, according to national guidelines, in the NHIS scheme
TB CASE FINDING (INCLUDING KEY POPULATIONS)		
Strategic Pillar Two - Increased utilisation of the Essential Package of Health Care Services	Priority Area 5: Communicable Diseases (Malaria, TB, Leprosy) and Neglected Tropical Diseases (NTDs)	Objectives - 1, 2, 3, 4, 6, 10

	<ul style="list-style-type: none"> ● Strengthen TB case detection, diagnostic capacity, and access to quality treatment services. ● Promote demand for TB services. ● Expand access to TB diagnosis and treatment services for persons co-infected by TB and HIV. ● Scale up paediatric TB diagnosis and treatment services. ● Increase access to diagnosis and management services for DR-TB. ● Strengthen collaboration with and capacity of CBOs to support TB programming. ● Increase access to integrated case management for NTDs (Buruli Ulcer, Leishmaniasis, Trypanosomiasis, Loasis, Schistosomiasis, Zoonosis, soil transmitted helminthic infections, onchocerciasis, filariasis) 	<ul style="list-style-type: none"> ● Strengthen and scale up TB diagnosis at all levels. ● Establishment of TB policy in workplace. ● Strengthen and scale up OPD screening for TB. Scale up TB services to all health facilities ● Strengthen Contact Investigation ● Awareness creation and sensitization of community. ● Community driven intervention in hard-to reach and high-risk areas. ● Scale up Integration of child/adolescent TB into RMNCAH+N as well as HIV services – Tertiary, secondary and Primary health facilities. ● Scale up TB services to all health facilities. ● Scale up Diagnosis and Treatment Capacity in MCH facilities. ● Strengthen Engagement of Professional bodies and International bodies ● Increase DR-TB case finding. ● Engagement of the community in TB case finding. ● TSR among TB patients supported by TS is $\geq 90\%$. ● Integrate one health approach (zoonotic TB)
	Priority Area 6: Non-Communicable Diseases (NCDs), Elderly, Mental, Oral and Eye health care:	Objective 1
	<ul style="list-style-type: none"> ● Expand access (geographic and financial etc.) to NCD prevention, screening, control, and treatment services. 	<ul style="list-style-type: none"> ● Improve active case finding among key populations (HIV infected individuals, contacts to active TB cases, Nomads, Migrants and IDPs, Prisoners, Slum dwellers, Children, Miners, Inmates of Police Cells, Diabetes Mellitus).
	Priority Area 2: Community Participation in Health	Objectives - 10

Strategic Pillar One - Enabled Environment for Attainment of Sector Outcomes	<ul style="list-style-type: none"> Strengthen institutional and coordinating mechanisms for promotion of community participation Strengthen capacities of communities to participate in the planning of health interventions at all levels. Strengthen capacities of communities to facilitate the implementation of community and facility level Minimum Service Package (MSP) 	<ul style="list-style-type: none"> Awareness creation and sensitization of community Engagement of the Community in TB Case Finding Community driven intervention in hard-to reach and high-risk areas.
Strategic Pillar Three – Strengthened health system for delivery of the EPHS	Priority Area 9: Human Resources for Health	Objectives 1, 3, 12
	<ul style="list-style-type: none"> Strengthen the task shifting and task sharing implementation with required guidelines. Improve capacity for HRH planning at all levels 	<ul style="list-style-type: none"> Strengthen and scale up TB diagnosis at all levels. Strengthen Engagement of Professional bodies and International bodies Capacity building of HCW across all level of TBLCP.
	Priority Area 10: Health Infrastructure	Objective 1.
	<ul style="list-style-type: none"> Accelerate the revitalisation of primary health care infrastructure for improved access to health services 	<ul style="list-style-type: none"> Scale up TB services to all health facilities. Improve human capacity to provide TB services in existing TB treatment centers
COMPREHENSIVE ENGAGEMENT OF ALL PRIVATE CARE PROVIDERS		
Strategic Pillar One - Enabled Environment for Attainment of Sector Outcomes	Priority Area 3: Partnerships for Health	Objective 7
	<ul style="list-style-type: none"> Promote the adoption and utilization of national policies and guidelines on PPP 	<ul style="list-style-type: none"> Expand engagement of private sector in TB service delivery Enforcement of the memo on mandatory reporting of TB in the private Improve implementation in accordance with the PPM guideline Expand engagement of private sector in TB service delivery

	<ul style="list-style-type: none"> Strengthen mechanisms for the implementation of PPP (e.g., contracting or out-sourcing, leases, concessions, social marketing, franchising mechanism) Scale-up PPP in planning and implementation of health programmes Promote joint (public and private sector) monitoring and evaluation of health programs 	<ul style="list-style-type: none"> Expand engagement of private sector in TB service delivery
Strategic Pillar One - Enabled Environment for Attainment of Sector Outcomes	Priority Area 1: Leadership and Governance	Objectives 7
	<ul style="list-style-type: none"> Design and institutionalize an incentivization and reward system for the efficient performance of the health sector at all levels Improve partnership with professional groups and other relevant stakeholders for effective service delivery and industrial harmony 	<ul style="list-style-type: none"> Engage professional bodies and academic institutions to support training, task shifting and/or other RSSH activities Engage professional bodies and academic institutions to support training, task shifting and/or other RSSH activities
TB LABORATORY SERVICES		
Strategic Pillar One - Enabled Environment for Attainment of Sector Outcomes	Priority Area 1: Leadership and Governance	Objectives 1:
	<ul style="list-style-type: none"> Strengthen coordinating mechanism of health development partners (Development Partners and Private Sector Partners) 	<ul style="list-style-type: none"> Partner coordination for laboratory activities at sub-national level
Strategic Pillar Three – Strengthened health system for delivery of the EPHS	Priority Area 9: Human Resources for Health	Objectives 1

	<ul style="list-style-type: none"> ● Improve HRH performance management systems at all levels 	<ul style="list-style-type: none"> ● Improved human resource and capacity development of TB laboratory personnel at all levels of laboratory services ● Strengthen and scale up TB diagnosis at all levels
	Priority Area 10: Health Infrastructure	Objectives 1
	<ul style="list-style-type: none"> ● Ensure availability of equipment and other health infrastructure in line with established norms and standards for the different levels of health care and promote the adoption and utilisation of national policies and guidelines on PPP ● Strengthen legal and coordinating framework for PPP at all levels ● Strengthen mechanisms for the implementation of PPP (e.g., contracting or out-sourcing, leases, concessions, social marketing, franchising mechanism) ● Scale-up PPP in planning and implementation of health programmes health institutions 	<ul style="list-style-type: none"> ● Increase access to rapid TB Laboratory diagnosis for increased case notification among all forms of TB including those living with HIV ● Improve quality assured TB Diagnostic network ● Strengthening specimen referral system within the TB laboratory network ● Strengthening TB laboratory Quality Management System (LQMS) at all levels of the network ● Enrol the National TB reference laboratories in Accreditation programs ● Expand and maintain infrastructure and biosafety measures for TB culture and DST ● Ensure availability of maintenance and service contracts for all equipment at all levels ● Ensure availability and utilisation of standard electronic R&R tools
	Priority Area 13: Research for Health	Objectives 12
	<ul style="list-style-type: none"> ● Laboratory Information System 	<ul style="list-style-type: none"> ● Develop operational research capacity (Evaluate use of good quality data to determine TB burden (DS-TB, DR-TB, and TB-HIV), result delivery, Client satisfaction, and laboratory performance indicators)
Strategic Pillar 3 Strengthened health system for delivery of the EPHS	Priority Area 9: Human Resources for Health	Objective 12
	<ul style="list-style-type: none"> ● Improve HRH performance ● management systems at all levels ● Strengthen the task shifting and task sharing implementation with required guidelines 	<ul style="list-style-type: none"> ● Pre-service curriculum of new TB diagnostic tools in schools of health technologies and universities ● Establish performance-based incentives such as recognising best performing labs, certificates, personnel recognition within the laboratories

TB TREATMENT AND CARE (INCLUDING COMORBIDITIES: HIV AND NON-COMMUNICABLE DISEASES - NCDS) WITH HIGH TREATMENT SUCCESS RATE		
Strategic Pillar Two - Increased utilisation of the Essential Package of Health Care Services	Priority Area 5: Communicable Diseases (Malaria, TB, Leprosy) and Neglected Tropical Diseases (NTDs) Objective 15	Objectives 7
	<ul style="list-style-type: none"> Strengthen TB case detection, diagnostic capacity, and access to quality treatment services. Expand access to TB diagnosis and treatment services for persons co-infected by TB and HIV Scale up paediatric TB diagnosis and treatment services Strengthen mechanism for coordination of TB/HIV collaborative activities at all levels of health care 	<ul style="list-style-type: none"> Improve integration of TB/HIV services Enhance the capacity of private facilities to diagnose and treat childhood TB Improve integration of TB/HIV services Include private sector in TB/HIV TWG at national and sub-national levels
Strategic Pillar One - Enabled Environment for Attainment of Sector Outcomes	Priority Area 1: Leadership and Governance	Objective 8
	<p>Scale-up strategic and operational planning at all levels.</p> <p>Design and institutionalise an incentivisation and reward system for the efficient performance of the health sector at all levels.</p> <p>Strengthen coordinating mechanism of health development partners (Development Partners and Private Sector Partners).</p>	<ul style="list-style-type: none"> Strengthen coordination mechanism for delivering integrated TB and HIV services at the national, state and health facilities.
	Priority Area 5: Communicable Diseases (Malaria, TB, Leprosy) and Neglected Tropical Diseases (NTDs).	Objective 8

Strategic Pillar Two - Increased utilisation of the Essential Package of Health Care Services	<ul style="list-style-type: none"> Strengthen TB case detection, diagnostic capacity, and access to quality treatment services. Expand access to TB diagnosis and treatment services for persons co-infected by TB and HIV. Strengthen collaboration with and capacity of CBOs to support TB programming. Strengthen mechanism for coordination of TB/HIV collaborative activities at all levels of health care. Expand access to Minimum Package of Preventive Interventions (MPPI) for HIV targeting key and general populations. Expand access of people living with HIV and AIDS to ART and co-infection management services. Strengthen referral and linkages between HIV/AIDS services and other health and social services. 	<ul style="list-style-type: none"> Reduce the burden of TB in people living with HIV and initiate early antiretroviral treatment (the Three I's for HIV/TB). Strengthen coordination mechanism for delivering integrated TB and HIV services at the national, state and health facilities. Reduce the burden of TB in people living with HIV and initiate early antiretroviral treatment (the Three I's for HIV/TB). Reduce the burden of HIV in patients with presumptive and diagnosed TB.
	Priority Area 6: Non-Communicable Diseases (NCDs), Elderly, Mental, Oral and Eye health care.	Objective 8
	<ul style="list-style-type: none"> Expand access (geographic and financial etc.) to NCD prevention, screening, control, and treatment services. Scale-up appropriate health services for the promotion of health and care of the elderly at all levels 	<ul style="list-style-type: none"> Intensify case finding among Diabetic mellitus (DM) patients at endocrinology and Geriatrics clinics
	Priority Area 7: Emergency Medical Services and Hospital Care.	Objective 8

	<ul style="list-style-type: none"> Strengthen infection prevention and control (IPC) in health care settings. Strengthen Infection, Prevention and Control (IPC) practices in health care settings. 	<ul style="list-style-type: none"> Reduce the burden of TB in people living with HIV and initiate early antiretroviral treatment (the Three I's for HIV/TB)
	Priority Area 8: Health Promotion and Social Determinants of Health.	Objective 8
	<ul style="list-style-type: none"> Strengthen health promotion coordination mechanisms at all levels. Strengthen legal, regulatory framework, policies, and implementation of plans for chemical hazards and poisoning, medical and Bio-waste and climate change. Build capacity of health workers for effective management of medical and Bio waste and hazardous chemicals at all levels of the health care system. Promote the development and implementation of legal, regulatory framework, policies and plans for occupational health in Nigeria. Build capacity of health care workers to respond to occupational health needs in the country. Scale up occupational preventive and promotive activities. 	<ul style="list-style-type: none"> Strengthen coordination mechanism for delivering integrated TB and HIV services at the national, state and health facilities. Reduce the burden of TB in people living with HIV and initiate early antiretroviral treatment (the Three I's for HIV/TB).
	Priority Area 9: Human Resources for Health	Objective 8

Strategic Pillar Three – Strengthened health system for delivery of the EPHS	<ul style="list-style-type: none"> Strengthen/establish HRHIS at state and federal levels. Establish mechanisms for annual HRH reviews and reporting for evidence and decision making at the Federal, State, and LGA levels. Improve HRH performance management systems at all levels. 	<ul style="list-style-type: none"> Strengthen coordination mechanism for delivering integrated TB and HIV services at the national, state and health facilities.
TB PREVENTION AND INFECTION CONTROL		
Strategic Pillar Three – Strengthened health system for delivery of the EPHS	Priority Area 7: Emergency Medical Services and Hospital Care Objectives 25 and 27	Objective 6
	<ul style="list-style-type: none"> Strengthen infection prevention and control (IPC) in health care settings Promote & enhance capacity (human and institutional) for continuous quality improvement of Outpatient service Strengthen infection prevention and control (IPC) in health care settings Promote & enhance capacity (human and institutional) for continuous quality improvement of Outpatient service 	<ul style="list-style-type: none"> Improve Infection control practices at most private health facilities Scale-up of quality improvement initiatives from 12 states to 36 states Improve Infection control practices at most private health facilities Scale-up of quality improvement initiatives from 12 states to 36 states
CHILDHOOD TB		
Strategic Pillar Two - Increased utilisation of the Essential Package of Health Care Services	Priority Area 4 - Reproductive, Maternal, New-born, Child & Adolescent Health plus Nutrition (RMNCAH+N)	Objective 3
	<ul style="list-style-type: none"> Expand coverage of IMCI (Community-IMCI, Community 	<ul style="list-style-type: none"> Scale up Integration of child/adolescent TB into RMNCAH+N as well as HIV services – Tertiary, secondary and Primary health facilities

	Case Management (ICCM) & IMCI)	
PROGRAMMATIC MANAGEMENT OF DRUG-RESISTANT TB (PMDT)		
Strategic Pillar Two - Increased utilisation of the Essential Package of Health Care Services	Priority Area 5 – Communicable Diseases (Malaria, TB, Leprosy) and Neglected Tropical Diseases (NTDs)	Objective 4
	<ul style="list-style-type: none"> ● Increase access to diagnosis and management services for DR-TB 	<ul style="list-style-type: none"> ● Increase DR-TB case finding
SUPPLY CHAIN AND LOGISTICS		
Strategic Pillar Three – Strengthened health system for delivery of the EPHS	Priority Area 12 – Health Information	Objectives 12
	<ul style="list-style-type: none"> ● Strengthen institutional framework and coordination for HIS at all levels ● Strengthen capacity to generate, transmit, analyse, and utilise routine health data, from all health facilities, including private health facilities ● Improve integration of existing surveillance systems and diseases registries into the overall health information system 	<ul style="list-style-type: none"> ● Strengthen programme management and capacity at all level for the achievement of the NSP target ● Ensure availability and utilisation of standard electronic R&R tools
COMMUNITY SYSTEM STRENGTHENING (INCLUDING KEY POPULATIONS)		
Strategic Pillar Two - Increased utilisation of the Essential Package of Health Care Services	Priority Area 2: Community Participation in Health	Objectives 3, 5, 6, 9, 10, 11
	<ul style="list-style-type: none"> ● Strengthen institutional and coordinating mechanisms for promotion of community participation ● Strengthen financial management systems at the community levels ● Promote partnerships with communities to address felt needs 	<ul style="list-style-type: none"> ● Strengthen Coordination and Governance ● Targeted Multi-Channelled Social and Behaviour Change for TB using Media ● Strengthened Targeted High Level Advocacy ● Awareness creation and sensitisation of community ● Strengthening Community Systems and Structures for effective participation in TB response ● Strengthen collaboration with and capacity of CBOs to support TB programming. ● Promote school health services Strengthening the referral system Increasing Access to treatment care and support

	<ul style="list-style-type: none"> Strengthen capacities of communities to participate in the planning of health interventions at all levels. Strengthen capacities of communities to facilitate the implementation of community and facility level Minimum Service Package (MSP) Strengthen collaboration with and capacity of CBOs to support TB programming. 	<ul style="list-style-type: none"> Engaging community support and peer groups in ensuring treatment adherence of DR-TB patients Strengthen linkage systems between first points-of contact in communities (PPMV, CP, traditional healers, traditional and religious leaders) and PPM referral facilities Strengthening Community Systems and Structures for effective participation in TB response Targeted Multi-Channelled Social and Behaviour Change for TB using Media Awareness creation and sensitisation of community driven intervention in hard-to-reach and high-risk areas Strengthening the referral system (Childhood TB) Improved access to TB services with Human Rights and Gender considerations. Engagement of community in TB case finding Strengthening Community Systems and Structures for effective participation in TB response
	Priority Area 5: Communicable Diseases (Malaria, TB, Leprosy) and Neglected Tropical Diseases (NTDs)	Objective 9, 10
	<ul style="list-style-type: none"> Promote demand for TB services Strengthen collaboration with and capacity of CBOs to support TB programme Promote innovative advocacy, social mobilisation and behaviour change intervention for the prevention and control of TB Promote community-based TB/Leprosy control initiatives 	<ul style="list-style-type: none"> Awareness creation and sensitisation of communities. Strengthening Community Systems and Structures for effective participation in TB response Targeted Multi-Channelled Social and Behaviour Change for TB using Media Awareness creation and sensitisation of community
	Priority Area 7: Emergency Medical Services and Hospital Care	Objective 5
	<ul style="list-style-type: none"> Strengthen community systems to support Palliative and End-of-life care services 	<ul style="list-style-type: none"> Engaging community support and peer groups in ensuring treatment adherence of DR-TB patients
	Priority Area 8: Health Promotion and Social Determinants of Health	Objective 9, 10, 11

	<ul style="list-style-type: none"> Strengthen community capacity for responses and ownership of health promotion. Promote the inclusion of health promotion in workplace health programs Promote the inclusion of health promotion in school curricula at all levels 	<ul style="list-style-type: none"> Improved access to TB services with Human Rights and Gender considerations Targeted Multi-Channelled Social and Behaviour Change for TB using Media Strengthened Targeted High Level Advocacy Awareness creation and sensitisation of community Strengthened Targeted High-Level Advocacy Engaging community support and peer groups in ensuring treatment adherence of DR-TB patients Awareness creation and sensitisation of community.
	Priority Area 14: Public Health Emergencies, Preparedness and Response	Objective 10
	<ul style="list-style-type: none"> Promote community participation in disease surveillance activities 	<ul style="list-style-type: none"> Awareness creation and sensitisation of community
STRATEGIC INFORMATION AND RESEARCH		
Strategic Pillar Three – Strengthened health system for delivery of the EPHS	Priority Area 12 – Health Information	Objectives 12
	<ul style="list-style-type: none"> Strengthen institutional framework and coordination for HIS at all levels Strengthen capacity to generate, transmit, analyse, and utilise routine health data, from all health facilities, including private health facilities Improve integration of existing surveillance systems and diseases registries into the overall health information system 	<ul style="list-style-type: none"> Strengthen programme management and capacity at all level for the achievement of the NSP target Ensure availability and utilisation of standard electronic R&R tools

Annex 2: Root cause analysis of the TB Programme

Weakness	Root cause	Intervention
Inadequate government funding of TB services at all levels	<ul style="list-style-type: none"> ▪ Lack of effective and targeted advocacy ▪ Inadequate budgetary appropriations for TB. ▪ Wrong perception about TB as non-revenue yielding by Policy Makers. ▪ Verticalisation of TB Control services by TB Programme Implementers. ▪ Non-inclusion of TB Programme in BHCPF and NHIS ▪ Under-prioritisation of TB services due to existence of competing priorities e.g., security, education, other health programmes etc. ▪ Donor funding presence have resulted in poor government response ▪ Non commitment of government bodies to TB programme ▪ Low funding and non-release of appropriated fund ▪ Over-dependence on foreign donors 	<ul style="list-style-type: none"> ▪ Strategic and targeted advocacy (akin to UNICEF strategy) at all levels -national and sub-national levels aimed at getting government to appropriate and release funds for TB ▪ Formation of strong AIDS, TB, and Malaria (ATM) resource mobilisation group (using harmonised advocacy tool kits) ▪ Ensure inclusion of TB services in BHCPF, NHIS and SOML ▪ High-level advocacy to the Presidency and state governors for allocation and release of funds to support the TB programme. ▪ Leverage the First lady of the country and Wives of State Governors to amplify advocacy for TB as a front-burner issue ▪ High level of advocacy to gov. for release of appropriate funds ▪ Strengthening the existing relationship with TB programme and national legislators ▪ Increase budgetary allocation for TB programme
Weak TB diagnostic system, including coverage, quality assurance, equipment optimisation and result turn-around time Weak TB diagnostic network, low coverage of lab QA and equipment maintenance challenges	<ul style="list-style-type: none"> ▪ Inadequate coverage of GeneXpert machines, with poor machine-to-sample ratio. ▪ Poor power supply, cartridges, human resources, and machine maintenance (cost of warranty extension) ▪ Poor attitude of laboratory personnel as regards result turnaround time ▪ Stoppage of state EQA meetings ▪ Inappropriate sample referral systems (NISRN, Riders for Health, Linkage coordinators, use of LGTBLS) ▪ Inadequate utilisation of clinical diagnosis ▪ Inadequate diagnostic tools and equipment ▪ Stock out of cartridges ▪ Donor dependence ▪ Poor planning and forecasting ▪ Non-involvement of regulatory bodies e.g., NAFDAC, SON, MLSSN ▪ Weak stakeholder analysis at the program design stage ▪ Lack of maintenance of GeneXpert ▪ No in-country GeneXpert module maintenance units 	<ul style="list-style-type: none"> ▪ Government to procure additional GeneXpert machines and their accessories to complement the existing machines provided by partners ▪ Government to ensure a sustainable means of funding GeneXpert warranties. ▪ National program to negotiate a downward review of the current GeneXpert warranty cost ▪ Strengthen the mentorship systems to ensure improved attitude of laboratory personnel in result turnaround-time and use of AFB microscopy when necessary. ▪ Government to source resources to reinstate state EQA meetings. ▪ NTBLCP and partners should design efficient sputum transport systems peculiar to specific locations ▪ Expand use of clinical diagnosis platforms
Poor integration of TB services with other relevant	<ul style="list-style-type: none"> ▪ Lack of coordinating platforms between TB program and other health programs e.g., NPHCDA, malaria, family planning, nutrition, 	<ul style="list-style-type: none"> ▪ Strengthen coordination between the national TB program and other sectors through setting up relevant committees

Weakness	Root cause	Intervention
sectors and appropriate application of relevant policies	<ul style="list-style-type: none"> ▪ Lack of multi-sectoral coordination and collaboration platform between TB and other sectors e.g., education, sports, agriculture, transport, National Orientation Agency. ▪ Lack of coordinating mechanism at facility level for TB integration with other departments/units ▪ No strong multi-sectoral collaboration ▪ Low engagement/collaboration of relevant agencies e.g., NCDC, Port authority, Enforcement Agencies ▪ Low awareness of Childhood TB among the RMNCAH and Nutrition programmers ▪ Low engagement of RMNCAH and Nutrition programmes ▪ Inadequate intra facility DOT linkage to other programmes ▪ Low involvement of CBO, CSOs in childhood TB case detection. ▪ Weak integration of in-service training packages (IMCI, iCCM, cIMCI, CMAM) ▪ Problem with Programme design 	<ul style="list-style-type: none"> ▪ Active Synergy/collaboration of relevant MDAs and IPs ▪ SBC directed at targeted Health care provider and community leaders ▪ Carry out Targeted Social and Behaviour Change communication campaigns ▪ Linkage with RMNCAH+N programmes and services
Sub-optimal case finding, TB reporting systems and feedback	<ul style="list-style-type: none"> ▪ Low community and private sector engagement ▪ Weak Coverage of TB diagnoses ▪ Stigmatisation ▪ Non-existence of TB workplace policy ▪ Sub-optimal GOPD screening implementation ▪ Low awareness at community level ▪ Low index of suspicion by HCW ▪ Inadequate access to TB services ▪ Limited awareness / demand creation activities ▪ Weak community ownership ▪ Absent/non-functional WDC/CDCs ▪ Myths and Misconceptions ▪ Weak intra- facility DOTs linkage ▪ Inadequate sensitisation/orientation/ISS/training/mentorship of HCW on TB in CH ▪ Inadequate supervisory /mentorship visits. ▪ Inadequate no of HFs (DOTS sites) ▪ Low awareness about TB among the general population and health care workers ▪ Poor access to health care ▪ Non-routine screening of all OPD attendees for TB 	<ul style="list-style-type: none"> ▪ Awareness and sensitisation, engagement of Community, religious leaders, CBOs World health committee, ▪ Addressing the issue with optimisation of Xpert machine <ul style="list-style-type: none"> ○ Increase number of Xpert machine ○ Redeployment of Xpert machines ○ Deployment of other diagnostic methods ○ Implementation of available MOU on Xpert MTB/Rif maintenance ▪ Demystifying all myths around TB services by massive sensitisation and awareness ▪ Promote patient right ▪ Social and Behavioural Change Communication ▪ SBCC should be directed at targeted Health Care Provider, community leaders and religious leaders ▪ The national TB program should liaise with the Ministry of Labour for the development of TB workplace policy <ul style="list-style-type: none"> ○ Include screening for incarcerated persons in (police cell, inmates) using existing structures in State/LGA such as CBO & CSO and law enforcement health services ▪ Strengthening TB screening at GOPD ▪ Inter-sectoral collaboration with the MDAs

Weakness	Root cause	Intervention
	<ul style="list-style-type: none"> ▪ Poor-reporting of diagnosed cases by public and private providers (both collaborating and non-collaborating facilities with NTP) ▪ Health system delay in diagnosis and commencement of treatment 	<ul style="list-style-type: none"> ▪ Integration of TB services into the general health services ▪ Sensitisation of general health care services
High donor dependence	<ul style="list-style-type: none"> ▪ Low budgetary allocation ▪ Competing priorities ▪ Inefficient advocacy 	<ul style="list-style-type: none"> ▪ Strategic and targeted advocacy
Weak Integration with RMNCAH + N group	<ul style="list-style-type: none"> ▪ Low awareness of Childhood TB among the RMNCAH and Nutrition programmers ▪ Low engagement of RMNCAH and Nutrition programme ▪ Inadequate intra facility DOT linkage to other programmes ▪ Low involvement of CBO, CSOs in CH TB case detection. ▪ Weak integration of in-service training packages (IMCI, iCCM, cIMCI, CMAM) ▪ Problem with Programme design 	<ul style="list-style-type: none"> ▪ Carry out Targeted Social and Behaviour Change communication campaigns ▪ Linkage with RMNCAH+N programmes and services

Annex 3: Framework of the Operational and Technical Assistance Plan NSP-TB 2021 – 2026

Objective 1: To increase TB case notification rate for all forms of TB from 60 per 100,000 population in 2019 to 153 per 100,000 population in 2026 through universal scale-up of patient-centred quality TB services addressing the needs of all populations

	Strategic Intervention 1.1. Improved human resource and capacity development of TB laboratory personnel at all levels of laboratory services								
	Unit	Quantity	Timeline				Implementer		
			Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	
	Activity 1.1.1. Review policy on human resource acquisition and retention								
Sub-activity 1.1.1.1: Conduct a 3 day meeting of 28 participants to review TB laboratory policy for the human resource acquisition and retention	3	28	1						NTBLCP
	Activity 1.1.2 Develop TB laboratory training, materials, programmes, plans and manuals/SOPs for all facilities								
Sub-activity 1.1.2.1: Conduct a 5-day meeting of 28 participants to review the existing TB laboratory training materials, programs plans and SOPs for smear microscopy, Xpert, LPA and C/DST	5	28	1						NTBLCP
	Activity 1.1.3 Develop a national TB diagnostic Manual of operation								
Sub-activity 1.1.3.1 Conduct a 5-day meeting of 28 participants to develop the national TB diagnostic and QA Manual of operations including review after 2 years	5	28	1		1				NTBLCP
Sub-activity 1.1.3.2: Conduct two-time 3 days review	3	15	1		1				NTBLCP

meeting of 15 participants on the national TB diagnostic and EQA operations manual									
Sub-activity 1.1.3.3: Print 5,500 TB laboratory policy manual for all TB laboratories (AFB-LED, GeneXpert and Culture lab and new WHO approved molecular diagnostics) including buffer	1	5,500	1		1				NTBLCP
Sub-activity 1.1.3.4 Distribute TB laboratory policy manual to all TB laboratories (AFB-LED, GeneXpert and Culture lab). 5,500 in 2021 and 5500 in 2024	1	5,500	1		1				NTBLCP
Activity 1.1.4. Conduct annual training and retraining of TB laboratory personnel on diagnostics and management at all levels									
Sub-activity 1.1.4.1. Conduct a 5-day ToT workshop of 25 participants and 3 facilitators for the national TB diagnostic and QA Manual of operations	5	28	1						NTBLCP
Sub-activity 1.1.4.2: Conduct a 5-day zonal training for 256 new smear microscopy sites (100 in 2021; 56 in 2022; 50 in 2023; 50 in 2024) 2 participants per site, 24 participants and 3 facilitators including secretariat staff per batch of 18 trainings	5	27	100	56	50	50			NTBLCP

Sub-activity 1.1.4.3: Conduct a 5-day training for each of the 256 new GeneXpert sites (100 in 2021; 56 in 2022; 50 in 2023; 50 in 2024) 5 participants per site (1280 participants) and 2 facilitators per site (512)	5	7	100	56	50	50			NTBLCP
Sub-activity 1.1.4.4 Conduct a 21-day refresher training of two participants per site and 5 facilitators for each of the LPA, C/DST sites at the NRL (27 in 2021, 33 in 2023 and 33 in 2025)	21	7	11		14		14		NTBLCP
Strategic Intervention 1.2. Strengthen and scale up TB diagnosis at all levels									
Activity 1.2.1. Increase on the number of Gx sites from 398 in 2019 to 654 sites by 2025									
Sub-activity 1.2.1.1: Conduct assessment of 256 facilities for the installation of the GeneXpert machines (100 in 2021, 56 in 2022, 50 in 2023, 50 in 2024 and maintain functionality in 2025)	1	37	100	56	50	50			NTBLCP
Sub-activity 1.2.1.2: Provide basic renovation and upgrading of infrastructures at the identified GeneXpert sites (see basic renovation list) ((100 in 2021, 56 in 2022, 50 in 2023, 50 in 2024)	1	37	100	56	50	50			NTBLCP

Sub-activity 1.2.1.3: Procure 256 GeneXpert machines and accessories (inverter, solar panels, batteries etc) for additional 256 new GeneXpert sites (100 in 2021, 56 in 2022, 50 in 2023 and 50 in 2024, maintain functionality in 2025)	1	37	100	56	50	50			NTBLCP
Sub-activity 1.2.1.4: Distribution and installation of the procured GeneXpert and accessories (100 in 2021, 56 in 2022, 50 in 2023 and 50 in 2024, maintain functionality in 2025)	1	37	100	56	50	50			NTBLCP
Sub-activity 1.2.1.5: Install the GeneXpert machines (100 in 2021, 56 in 2022, 50 in 2023 and 50 in 2024, maintain functionality in 2025) at the sites	1	37	100	56	50	50			NTBLCP
Sub-activity 1.2.1.6: Site based training during installation of GeneXpert machine for 4 Lab staff, 4 Clinicians, 4 GHCW, 4 Nurses for 4 days (100 in 2021, 56 in 2022, 50 in 2023 and 50 in 2024)	4	20	100	56	50	50			NTBLCP

Activity 1.2.2. Increase the number of microscopy centers from 3106 to by 3727 by 2024									
Sub-activity 1.2.2.1: Conduct an assessment for the identification of health facilities (public and private) for the establishment of AFB microscopy services (100 in 2021, 56 in 2022, 50 in 2023 and 50 in 2024)	1	37	100	56	50	50			NTBLCP
Sub-activity 1.2.2.2: Conduct assessment of existing 3,220 AFB microscopy centres to identify infrastructural needs during routine supervision using a checklist	1	3106	1	1	1	1	1		NTBLCP
Sub-activity 1.2.2.3: Provide basic renovation of the identified facilities to provide AFB microscopy services (3206 in 2021, 3262 in 2022, 3312 in 2023 and 3362 in 2024)	1	3362	1	1	1	1			NTBLCP
Sub-activity 1.2.2.4: Develop a protocol for maintenance of microscopes and other small laboratory equipment (at no cost)	1	1	1						NTBLCP
Activity 1.2.3. Hire the services of 2 maintenance Engineers biannually									
Sub-activity 1.2.3.1: Hire the services of 2 maintenance Engineers biannually for 5-days for the retrieval and repair of non-functional laboratory equipment in each of the 37 states	5	2	37	37	37	37	37		NTBLCP

Activity 1.2.4. Increase the number of functional TB Reference laboratories from 10 to 15 by year 2023									
Sub-activity 1.2.4.1: Conduct a 2-day assessment visit for the identification of health facilities for the establishment of additional culture facilities (2021 - 2; 2022 - 1; 2023- 2)	2	5	2	1	2				NTBLCP
Sub-activity 1.2.4.2: Set up 4 new culture laboratories with capacity to do drug susceptibility testing (2021 - 2; 2022 - 2)	5	2	2	2					NTBLCP
Activity 1.2.5. Increase LPA sites for both first- and second-line DST									
Sub-activity 1.2.5.1: Conduct a 2-day assessment visit of 2 assessors for the identification of health facilities for the establishment of additional LPA facilities (2021 - 2; 2022 - 1; 2023- 2)	2	2	2	1	2				NTBLCP
Sub-activity 1.2.5.2: Set up 5 new LPA facilities in addition to the existing 9 sites (2021 - 2; 2022 - 1; 2023- 2)	5	2	2	1	5				NTBLCP
Activity 1.2.6: Increase capacity for culture (solid & liquid) and DST among all TB culture labs									
Sub-activity 1.2.6. 1: Conduct a 3-weeks training of 28 participants and 5 facilitators in liquid culture and DST for the 14 culture laboratories	21	33	1						NTBLCP

Sub-activity 1.2.6. 2: Procure 5 days technical assistance of two consultants to the NTRL after every two years	5	2	1		1				NTBLCP
Sub-activity 1.2.6. 3: Participate 21 days two SRL trainings for 4 persons in DST for new and repurposed TB drugs every two years	21	4	1		1				NTBLCP
Sub-activity 1.2.6. 4: Conduct refresher training in culture and DST for 22 participants and 5 facilitators in 2021, 28 participants and 5 facilitators in 2023 in the 14 TB culture laboratories after every two years	21	14	27		33				NTBLCP
Sub-activity 1.2.6.5: Conduct a 2-day zonal ToT of two participants per state and FCT (n=74) and 12 facilitators on sample collection, packaging and transportation every two years (86 in 2021, 86 in 2023 and 86 in 2025)	2	86	1		1		1		NTBLCP

Activity 1.2.7: Review of TB diagnostic algorithm to accommodate new innovations									
Sub-activity 1.2.7.1: Conduct 2-day TB diagnostic review meetings of 25 persons to revise TB diagnostic algorithm after every two years to accommodate new innovations	2	25	1		1				NTBLCP
Activity 1.2.8: Sensitisation and awareness of all stakeholders on TB diagnostic network services									
Sub-activity 1.2.8.1: Conduct a 2-day sensitisation meeting and awareness of 80 stakeholders on TB diagnostic network services (QA-37, RL-14, NTBLCP-10, IP-15, STBLPM-4)	2	80	1						NTBLCP
Activity 1.2.9: TB laboratory network assessment (mid and end term reviews)									
Sub-activity 1.2.9.1: Conduct a two weeks (14 days) laboratory network assessment (14 local participants and 14 international participants/consultants)	14	28			1		1		NTBLCP
Activity 1.2.10: Development and monitoring of key performance indicators at all levels of TB laboratory network.									
Sub-activity 1.2.10.1: Conduct two (2021 & 2023) 5-day national meetings of 20 participants to develop and review key TB laboratory performance indicators for all services	5	20	1		1				NTBLCP

Sub-activity 1.2.11: Mapping service point areas including sample referral in six Geo-political zones to reduce diagnostic delays due to lack of equipment or breakdown									
Sub-activity 1.2.11.1: Conduct two (2021 & 2023) 2-day national mapping meeting of 15 persons to allocate service points for TB laboratory diagnostic services	2	15	1		1				NTBLCP
Activity 1.2.12: Develop and distribute manual for sample transport system and M&E framework to track key indicators									
Sub-activity 1.2.12.1: Conduct three 5-day workshop of 20 persons to develop a national sample transportation manual including key performance indicators every after 2 years (2021, 2023, 2025)	5	20	1		1		1		NTBLCP
Sub-activity 1.2.12.2: Conduct a 5 day workshop of 25 persons to finalise sample transport manual including key performance indicators	5	25	1						NTBLCP

Activity 1.2.13: Review existing QA guidelines, plans, and training materials for Laboratory Quality Management System (LQMS) twice in the NSP period									
Sub Activity 1.2.13.1. Conduct two 5 day workshop of 20 persons and 3 facilitators to review existing QA guidelines, plans, and training materials for Laboratory Quality Management System (LQMS) twice (2021 & 2023) in the NSP period	2	23	1		1				NTBLCP
Activity 1.2.14: Expand and maintain infrastructure and biosafety for TB culture and DST									
Sub Activity 1.2.14.1. Conduct two (2021, 2024) 5-day workshop of 15 persons to review the national TB biosafety manual and infection control and develop a biosafety audit checklist	5	15	1		1				NTBLCP
Sub Activity 1.2.14.2. Print and disseminate the national biosafety manual to all TB laboratories (n=3377); twice 2021 & 2024)	1	3377	1		1				NTBLCP
Sub Activity 1.2.14.3. Conduct a 5-day ToT of the TB laboratory biosafety manual and repeat after every two years for 15 participants and 3 facilitators	5	18	1		1		1		NTBLCP

Sub Activity 1.2.14.4: Conduct biannual audit for TB laboratory biosafety and infrastructure for all H/Fs at all levels done by national and state QA officers during the support supervision visits (23 participants after every six months)	2	37	2	2	2	2	2		NTBLCP
Activity 1.2.15. Establish performance-based incentives such as recognising best performing labs, certificates, personnel recognition within the laboratories									
Sub Activity 1.2.15.1: Provide reward/incentive for three best performing state laboratory personnel during the annual TBL program manager's meeting	1	3	1	1	1	1	1		NTBLCP
Sub Activity 1.2.15.2: Identify high performing GeneXpert sites based on verifiable criteria	1	2	1	1	1	1	1		NTBLCP
Sub Activity 1.2.15.3: Provide reward/incentive for each test performed by laboratory personnel on Xpert MTB/RIF bench for improved quality result and high/increased performance of Xpert MTB/RIF test to increase case detection.	1	7,200,000	1,440,000	1,440,000	1,440,000	1,440,000	1,440,000		NTBLCP

Activity 1.2.16: Training of clinicians on the clinical and programmatic management of TB for public and private practitioners									
Sub-activity 1.2.16.1 Update and print 18,900 training manuals on the clinical and programmatic management of TB	Updated and printed training manuals	18,900	18,900						NTBLCP
Sub-activity 1.2.16.2: Conduct a 2-day residential training for 18,652 of clinicians in the country	2-Day residential training for Clinicians	20,518	8,207	8,207	4,105				NTBLCP
Sub-activity 1.2.16.3: Conduct a 3-day residential training (task-shifting) for Officers in Charge of PHCs in 8,809 wards in the country on childhood TB diagnosis	3-Day residential training for PHC OiCs	9691	4846	4845					NTBLCP
Activity 1. 2..17: Scale up free chest X-ray services for children and adults to Secondary and Tertiary Health Facilities									
Sub-activity 1.2.17.1: Provide free chest X-ray for 1,120,000 under 5 years beneficiaries	Free X-Ray for U5	1,120,000	224,000	224,000	224,000	224,000	224,000		NTBLCP
Sub-activity 1.2.17.2: Provide free chest X-ray for 2,800,000 adult beneficiaries in 5 years	Free X-Ray for Adults	2,800,000	560,000	560,000	560,000	560,000	560,000		NTBLCP
Sub-activity 1.2.17.3: Provide transport vouchers for 71% of under 5 beneficiaries	Transport Vouchers for U5 Children	795,200	159,040	159,040	159,040	159,040	159,040		NTBLCP

Sub-activity 1.2.17.4: Annual procurement and installation of 3 digital Chest X-ray machines in 36 + 1 states	Procurement and Installation of Digital Chest X-Ray Machines	555	111	111	111	111	111		NTBLCP
Strategic Intervention 1.3: Strengthening TB laboratory Quality Management System (LQMS) at all levels of the network									
Activity 1.3.1. Training of laboratory personnel on basic QMS activities									
Sub-activity 1.3.1.1: Conduct a 5-day TOT for 20 TB laboratory QMS mentors and 5 facilitators after every 2 years	5	25	1		1		1		NTBLCP
Sub-activity 1.3.1.2: Conduct a 2-day state quarterly EQA meeting for Smear Microscopy and GeneXpert Laboratories (52 participants including QA officer, their deputies and 4 NTP) for 8288 persons annually	2	2072	4	4	4	4	4		NTBLCP
Sub-activity 1.3.1.3: Support 5 resident NRL lab staff and 20 external staff to prepare GeneXpert panels for 5 days (498 in 2021, 554 in 2022, 604 in 2023, 654 in 2024, 654 in 2025) for GeneXpert sites at the 2 NRLs twice a year for 5 years.	5	25	2	2	2	2	2		NTBLCP

Sub-activity 1.3.1.4: Conduct a biannual 5 day meeting for 25 participants the development for GeneXpert and LPA site specific reports	5	25	2	2	2	2	2		NTBLCP
Sub-activity 1.3.1.5: Use courier to distribute GeneXpert panels to GeneXpert sites (498 in 2021, 554 in 2022, 604 in 2023, 654 in 2024, 654 in 2025) and LPA and Culture sites (12 in 2021, 12 in 2022, 14 in 2023, 14 in 2024 and 14 each in 2025) twice a year for 5 years.	1	654	2	2	2	2	2		NTBLCP
Strategic Intervention 1.4: National TB reference laboratories Accreditation programmes									
Activity 1.4.1. Enrol the National TB reference laboratories in Accreditation programmes									
Sub-activity 1.4.1.1. Conduct a 5-day stakeholders accreditation preparation activities for the RLs including national and international audits (2 participants per 5 RL and 4 facilitators, in 2021 and 2 participants per 7 RL and 4 facilitators in 2023)	5	33	1		1				NTBLCP
Sub-activity 1.4.1.2. Baseline assessment for 10 RLs with 2 assessors per RL (7 RL assessment in 2021 and 3 RLs in 2023)	5	2	7		3				NTBLCP

Sub-activity 1.4.1.3. Workshop 1 for 10 RLs with 2 assessors per RL (7 RL assessment in 2021 and 3 RLs in 2023)	1	28	1		1				NTBLCP
Sub-activity 1.4.1.4. Conduct first follow-up assessment of the 10 reference laboratories with 2 assessors per RL (7 RL assessment in 2021 and 3 RLs in 2023)	1	20	1		1				NTBLCP
Sub-activity 1.4.1.5. Conduct 5 days Workshop 2 for 10 RLs with 2 assessors per RL (7 RL assessment in 2021 and 3 RLs in 2023)	5	28	1		1				NTBLCP
Sub-activity 1.4.1.6. Conduct 5 days workshop 3 for 13 laboratories in 2023 and 13 in 2024: 4 facilitators per workshop 3 (8 facilitators) and 26 participants	5	34			1	1			NTBLCP
Sub-activity 1.4.1.7. Conduct 5 days 3rd follow up assessment of the 13 reference laboratories with 2 assessors per RL (13 RL assessment in 2023 and in 2024)	5	26			1	1			NTBLCP
Sub-activity 1.4.1.8. Conduct 3 days Local SLMTA Audit	3	26			1	1			NTBLCP

Sub-activity 1.4.1.9. Conduct Local Mentorship for 2 weeks (14 days) by 1 SLMTans/Auditors per RL	14	1			1	1			NTBLCP
Sub-activity 1.4.1.10. Conduct 2 days national accreditation visit by MLSCN to 13 RLs	2	13			1	1			NTBLCP
Sub-activity 1.4.1.11. Procure application fees for SANAs Accreditation for 13 RLs	1	13			1	1			NTBLCP
Sub-activity 1.4.1.12. Conduct 5 days document review by external accreditors (SANAs)	5	26			1	1			NTBLCP
Sub-activity 1.4.1.13. Pre assessment fees for 13 RLs	1	13			1	1			NTBLCP
Strategic Intervention 1.5. Scale of novel oral DR-TB regimen and new drugs									
Activity 1.5.1. Increase capacity of diagnostic laboratory using the WHO rapid molecular tools culture (solid & liquid) and DST among all TB culture labs									
Sub Activity 1.5.1.1. TB LAMP Equipment: Direct Importation	1	250	100	50	50	50			NTBLCP
Sub Activity 1.5.1.2. TB LAMP Equipment- Local Procurement	1	250	1	1	1	1	1		NTBLCP
Sub Activity 1.5.1.3. LF-LAM: Direct Importation	1	1435	1	1	1	1	1		NTBLCP
Sub Activity 1.5.1.4. LF LAM- Local Procurement	1	1435	1	1	1	1	1		NTBLCP

Sub Activity 1.5.1.5. TrueNat- Local Procurement			1	1	1	1	1		NTBLCP
Strategic Intervention 1.6: Establishment of TB policy in workplace									
Activity 1.6.1: Engagement of authorities of Ministries of Labour & Interior to adopt and implement TB services in workplace									
Sub-activity 1.6.1.1: High-level advocacy to decision makers in the Ministries of Labour & Interior to include routine TB screening into the workplace policy.	High Level Advocacy to Ministries of Labour and Interior	2	1		1				NTBLCP & STBLCP
Sub-activity 1.6.1.2: Sensitisation of Labour leaders at state level to ensure implementation of routine TB screening in workplaces.	Sensitisation meeting with Labour Leaders	2	1		1				STBLCP
Strategic Intervention 1.7: Improve active case finding among key populations (HIV infected individuals, Contacts to active TB cases, Nomads, Migrants and IDPs, Prisoners, Slum dwellers, Children, Miners, Inmates of Police Cells, Diabetes Mellitus)									
Activity 1.7. 1: Conduct active contact tracing and screening regularly									
Sub-activity 1.7.1.1: Compile list of all index PTB patients currently on treatment as at January 2021.	List of Index PTB patients currently on treatment	All index cases of PTB currently on treatment as at Jan 2021	All index cases of PTB currently on treatment as at Jan 2021	All index cases of PTB currently on treatment as at Jan 2022	All index cases of PTB currently on treatment as at Jan 2023	All index cases of PTB currently on treatment as at Jan 2024	All index cases of PTB currently on treatment as at Jan 2025		Health Facility/LGTBLS

Sub-activity 1.7.1.2: Identify and recruit 2 contact tracers/LGA in 774 LGAs.	Recruited Contact Tracers	1548	1548						STBLCP
Sub-activity 1.7.1.3: One day orientation for 1,548 contact tracers on TB screening and contact investigation	One-day orientation for Contact Tracers	1672	1672						STBLCP/LGTBLS
Sub-activity 1.7.1.4: Develop, print, and distribute contact investigation forms	Developed and Printed Contact investigation forms	9,079,098	1599288	1695156	1795164	1926222	2063268		NTBLCP
Sub-activity 1.7.1.5: Conduct contact investigation of bacteriologically diagnosed index cases	conduct contact investigation	1,134,887	199911	211894.5	224395.5	240777.75	257908.5		STBLCP/LGTBLS
Sub-activity 1.7.1.6: Monthly monitoring of contact investigation by LGTBLS/STBLCP	Monitoring of Contact investigations	1,134,887	199911	211894.5	224395.5	240777.75	257908.5		NTBLCP/STBLCP
Sub-activity 1.7.1.7: Provision of incentives per index case visited by the contact tracer	Provision of incentives per index TB case	1,134,887	199911	211894.5	224395.5	240777.75	257908.5		STBLCP

Activity 1.7.2: Targeted active case finding among Nomadic/Migrant population									
Sub-activity 1.7.2.1: Identify 12 States with highest population of Nomads by desk review	States with highest population of Nomads	12	12						NTBLCP
Sub-activity 1.7.2.2: Identify a contact person for Nomads from the ministry of livestock in each of the 12 States with highest population of Nomads.	contact person (desk officer) for Nomads in Min. of Livestock	12	12						STBLCP
Sub-activity 1.7.2.3: Support 2 persons from the state on a 5-day field visit to identify nomadic community leaders as well as map nomadic communities, cattle routes, resting points and TB health facilities along/proximal to identified nomadic communities and cattle routes in each of the 12 states	5-days field visit to map and link nomadic communities, routes, and link to TB HF	12	12						STBLCP/LGTBLS

Sub-activity 1.7.2.4: Conduct a 1-day stakeholders meeting of 20 persons including nomadic community leaders, representatives of the livestock (veterinary) health service etc on TB control among Nomads (transportation, DSA) in each of the 12 states	1-day stakeholders meeting on TB control among Nomads	12	12						NTBLCP/STBLCP
Sub-activity 1.7.2.5: Production of radio jingles on Tuberculosis in relevant local languages	produce radio jingle on TB	2	24						STBLCP
Sub-activity 1.7.2.6: Airing of radio jingles thrice weekly in each State	airing of radio jingles	720	144	144	144	144	144		STBLCP
Sub-activity 1.7.2.7: Implement quarterly 1-day (2 nights) outreach in nomadic settlements in the 12 states for screening nomads for TB.	quarterly outreach at nomadic settlements	240 outreaches	48	48	48	48	48		STBLCP/LGTBLS
Activity 1.7.3: Establishment and implementation of TB services in IDP camps									
Sub-activity 1.7.3.1: Identify and map 328 IDP camps to TB services through the state/LGA TBLCP	IDP Camps linked to TB services	328 IDP Camps	328						NTBLCP/STBLCP
Sub-activity 1.7.3.2: Update the list of IDP camps in the Federation	Updated list of IDP Camps	328 IDP Camps	328						STBLCP/LGTBLS

Sub-activity 1.7.3.3: One-day orientation on TB to IDP camp administrators and IDP leaders	Orientation on TB in IDP Camps	674	674		656 (Refresher Orientation)				STBLCP/LGTBLS
Sub-activity 1.7.3.4: Identify and mentor 656 (2*328) IDP liaison officers on TB identification, specimen referral and linkage to treatment	Mentoring of Liaison Officers in IDP Camps	674	674						STBLCP/LGTBLS
Sub-activity 1.7.3.5: Conduct Quarterly outreaches (over 2 days) in each IDP camp	Outreach visits to IDP Camps	6560	1312	1312	1312	1312	1312		STBLCP/LGTBLS
Sub-activity 1.7.3.6: Provide monthly communication support for IDP LO	Communication allowance	656	656	656	656	656	656		STBLCP/LGTBLS
Sub-activity 1.7.3.7: Provision of 4*328 community R & R tools for TB cascade documentation	PSM Group to handle								
Sub-activity 1.7.3.8: Provision of 328 specimen referral boxes for specimen transportation	PSM Group to handle								
Activity 1.8.4: Regular screening of inmates of Nigerian Correctional Service Centres/Police cells for TB									
Sub-activity 1.8.4.1: Sensitisation of heads of correctional and Police division centres on TB		1733	1213	520					NTBLCP/STBLCP

Sub-activity 1.8.4.2: Orientation of staff of correctional service centres/police divisions on TB screening among inmates		22,529	15770	6759					STBLCP/LGTBLS
Sub-activity 1.8.4.3: Implementation and monitoring of TB services at correctional service centres/Police division by LGTBLS/STBLCP		1733	1213	1733	1733	1733	1733		STBLCP/LGTBLS
Activity 1.8.5. Adoption and implementation of WHO TB/DM Guidelines									
Sub-activity 1.8.5.1: Carry out one-day advocacy visit to Stakeholders at the State level on the importance of Community engagement in TB Control	TB/HIV group								
Activity 1.8.5.2: Targeted active TB case finding among Miners like Quarries									
Sub-activity 1.8.5.3 Advocacy and Sensitisation to the umbrella body of miners.		108 persons	108						STBLCP
Sub-activity 1.8.5.3: Identify and map out 26 mining LGA (30% of 85 LGA) in 6 states		26	26						STBLCP

Sub-activity 1.8.5.4: Recruitment and orientation of 130 ad hoc staff on TB identification and referral (active TB case finding) in mining communities		130	130						STBLCP/LGTBLS
Sub-activity 1.8.5.5: Implementation of targeted case finding in miners' communities		130	130	130	130	130	130		STBLCP
Strategic Intervention 1.9: Integrate 'One Health' approach (zoonotic TB)									
Activity 1.9.1: Adoption and implementation of the one health strategic plan 2019-2023									
Sub-activity 1.9.1.1: Advocacy visit to the DG NCDC through National One Health Coordinating Unit		1	1						NTBLCP
Sub-activity 1.9.1.2: Convene a meeting with the OH desk officers - Human Health/Animal Health/Environmental Health with NTBLCP.		1	1						NTBLCP
Sub-activity 1.9.1.3: Meeting between heads of Veterinary Department and TBLCP at the state and LGA level		1	1						STBLCP

Sub-activity 1.9.1.4: Participate in NTBLCP Quarterly review meeting by State Veterinary and Environment Desk Officers on Animal Health and Environmental Health.		740	148	148	148	148	148		STBLCP
Strategic Intervention 1.10: Strengthen and scale up screening of clients at all outpatient department (OPD) and TB cascade recording and reporting at all levels									
Activity 1.10.1: Scale up screening of clients at all OPD and TB cascade recording/reporting in high volume health facility settings.									
Sub-activity 1.10.1.1 Advocacy to Health Facility management and mapping of OPD for TB screening and cascade recording & reporting		6,528	2,611	2,611	1,306				NTBLCP/STBLCP
Sub-activity 1.10.1.2: Conduct 1-day orientation of 110,976 participants (in 6,528 batches) on screening of clients at all OPD and TB cascade recording & reporting		110,976	44,390	44,390	22,196				NTBLCP/STBLCP
Sub-activity 1.10.1.3: Implement screening of clients at all OPD and TB cascade recording/reporting by trained participants in 6,528 health facilities		6,528	6,528	6,528	6,528	6,528	6,528		NTBLCP/STBLCP

Sub-activity 1.10.1.4: Develop, print, and distribute relevant R&R tools for screening (Screening tools, stickers, and weekly report tools)	Developed and printed R&R tools	2,639,025 stickers, 32,640 laminated screening tools, 1,566,720 weekly reporting tools per year	527805 stickers, 6528 laminated screening tools, 313,344 weekly reporting tools per year	527805 stickers, 6528 laminated screening tools, 313,344 weekly reporting tools per year	527805 stickers, 6528 laminated screening tools, 313,344 weekly reporting tools per year				NTBLCP/STBLCP
Sub-activity 1.10.1.5: Conduct weekly review and analysis of TB cascade data per OPD by focal persons	Review and analysis of TB cascade data by facility		6528	2611	5222	6528	6528		Health Facility/LGTBLS
Sub-activity 1.10.1.6: Provide monthly stipends per ad hoc staff for OPD screening	Monthly stipend for ad hoc staff	1088	1088	1088	1088	1088	1088		STBLCP/LGTBLS
Strategic Intervention 1.11: Scale up TB services to all health facilities									
Activity 1.11.1: Expansion of TB service to all Health facilities without TB services at all levels (both Private and Public)									
Sub-activity 1.11.1.1: Assessment and selection of 16,300 non-TB treatment & referral health facilities.		16,300	8,150	8,150					NTBLCP/STBLCP
Sub-activity 1.11.1.2: Conduct a 5-day residential training for 32,600 new TB service providers on clinical and programmatic management of TB (DS & DR-TB)		32,600	16,300	16,300					NTBLCP/STBLCP

Sub-activity 1.11.1.3: Assessment and selection of 4,075 non-TB referral health facilities.		4,075	4,075						STBLCP/LGTBLS
Sub-activity 1.11.1.4: Conduct a 1-day non-residential orientation on TB identification and referral for 4,075 personnel		4,075	4,075						STBLCP/LGTBLS
Strategic Intervention 1.12: TB in Emergency/ Crisis Situation									
Activity 1.12.1: Review, print and disseminate the national SOP on managing TB during emergency/crisis situation									
Sub-activity 1.12.1.1									
Sub-activity 1.12.1.2									
Activity 1.12.2: Establish linkage with relevant emergency management agencies and other stakeholders (SEMA, MoH, state NLC/TUC, UN-HCR, WHO, UNICEF, Red Cross, MSF, State Disaster Management Committee, etc.)									
Sub-activity 1.12.2.1									
Sub-activity 1.12.2.2									
Activity 1.12.3: Provide supervisory supports to the camp clinic/platform									
Sub-activity 1.12.3.1									
Sub-activity 1.12.3.2									
Strategic Intervention 1.13: TB in Lung Health									
Activity 1.13.1: Develop technical and operational guidelines on PAL									
Sub-activity 1.13.1.1									
Sub-activity 1.13.1.2									

Activity 1.13.2: Establish a national working group (NWG) to assess the epidemiological situation of respiratory diseases									
Sub-activity 1.13.2.1									
Sub-activity 1.13.2.2									
Activity 1.13.3: Establish intra- and inter-organisational coordination bodies for the PAL strategy									
Sub-activity 1.13.3.1									
Sub-activity 1.13.3.2									
Objective 2: To achieve and sustain TB treatment success rate of 90% by 2025									
Strategic Intervention 2.1: Ensure TSR among TB patients supported by TS is $\geq 90\%$									
Activity 2.1.1: Provision of social support to patients as motivation for treatment completion.									
Sub-activity 2.1.1.1: Monthly social support to every TB patient throughout the period of treatment	Social support for TB patient	1,719,526	302896	321052	339993	364815	390770		NTBLCP/STBLCP
Sub-activity 2.1.1.2: Linking of patient-selected treatment supporter to residential CBOs	link patient-selected TS to CBOs	1,513,183	266549	282526	299193	321037	343878		STBLCP/LGTBLS

Sub-activity 2.1.1.3: 1-day non-residential Orientation for 2 CBO staff on TB treatment monitoring (drug administration and follow-up investigation)	orientation of 2 CBO staff on TB treatment monitoring	1,770	1,770						STBLCP/LGTBLS
Sub-activity 2.1.1.4: Monthly monitoring visits of TB patients & TS in the community	monitoring visits of TB patients & TS in the community	139320	27864	27864	27864	27864	27864		STBLCP/LGTBLS
Sub-activity 2.1.1.5: Monthly stipend to CBO for managed care	monthly stipend to CBO for managed care	1,513,183	266549	282526	299193	321037	343878		STBLCP
Activity 2.1.2: Advocacy to the state, LGA and community stakeholders									
Sub-activity 2.1.2.1: Carry out one-day advocacy visit to Stakeholders at the State level on the importance of Community engagement in TB Control	NTP Staff								
Sub-activity 2.1.2.2: Conduct 5-day training for 25735 HF (2 HW per facility) to provide TB services	Health workers	25735	2	2	2	2	2		

Strategic Intervention 2.2: Care and Support for TB Patients									
Activity 2.2.1: Inclusion of TB Treatment and Care in Social Welfare Packages									
Sub-activity 2.2.1.1: Advocacy to National Health Insurance Scheme (NHIS) & SHIS management to include all elements of TB care into insurance scheme benefit package.		37 (36 SHIS + 1 FCT)	37	37	37	37	37		NTBLCP/STBLCP
Sub-activity 2.2.1.2: Advocacy to leadership of National and State Assemblies to enact laws and motions aimed at eliminating discrimination and ensure job security for TB patients.		37 (36 states + 1)	37	37	37	37	37		NTBLCP/STBLCP
Sub-activity 2.2.1.3: To Link TB affected households to food security programs		390,770	302896	321052	3399993	364815	390770		NTBLCP/STBLCP

Objective 3: To enhance childhood TB detection and treatment through innovative provision of integrated services towards achieving childhood TB proportion of 16% among all forms of TB cases.									
Strategic Intervention 3.1: Align treatment capacity scale-up with increased diagnostic capacity to reach a treatment success rate of 90% in children by 2025									
Activity 3.1.1: Provision of social support to reduce financial barriers to accessing care for child TB									
Sub-activity 3.1.1.1: Provide funds for movement of sputum samples to GeneXpert diagnostic centres		11,406,085	363,480	385,260	203,995				NTBLCP
Sub-activity 3.1.1.2: Provide funds for movement of children for chest x-ray		1031715	181740	192,630	203,995	218,890	234,460		NTBLCP
Sub-activity 3.1.1.3: Provide funds for chest X-ray of presumptive child TB cases diagnostic centres	Chest Xray for children	2063430	363480	385260	407990	218,890	234,460		NTBLCP
Sub-activity 3.1.1.4: Provide funds for Tuberculin skin test (TST) for presumptive child TB	Tuberculin skin test	2063430	363480	385260	407990	437780	468920		NTBLCP
Sub-activity 3.1.1.5: Provide funds for purchase of NG tubes to diagnose TB in children.		3301892	218088	231560	244794	262668	281352		NTBLCP

Activity 3.1.2: Build capacity of STBLCPM, LGA PHC coordinators, State programme staff, LGA TBLS and other health care workers on child TB including contact investigations, TPT and recording and reporting									
Sub-activity 3.1.2.1: Conduct 5-day expert meeting to update training manuals on child TB incorporating new recommendations in contact investigations, TB preventive therapy and recording and reporting	Expert meeting								NTBLCP
Sub-activity 3.1.2.2: Conduct 6-days comprehensive training for drug susceptible and drug resistant TB to State programme managers on child TB in all 36 states and the FCT	Child DS & DR TB training for State Programme Managers								NTBLCP
Sub-activity 3.1.2.3: Print 4,000 copies of updated training manual on diagnosis and management of drug susceptible and drug resistant TB	Updated training manual on diagnosis and management of DS & DR TB	4000							NTBLCP

Sub-activity 3.1.2.4: Distribute 4,000 copies of updated training manual on diagnosis and management of drug susceptible and drug resistant TB	Updated training manual on diagnosis and management of DS & DR TB	4000								NTBLCP
Sub-activity 3.1.2.5: Conduct 6-days comprehensive training for drug susceptible and drug resistant TB to all 774 LGA TBLS across the country and the FCT	Child DS & DR TB Training for TBLS									NTBLCP
Sub-activity 3.1.2.6: Conduct 6-days comprehensive training for drug susceptible and drug resistant TB to all 774 LGA PHC coordinators across the country and the FCT	Child DS & DR TB Training for PHC Coordinators									NTBLCP
Sub-activity 3.1.2.7: Conduct 6 days training on management and control of child TB for 360 health care workers (2 doctors/2 nurses) from tertiary institutions across the country	Child TB management and control training for HCW in tertiary facilities									NTBLCP

Sub-activity 3.1.2.8: 4 days training on management and control of TB in children for 444 participants in the 1st and 2nd year (2 Doctors and 2 nurses/health workers from 2 GH and 1 Specialist hospital per State x 37 States). 25 people per training	Child TB management and control training for HCW in GH facilities								NTBLCP
Sub-activity 3.1.2.9: Conduct 1-day training for 740 nurses (2 per facility and 10 facilities per state) from secondary facilities on gastric aspiration for child TB diagnosis	Training for gastric washing for diagnosis for HCW nurses								NTBLCP
Strategic Intervention 3.2: Strengthen the referral system between the peripheral facilities and tertiary/secondary institutions to improve case management of complications and more severe forms of TB in children									
Activity 3.2.1: Linking of peripheral facilities to one tertiary/secondary hospital using the spoke and hub system									
Sub-activity 3.2.1.1: Support Quarterly communication cost at 5,000 Naira for the 109 focal persons above	Communication cost for focal paediatrician	109							NTBLCP

Sub-activity 3.2.1.2: Build the capacity of peripheral facility staff for the referral process - This is already part of the training curriculum as captured above									NTBLCP
Strategic Intervention 3.3: Increase awareness of child TB among children through promotion of school health services									
Activity 3.3.1: Sensitisation/orientation of school children on TB									
Sub-activity 3.3.1.1: Conduct mapping of all formal primary schools within slums in all LGAs in the country	Mapping of formal primary schools within slums								NTBLCP
Sub-activity 3.3.1.2: Conduct mapping of all informal schools within slums for children in all LGAs in the country	Mapping of informal schools within slums								NTBLCP
Sub-activity 3.3.1.3: Conduct 1-day advocacy visit by STBLCPM and LGA TBLS to LGA School authority in all 774 LGAs in Nigeria									NTBLCP
Sub-activity 3.3.1.4: Conduct 1-day advocacy visit by STBLCPM and LGA TBLS to heads of 5 primary schools in all LGAs									NTBLCP

Sub-activity 3.3.1.5: Conduct 1-day advocacy visit by STBLCPM and LGA TBLS to heads of 5 informal schools where children attend in all LGAs	Advocacy visit									NTBLCP
Sub-activity 3.3.1.6: Orientation/sensitisation of school children in 5 formals primary schools within slums per LGA in all 774 LGAs across the country on identification of symptoms of child TB and facilitate referral to DOTS centres										
Sub-activity 3.3.1.7: Orientation/sensitisation of school children in 5 informal schools within slums where children attend per LGA in all 774 LGAs across the country on identification of symptoms of child TB and facilitate referral to DOTS centres										NTBLCP

Objective 4: To increase proportion of estimated MDR/RR-TB cases notified from 11% in 2019 to 75% by 2026									
Strategic Intervention 4.1: Strategically improve access to DR-TB diagnosis									
Activity 4.1.1: Universal Access of DR-TB patients to LPA /Culture and DST.									
Sub-activity 4.1.1.1: Provide LPA, for 64384 DRTB patients 10921 in 2021, 11881 in 2022, 12904 in 2023, 13846 in 20204 and 14832 in 2025	NTP Staff	64,384	10,921	11,881	12,904	13,846	14,832		NTBLCP
Sub-activity 4.1.1.2: Provide C/DST, for 64384 DRTB patients 10921 in 2021, 11881 in 2022, 12904 in 2023, 13846 in 20204 and 14832 in 2025	Lab	64,384	10,921	11,881	12,904	13,846	14,832		NTBLCP
Strategic Intervention 4.2: Strategically implement active case finding for DR-TB									
Activity 4.2.1 Contact tracing and chest Xray for Presumptive TB cases									
Sub-activity 4.2.1.1: Conduct contact tracing for all DR-TB patients diagnosed 10921 in 2020, 11881 in 2022, 12904 in 2013, 13846 at 20204, 14832 at 2020	NTP Staff	64,384	10,921	11,881	12,904				NTBLCP

Sub-activity 4.2.1.2 Conduct annual Chest Xray, screening for healthcare workers in Treatment centers, high volume facilities and caregivers of DRTB patients	NTP Staff						13,846	14,832		
Objective 5: To increase the proportion of enrolled DR-TB patients from 83% in 2019 to 100% in 2026										
Strategic Intervention 5.1 To strategically scale up treatment for DR-TB in Nigeria										
Activity 5.1.1: To Strengthen Coordination of DR-TB activities by creating a platform for routine meetings at the National and state Programme level										
Sub-activity 5.1.1.1: Conduct a 2-day Quarterly National DR-TB committee meeting										
Sub-activity 5.1.1.2: Conduct a one clinical expert team meeting in each state for the Treatment centers and OPD doctors										
Sub-activity 5.1.1.3 Oversight visit to DR-TB treatment centers and DRTB GOPD sites to ensure quality health care delivery										
Sub-activity 5.1.1.4 Conduct supervision visits to states by NTBLCP and supervision by STBLCP to LGAs										

Activity 5.1.2: Establish DR-TB treatment centers in the remaining 9 states of the federation without a Treatment center									
Sub-activity 5.1.2.1: Establish DR-TB treatment center in the following states, Ekiti, Delta, Bayelsa, Yobe, Kebbi, Borno, FCT, Niger, Enugu									
Sub-activity 5.1.2.2 Maintenance and support for MDR treatment centres and facility staff (9 facilities)									
Strategic Intervention 5.2 Scale of novel oral DR-TB regimen									
Activity 5.2.1 Capacity building of health care workers to implement the new oral MDR-TB regimen									
Sub-activity 5.2.1.1: Conduct a 5 day training of 30 health care workers (states team, GOPD doctors, TBL supervisor, DOTS officers and Community health care workers on the implementation of the new oral NDR-TB drugs)									

Strategic Intervention 5.3: Scale up of quality improvement (QI) systems: Nigeria TB Qual to all DR-TB treatment centers and DRTB GOPDS.									
Activity 5.3.1: Setting up of Quality improvement teams in Health facilities									
Sub-activity 5.3.1.1 Scale up of quality improvement mechanism to remaining 24 states + FCT. Identify 2 persons (DRTB FP and Head nurse) from each treatment center and DRTB GOPD sites and provide capacity building.									
Sub-activity 5.3.1.2: Facilitate two monthly meetings of state and facility QI teams involving 5 persons in each of the facilities to discuss QI issues									
Sub-activity 5.3.1.3 QI champions from the central unit (NTBLCP) to provide quarterly supervision to state/facility QI teams									
Sub-activity 5.3.1.4 Conduct clinical mortality review of Treatment centers and DRTB GOPD sites with reports of high mortality									
Strategic Intervention 5.4 Reducing time to enrolment of DR-TB patients.									
Activity 5.4.1: Provision of portable ECG machines to every OPD site in each state to ensure prompt clinical decision-making									

Sub-activity 5.4.1.1: Provision of portable ECG machines to 185 existing DRTB GOPDs to decentralise treatment enrolment, time-to-initiation and improve treatment monitoring	NTP staff								
Sub-activity 5.4.1.2: Provide desktop computers and printers for treatment centers and DRTB GOPD sites to record and print patients' ECG results									
Sub-activity 5.4.1.3: Specimen collection at DOT units and transportation by CBOs for ambulatory patients for baseline investigations in quality assured laboratories									
Objective 6: To rapidly scale up TB preventive services with the number of persons receiving TPT increasing annually from 121,784 in 2018 to 702,076 by 2026									
Strategic Intervention 6.1: Strengthen Contact Investigation and TB Preventive Therapy in children/adolescent									
Activity 6.1.1: Scale up contact investigation among children of bacteriologically positive TB access									
Sub-activity 6.1.1.1: Print 30,000 copies of guidelines on integration of TB care into RMNCAH+N			30,000						NTBLCP
Sub-activity 6.1.1.2: Distribute 30,000 copies of guidelines on integration of TB care into RMNCAH+N			30,000						NTBLCP

Sub-activity 6.1.1.3: Conduct 3 days meeting of 20 participants to develop simplified SOP on contact investigation and TPT in children									NTBLCP
Sub-activity 6.1.1.4: Print 30,000 SOPs on contact investigation and TPT									NTBLCP
Sub-activity 6.1.1.5: Distribute 30,000 SOPs on contact investigation and TPT									NTBLCP
Sub-activity 6.1.1.6: Conduct 1-day orientation/sensitisation of 15,000 health care workers across the country (1 per DOTS centre) on contact investigation and TPT									NTBLCP
Sub-activity 6.1.1.7: Collaborate with professional associations, heads of health institutions to include contact investigations and TPT as part continuing medical education programmes									NTBLCP

Sub-activity 6.1.1.8: Support CBOs to undertake contact investigation of child contacts of bacteriologically adult TB cases (As captured in Community TB section)									NTBLCP
Sub-activity 6.1.1.9: Support parents to transport children () to DOTS facilities for screening prior to commencement of TPT (As captured in Community TB section)									NTBLCP
Strategic Intervention 6.2: Infection Prevention and Control									
Activity 6.2.1: Strengthen infection control committees and plan in all facilities.									
Sub-activity 6.2.1.1: Designate dedicated infection control focal persons in all facilities, who equally ensures close and routine monitoring of TB-HIV collaboration.	Infection control focal persons	Tertiary: 170 Secondary: 5478	Jan-Mar, 2021	0	0	0	0		NTBLCP
Sub-activity 6.2.1.2: Conduct 2-day residential training on IC for 5648 IC focal persons from tertiary & secondary in public and private facilities.	IC FPs	5648	Mar-Dec 2021	0	0	0	0		NTBLCP

Sub-activity 6.2.1.3: Conduct bimonthly infection control committees' meetings in all tertiary and secondary facilities	Meetings	30	Jan-Dec 2021	Jan-Dec 2022	Jan-Dec 2023	Jan-Dec 2024	Jan-Dec 2025		NTBLCP
Sub-activity 6.2.1.4: Procurement of TBIC commodities	Latex glove mask Face N95 mask		Jan-Mar 2021		Jan-Mar 2023				
Sub-activity 6.2.1.5: Distribution of TBIC commodities to states	State	37	Mar-Dec 2021		Mar-Dec, 2023				
Sub-activity 6.2.1.6: Orientation/sensitisation of HCWs/patients on infection control at no cost at all levels	Clinicians OICs (PHC) Nurses/CHEWs	18652 8809 32,600	Jan-Dec 2021	Jan-Dec 2022	Jan-Dec 2023	Jan-Dec 2024	Jan-Dec 2025		NTBLCP
Objective 7: To improve access to quality TB care through comprehensive engagement of all private care providers with the sector accounting for 35% of notified TB cases by 2026.									
Strategic Intervention 7.1: Enforcement of the memo on mandatory reporting of TB in the private sector.									
Activity 7.1.1: Advocacy to each state private health facility regulatory body to enforce the NCH memo on compulsory TB reporting.									
Sub-activity 7.1.1.1: Engage the services of a graphic artist in the development of state-specific advocacy tool	1	1	1						NTBLCP/IHVN

Sub-activity 7.1.1.2: one day consensus meeting to finalise state specific advocacy tool	1	1	1						NTBLCP/IHVN
Sub-activity 7.1.1.3: Print 20 copies of advocacy tools per state	20	720	1						NTBLCP/IHVN
Sub-activity 7.1.1.4: Constitute advocacy team of 5-7 persons per state and conduct advocacy visit	1	36	36						STBLCP
Activity 7.1.2: Advocacy and sensitization to professional regulatory bodies e.g., Medical and Dental council of Nigeria (MDCM), Pharmaceutical Council of Nigeria (PCN), Medical Lab Science Council of Nigeria (MLSCN), Nursing and Midwifery Council									
Sub-activity 7.1.2.1: Conduct a one-day advocacy visit	1	36	36						STBLCP
Activity 7.1.3: Sensitisation meetings with private providers' associations									
Sub-activity 7.1.3.1: Conduct a 2-day sensitisation meeting	1	36	36						STBLCP
Activity 7.1.4: Sensitisation of LGA Medical Officer of Health on mandatory TB case notification by private facilities									
Sub-activity 7.1.4.1: Conduct a 1-day sensitisation meeting for LGA MOH on mandatory TB case notification by private facilities	1	36	36						STBLCP

Activity 7.1.5: Development, printing, and dissemination of SBC materials on mandatory reporting of TB									
Sub-activity 7.1.5.1: Engage the services of a graphic artist in the development of the SBC materials	1	1	1						NTBLCP/IHVN
Sub-activity 7.1.5.2: One day consensus meeting to agree on the content and design of the SBC materials	1	1	1						NTBLCP/IHVN
Sub-activity 7.1.5.3: Print 50,000 copies of the SBC materials	1	1	1						NTBLCP/IHVN
Sub-activity 7.1.5.4: Distribute SBC materials at sub-national and district levels	1	1	1						NTBLCP/IHVN
Activity 7.1.6: TBLS to get the update on TB data notification from private facilities from the MOH during quarterly supervisory visits									
Sub-activity 7.1.6									
Activity 7.1.7: Subject to availability of funds and government support for sustainability, provision of incentives/enablers for non-engaged PPM facilities reporting TB cases									
Sub-activity 7.1.7.1: Support MOH and TBLS to attend Data harmonisation meeting at district levels									STBLCP
Sub-activity 7.1.7.2: Make electronic TB reporting application widely available			1						NTBLCP/IHVN/SHOP S PLUS

Strategic Intervention 7.2: Enhance the capacity of private facilities to diagnose and treat childhood TB									
Activity 7.2.1: Regular capacity building sessions on diagnosis and treatment of childhood TB									
Sub-activity 7.2.1.1: conduct 3-day training of private health care providers on management of childhood TB at zonal levels		60	12	12	12	12	12		NTBLCP/IHVN
Activity 7.2.2: Facilitate access to clinical diagnosis for childhood TB through free chest X-ray and linkages with radiologists (Scale up free chest Xray services for children and adults to secondary and tertiary facilities)									
Sub-activity 7.2.2.1: Purchase 5 chest-Xray per zone for engaged PPM facilities	1	5	1						NTBLCP
Sub-activity 7.2.2.2: Support transport of childhood TB presumptive to nearest chest-Xray centers									NTBLCP
Activity 7.2.3: Regular on-site mentoring of private providers by paediatricians on diagnosis of childhood TB									
Sub-activity 7.2.3.1: Conduct 3-day quarterly mentoring visits to 2 PPM facilities at zonal level	1	90	16	16	16	16	16		NTBLCP/IHVN/SHOP S PLUS

Activity 7.2.4: Continuous medical education of private providers on policy changes in management of childhood TB									
Sub-activity 7.2.4.1: Conduct ECHO (Extension for Community Healthcare Outcome) session to disseminate update in policy changes in management of childhood TB on association meeting days	1	3 ECHO hubs- one at the NTBLCP office in Abuja; one at the Ministry of Health in Lagos and one at the Ministry of Health in Kano	3	24	24	24	24		SHOPS Plus
Strategic Intervention 7.3: Systematic screening of OPD attendees for TB									
Activity 7.3.1: Sensitise management of private facilities and providers association on the benefits of OPD screening									
Sub-activity 7.3.1.1: Link this with 7.1.2.1									
Activity 7.3.2: Provide R&R tools to enhance effective OPD screening									
Sub-activity 7.3.2.1: Print 500,000 copies of R&R tools for OPD screening in private health facilities			1						
Activity 7.3.3: Monitor the processes and yield from OPD screening									
Sub-activity 7.3.3.1: Review of quarterly data collected			4	4	4	4	4		
Strategic Intervention 7.4: Inclusion of TB prevention, diagnosis (GX, DST) and treatment (1st and 2nd line) services, according to national guidelines, in the NHIS scheme									
Activity 7.4.1: High level advocacy visit to Executive secretary, NHIS to include TB services in the scheme									

Sub-activity 7.4.1.1: composition of advocacy team of 15 people to include the Perm. Secretary, Director of Public Health, National Coordinator of NTP, representatives of WHO, USAID and representatives of relevant associations of private providers			1						
Sub-activity 7.4.1.2: Conduct a one-day advocacy visit			1						
Activity 7.4.2: Facilitate actuarial analysis to determine the cost of including TB services in NHIS (in collaboration with the NHIS)									
Sub-activity 7.4.2.1: Engage a consultant to conduct an actuarial analysis in collaboration with NHIS team	1	1	1						
Activity 7.4.3: Inclusion of National TB control team in the development of the new guideline for NHIS									
Sub-activity 7.4.3.1: To be determine post advocacy visit									
Strategic Intervention 7.5: Expand engagement of private sector in TB service delivery									
Activity 7.5.1: Mapping of all private health facilities (PPMVs, CPs, Labs, nursing homes, maternity, and hospitals)									
Sub-activity 7.5.1.1: Obtain the list of each private facility type from DPRS of state ministries of health and private provider associations (no cost)			1						

Sub-activity 7.5.1.2: Engage ad-hoc teams to identify the location of each facility and do GIS mapping	37 states	3870 (5 per LGA)	1						
Sub-activity 7.5.1.3: Sort facility list and mapping by facility type and LGA			1						
Activity 7.5.2: Rapid assessment of unengaged private facilities to determine potential for yielding TB cases									
Sub-activity 7.5.2.1: Develop a simple questionnaire for facility assessment capturing OPD volume, diagnostic services available and historical TB data			1						
Sub-activity 7.5.2.2: The ad-hoc teams engaged above administer assessment questionnaire during mapping	37 states	3870 (5 per LGA)	1						NTBLCP/IHVN/SHOP S PLUS
Sub-activity 7.5.2.3: Analyse data obtained from mapping and rapid assessment			1						
Sub-activity 7.5.2.4: Conduct a desk review of rapid assessment data			1						
Activity 7.5.3: Selection of private facilities for training and engagement									
Sub-activity 7.5.3.1: Establish criteria for facility selection (including potential for yielding TB cases) and select facility			1						

Activity 7.5.4: Signing of MOU									
Sub-activity 7.5.4.1: Facilitate an MOU signing meeting with XX no of facilities selected for engagement and training			1						
Activity 7.5.5: Training of private care providers									
Sub-activity 7.5.5.1: 2-days Training of PMVs/CPs in identification and referral and M&E of presumptive TB cases	300 PPMVs per state 100 CPs per state	37	37						NTBLCP/IHVN/SHOP S PLUS
Sub-activity 7.5.5.2: 3-days Training of providers in new PFP and FBO sites to conduct TB prevention, diagnosis and treatment activities including referral, notification, and M&E	200 per state	37	37						NTBLCP/IHVN/SHOP S PLUS
Sub-activity 7.5.5.3: 5-days Training laboratory staff in newly engaged stand-alone Private laboratories in proper TB diagnostics, record keeping, reporting, informing patients about TB and the importance of TB treatment and referral	50 per state	37	37						NTBLCP/IHVN/SHOP S PLUS
Sub-activity 7.5.5.4: 3 days DR TB training for 10% of care providers from private-for-profit and faith-based organizations to provide DR TB care for patients	20 per state	740							NTBLCP/IHVN/SHOP S PLUS

Activity 7.5.6: Capacity building for implementers									
Sub-activity 7.5.6.1: Support attendance at annual peer learning meetings of implementing partners	1	5	1	1	1	1	1		NTBLCP/IHVN/SHOP S PLUS
Activity 7.5.7: Provision of working tools for PPM TB services									
Sub-activity 7.5.7.1: Review and adaptation of R and R tools for the private sector	1	1	1						NTBLCP/IHVN/SHOP S PLUS
Sub-activity 7.5.7.2: Printing and distribution of tools	1	1	1						NTBLCP/IHVN/SHOP S PLUS
Activity 7.5.8: Empower more stand-alone laboratories with GeneXpert machines and other advanced diagnostic tools to diagnose TB (At least 2 private lab per state should have a GeneXpert machine)									
Sub-activity 7.5.8.1: Mapping of areas at sub-national levels for strategic placement of the procured diagnostic tools			1						NTBLCP/IHVN/SHOP S PLUS
Sub-activity 7.5.8.2: Procurement and placement of GeneXpert and other advanced diagnostic tools in selected stand-alone labs	50 per state	1850	1						NTBLCP/IHVN/SHOP S PLUS
Sub-activity 7.5.8.3: Signing of MOUs with stand-alone labs	50 per state	1850	1						NTBLCP/IHVN/SHOP S PLUS

Sub-activity 7.5.8.4: Capacity building of X number of lab personnel in the selected stand-alone labs	Link with sub-activity 7.5.5.3	3700 (2 per lab)	740	740	740	740	740		NTBLCP/IHVN/SHOP S PLUS
Activity 7.5.9: Regular monitoring and supportive supervision in the private sector									
Sub-activity 7.5.9.1: 5 days quarterly mentoring, supervision to PPM sites (FBOs/PfP)	1	100	20	20	20	20	20		NTBLCP/IHVN/SHOP S PLUS
Sub-activity 7.5.9.2: 5 days quarterly mentoring, supervision to PPM sites (CPs/PMVs/TBAs)	link with activity 7.6.9.1								NTBLCP/IHVN/SHOP S PLUS
Sub-activity 7.5.9.3: 5 days quarterly on-site data verification to PPM sites (FBOs/PfP)	1	100	20	20	20	20	20		NTBLCP/IHVN/SHOP S PLUS
Sub-activity 7.5.9.4: 5 days quarterly joint DQA to PPM sites	1	100	20	20	20	20	20		NTBLCP/IHVN
Activity 7.5.10: Incentives for the private sector to report									
Sub-activity 7.5.10.1: Incentive for presumptive and positive cases referred by the FBOs/PfP/PMVs/CPs/TBAs	1,000 per positive case 200 for presumptive	1000 per positive case and 200 per presumptive	4	4	4	4	4		NTBLCP/IHVN/SHOP S PLUS

Sub-activity 7.5.10.2: Incentive for private stand-alone labs to screen for TB	1,000 per positive case	1000 per positive case	4	4	4	4	4		NTBLCP/IHVN/SHOP S PLUS
Sub-activity 7.5.10.3: Incentive for private facilities to ensure treatment success (scheme IV)	1,000 per diagnosed patient per month to follow up patients on treatment	1000 per case per month to follow up patients to ensure they complete their treatment	4	4	4	4	4		NTBLCP/IHVN/SHOP S PLUS
Sub-activity 7.5.10.4: Consultation support for DR TB patients being managed at PPM OPD sites									
Activity 7.5.11: Engagement of Linkage Coordinators for the private sector									
Sub-activity 7.5.11.1: Engagement of Linkage Coordinators to ensure complete referral and linkage of patients for TB services	40 per state	40 per state	1480						
Sub-activity 7.5.11.2: Monthly Transport allowance for linkage coordinators	15000 per month per linkage coordinator	185	37	37	37	37	37		
Sub-activity 7.5.11.3: Monthly Communication allowance for Linkage Coordinators	10000 per month per linkage coordinator	185	37	37	37	37	37		
Activity 7.5.12: Scale up the use of TB notification app to non engaged private providers to enable notification of all TB cases									
Sub-activity 7.5.12.1: Make notification app available for free download			1						NTBLCP/IHVN/SHOP S PLUS

Activity 7.5.13: Scale up electronic notification and reporting to all private health care providers									
Sub-activity 7.5.13.1: NETIMS to capture all engaged PPM facilities			1						NTBLCP
Sub-activity 7.5.13.2: Deployment of mobile notification applications in the private sectors	1	1	1						NTBLCP/IHVN/SHOP S PLUS
Activity 7.5.14: Expand procurement and supply chain network to include all engaged private facilities and labs									
Sub-activity 7.5.14.1: Forecasting of Procurement and supply chain network to include all engaged PPM facilities			1						NTBLCP
Strategic Intervention 7.6: Strengthen linkage systems between first points-of-contact in communities (PPMV, CP, traditional healers, traditional and religious leaders) and PPM referral facilities									
Activity 7.6.1: Advocacy to CAN, NAFSAT, other leadership of large denominational religious groups, association of traditional healers and rulers (where they exist) at sub-national level									
Sub-activity 7.6.1.1: Compose an advocacy team of 7 People to include the STBLCPM, PPM FP, LGATBLS, a representative of 1 CBOs, and 3 others at sub-national level			36						STBLCP
Sub-activity 7.6.1.2: Conduct advocacy visits to leadership of large denominational religious groups, association of traditional healers and rulers	1	36	36						STBLCP

Activity 7.6.2: Sub-national TB control programme to facilitate bi-annual meetings between the first points-of-contact for health care in the communities and the PPM treatment facilities									
Sub-activity 7.6.2.1: conduct bi-annual meetings to foster relationship between the first points-of-contacts of health care in the communities and the PPM treatment facilities	1	360	72	72	72	72	72		STBLCP
Activity 7.6.3: Directory of nearest PPM referral facilities to be disseminated to all first points-of-contact									
Sub-activity 7.6.3.1: Update the existing TB service facility directory and delineate by state/LGAs			1						NTBLCP
Sub-activity 7.6.3.2: Disseminate the updated directory to states/LGAs			1						NTBLCP
Strategic Intervention 7.7: Engage professional bodies and academic institutions to support training, task shifting and/or other RSSH activities									
Activity 7.7.1: Orientation of professional bodies on TB control									
Sub-activity 7.7.1.1: Make a list of professional bodies to be invited to include: HCPAN, AGPMPM, AGPNPN, GMLD, AMLSN, ACP, PMVs. (2 per professional bodies)			1						
Sub-activity 7.7.1.2: Conduct a 2-day orientation meeting	1	1	1						NTBLCP

Sub-activity 7.7.1.3: Develop a measuring package to assess the yield of the orientation			1						NTBLCP
Activity 7.7.2: Inclusion of umbrella bodies of private facilities in TB control activities (e.g., TWG) and support for attendance of implementers at annual scientific conferences of professional bodies									
Sub-activity 7.7.2.1: Include 1 representative of umbrella bodies of private facilities in state review meeting	1	1	1						NTBLCP
Sub-activity 7.7.2.2: Sponsor the attendance of 2 people to attend annual scientific conferences bi-annually	1	5	1	1	1	1	1		NTBLCP
Activity 7.7.3: Provide incentives and enablers e.g., support CME/CPD (Continuous professional development) activities, provision of tax holidays for engaged private TB service providers									
Sub-activity 7.7.3.1: Increase the slot of representative for annual review meeting by one	1	5	1	1	1	1	1		NTBLCP
Sub-activity 7.7.3.2: Request for a list of one national annual CME/CPDs and one(two) state CME/CPD per association with the time schedule.			1						Professional bodies of private health care providers
Sub-activity 7.7.3.3: Advocacy visit to FIRS for exemption of engaged private health facilities from a reasonable tax concession with state counterpart.			1						NTBLCP

Strategic Intervention 7.8: Improve implementation in accordance with the PPM guideline									
Activity 7.8.1: Print and disseminate PPM guidelines at sub-national, district and facility levels									
Sub-activity 7.8.1.1: Print 200,000 copies of the developed guideline and distribute at sub-national and district levels	1	1	1						NTBLCP
Activity 7.8.2: Hold quarterly meetings of the PPM steering committee at the national level and communicate the meeting outcome to sub-national and district levels									
Sub-activity 7.8.2.1: Conduct 2- day quarterly meetings of the PPM steering committee of 25 members	1	20	4	4	4	4	4		NTBLCP
Sub-activity 7.8.2.2: Disseminate outcomes of the meetings at subnational level electronically			4	4	4	4	4		NTBLCP
Activity 7.8.3: Incorporate the PPM content of TB control strategy into existing TB/HIV TWG at sub-national levels (where they exist)									
Sub-activity 7.8.3.1: Identify the existence of appropriate Health-related Technical Working Group that can accommodate the PPM content			1						STBLCP
Sub-activity 7.8.3.2: Advocate for the inclusion of PPM into the Identified TWG			1						STBLCP

Strategic Intervention 7.9: Improve Infection control practices at most private health facilities									
Activity 7.9.1: Orientation of health workers on appropriate infection control practices for TB									
Sub-activity 7.9.1.1: conduct a one-day training of 300 private health care providers at zonal level	1	6	1						NTBLCP
Activity 7.9.2: Regular meetings on Infection control at all referral PPM facilities and support them with available infection control materials and practices									
Sub-activity 7.9.2.1: Disseminate guidelines on the constitution of Infection control committee at health facilities			1						NTBLCP
Sub-activity 7.9.2.2: constitute Infection control committees at all private health facilities			1						STBLCP
Sub-activity 7.9.2.3: Linkage with hospital management board at sub-national and district levels for disposal of harmful wastes from private facilities			1						STBLCP
Strategic Intervention 7.10: Improve integration of TB/HIV services									
Activity 7.10.1: Set up one-stop shop for TB/HIV services in the private sector									
Sub-activity 7.10.1.1: Inclusion of private providers providing only HIV services in DOT expansion training	Refer to TB/HIV and case finding Thematic area for this								
Activity 7.10.2: Include private sector in TB/HIV TWG at national and sub-national levels									
Sub-activity 7.10.2.1: Bi-annual TB/HIV meetings nationally	Refer to TB/HIV Thematic area for this								

Sub-activity 7.10.2.2: quarterly TB/HIV meetings sub-nationally	Refer to TB/HIV Thematic area for this								
Strategic Intervention 7.11: Scale-up of quality improvement initiatives from 12 states to 36 states									
Activity 7.11.1: Advocacy and stakeholder engagement meeting									
Sub-activity 7.11.1.1: 2-day central meeting of stakeholders from private and public sectors	1	1	1						
Activity 7.11.2: Engagement of State Ministries of Health, State TB control programmes and Site leadership									
Sub-activity 7.11.2.1: 2-day advocacy visits to each of 24 scale-up states for buy-in teams	1	24	24						NTBLCP/IHVN
Sub-activity 7.11.2.2: Set up of state MP teams and facility QI	1	24	12	12					NTBLCP/IHVN
Activity 7.11.3: Administration of baseline assessment tools									
Sub-activity 7.11.3.1: 5 day visit by central/state teams to conduct baseline assessment of new facilities	1	24	24						NTBLCP/IHVN
Activity 7.11.4: Trainings on Quality Improvement									
Sub-activity 7.11.4.1: Quality Improvement/Performance Measurement Trainings of NTBLCP staff for 5 days	1	1	1						IHVN

Sub-activity 7.11.4.2: Quality Improvement/Performance Measurement Trainings of State/facility-based QI teams for 5 days	1	24	24						NTBLCP/IHVN
Activity 7.11.5: Granular Site management									
Sub-activity 7.11.5.1: 1-day site-based monthly performance review meetings to review site performance data, promptly identify gaps and proffer improvement strategies (across 6 facilities per state)	36	2160	432	432	432	432	432		NTBLCP/IHVN
Activity 7.11.6: Distribution of NigQual TB guideline									
Sub-activity 7.11.6.1: 5 days meeting to review NigQual TB guideline	1	1	1						NTBLCP/IHVN
Sub-activity 7.11.6.2: Printing and dissemination of 500 copies of NigeriaQual TB guideline to all participating sites across new states	1	1	1						IHVN
Activity 7.11.7: Support implementation, monitoring and evaluation of site-based QI projects									
Sub-activity 7.11.7.1: Support MP Teams to provide oversight to facility TBQual teams	1	720	144	144	144	144	144		NTBLCP/IHVN

Sub-activity 7.11.7.2: 4-day Quarterly supervisory site visits to review activities of facility QITs	1	90	16	16	16	16	16		NTBLCP/IHVN
Activity 7.11.8: Implementation of an Improvement collaborative									
Sub-activity 7.11.8.1: Virtual review meetings and learning sessions	4	720	144	144	144	144	144		STBLCP
Sub-activity 7.11.8.2: Regular on-site supportive supervisory visits to provide hands-on technical support on the application of QI principles and methodology	Link with activity 7.12.7.2								
Activity 7.11.9: Patient-centered care to improve health outcome									
Sub-activity 7.11.9.1: Development and printing of 50,000 patient health education materials	1	1	1						NTBLCP/IHVN
Sub-activity 7.11.9.2: Development of electronic health education and adherence counselling tools (Videos, audio and interactive) to empower patients to make informed decisions about their health.	1	1	1						NTBLCP/IHVN

Sub-activity 7.11.9.3: Development of a conceptual framework for patient-centered care in the TB program			1						NTBLCP/IHVN
Sub-activity 7.11.9.4: Design of the patient reported outcome measure (PROM) tool for MDRTB patient			1						NTBLCP/IHVN
Sub-activity 7.11.9.5: Design of patient reported experience tool for all TB patient (PREM)			1						NTBLCP/IHVN
Objective 8: To strengthen provision of integrated services for all co-infected with TB and HIV, Patients with Diabetes, and other co-morbidities									
Strategic Intervention 8.1: Reduce the burden of TB in people living with HIV and initiate early antiretroviral treatment (the Three I's for HIV/TB)									
Activity 8.1.1: Intensify TB screening of all persons during HIV testing and for all PLHIVs at every encounter in all facilities and ART clinics									
Sub-activity 8.1.1.1: Leverage on HIV adhoc staff to strengthen routine TB screening of PLHIVs in all ART clinics	PLHIVs	1,000,000	Jan-Dec 2021	Jan-Dec 2022	Jan-Dec 2023	Jan-Dec 2024	Jan-Dec 2025		NTBLCP
Sub-activity 8.1.1.2: Leverage on HIV adhoc staff to strengthen routine TB screening of persons tested for HIV in all facility testing points	Persons tested for HIV		Jan-Dec 2021	Jan-Dec 2022	Jan-Dec 2023	Jan-Dec 2024	Jan-Dec 2025		NTBLCP

Activity 8.1.2: Leverage on HIV community testing/outreaches (HIV surge states) to screen for TB									
Sub-activity 8.1.2.1: Provide transport support for 2CTWs in each of the HIV surge state to visit HIV community testing/outreaches in HIV surge states for TB screening, sputum collection and transport of samples to GeneXpert sites from persons tested for HIV	CTWs	20	Jan-Dec 2021	Jan-Dec 2022	Jan-Dec 2023	Jan-Dec 2024	Jan-Dec 2025		NTBLCP
Activity 8.1.3: Intensify clinical screening using chest X-ray for all new HIV positive clients and presumptive PLHIVs with high index of suspicion with negative Xpert MTB/RIF result.									
Sub-activity 8.1.3.1: Development of desk guides for clinicians to support easy identification of TB via X-rays	Set of TB X-ray desk guides	1 Set of TB X-ray desk guides	Q1 2021	0	0	0	0		NTBLCP
Sub-activity 8.1.3.2: Printing of desk guides for clinicians to support easy identification of TB via X-rays	Set of TB X-ray desk guides	2,500	Q2, 2021	0	0	0	0		NTBLCP
Sub-activity 8.1.3.3: Distribution of desk guides for clinicians to support easy identification of TB via X-rays to 36+1 States	States	37	Q3 2021	0	0	0	0		NTBLCP

Sub-activity 8.1.3.4: Conduct 2-day orientation for 2000 radiographers/Medical Officers on TB case finding using X-ray films to improve index of suspicion for TB in 36+1 states. Dissemination of desk guides and creation of WhatsApp platform for all participants to support TB diagnosis using X-ray films	Clinicians	1500	Q4, 2021	Q1-Q4, 2021	0	0	0	NTBLCP
	Radiographers	500						
Sub-activity 8.1.3.5: Provide support for team of 10 experts in each state for monthly review of chest X-ray films to avoid missing TB cases.	Medical Experts	370	Jan-Dec 2021	Jan-Dec 2022	Jan-Dec 2023	Jan-Dec 2024	Jan-Dec 2025	NTBLCP
Activity 8.1.4: Introduce 3 months of weekly isoniazid and rifapentine, (3-HP) as TPT								
Sub-activity 8.1.4.1: Procure 3HP for 1, 197,723 patients	INH 300mg	43,118,028	Jan-March 2021	Jan-March 2022	Jan-March 2023	Jan-March 2024	Jan-March 2025	NTBLCP
	Rifapentine 150mg	86,236,056						

Sub-activity 8.1.4.2: Distribute 3HP TPT to states	States	37	Jan-March 2021	Jan-March 2022	Jan-March 2023	Jan-March 2024	Jan-March 2025		NTBLCP
Sub-activity 8.1.4.3: Conduct TOT for 120 persons on 3HP and other TPT combinations	Trainers	120	Jan-Feb 2021	0	0	0	0		NTBLCP
Sub-activity 8.1.4.4: Conduct orientation of 11,144 HCWs (1 DOT officer each from 10,000 DOT centers, 1 LGTBLS from the 774 LGAs and 10 state team members from the 36+1 states) on 3HP and other TPT combinations	Health workers	11,144	Mar-Dec, 2021	0	0	0	0		NTBLCP
Sub-activity 8.1.4.5: Initiate 1, 197,723 eligible patients on 3HP	Patients	1, 197,723	Dec, 2021	Jan-Dec 2022	Jan-Dec 2023	Jan-Dec 2024	Jan-Dec 2025		NTBLCP
Activity 8.1.5: Continuous engagement of tertiary and secondary facilities on need for TPT among all PLHIVs including positive pregnant women (PPW)									
Sub-activity 8.1.5.1: Leverage on facility clinical meetings to sensitise clinicians on benefits of TPT to all PLHIVs including PPW.	Clinical meetings	170	Jan-Dec 2021	Jan-Dec 2022	Jan-Dec 2023	Jan-Dec 2024	Jan-Dec 2025		STBLCP
Activity 8.1.6: Institutionalise One-Stop Shop (OSS) for TB/HIV services at all stand-alone PMTCT sites and OSS centers for key populations									
Sub-activity 8.1.6.1: Conduct assessment of 185 PMTCT and OSS stand-alone sites for DOT expansion	PMTCT and OSS Sites	185	Jan-Mar, 2021	0	0	0	0		NTBLCP

Sub-activity 8.1.6.2: Conduct training for 370 health workers who provide services at PMTCT and OSS stand-alone sites	Doctors Nurses	70 300	April-June, 2021	0	0	0	0		NTBLCP
Activity 8.1.7: Referral services for all newly diagnosed HIV patients									
Sub-activity 8.1.7.1: Leverage on adhoc staff in ART sites to continue escort services for all newly diagnosed TB cases for early initiation on DOT	Diagnosed TB cases	58,616	Jan-Dec 2021	Jan-Dec 2022	Jan-Dec 2023	Jan-Dec 2024	Jan-Dec 2025		NTBLCP
Sub-activity 8.1.7.2: Develop directory App for all DOTS/ART sites	DOT/ART sites App development	1 set of DOT/ART sites app	Jan-Dec 2021	0	0	0	0		NTBLCP
Activity 8.1.8: Provide close supervision to HCWs/adhoc staff at all levels to ensure complete documentation in paper-based and electronic tools.									
Sub-activity 8.1.8.1: Increase frequency of quarterly State supervision to LGAs/facilities from 4days to 9days.	Supervisions	6,660	X	X	X	X	X		NTBLCP
Activity 8.1.9: Operationalise revised guidelines on management of latent TB infection (LTBI)									
Sub-activity 8.1.9.1: Print revised guideline/tools on management of LTBI	Set of revised guidelines on LTBI	20,000	Jan-Mar, 2021	0	0	0	0		NTBLCP
Sub-activity 8.1.9.2: Distribute revised guideline/tools on LTBI to 36+1 States	States	37	April-June, 2021	0	0	0	0		NTBLCP
Sub-activity 8.1.9.3: Procure 253,010,520 INH 300mg TPT for above 5years LTBI	INH 300mg	253,010,520	Jan-Mar 2021	Jan-March 2022	Jan-Mar 2023	Jan-March 2024	Jan-March 2025		NTBLCP

Sub-activity 8.1.9.4: Distribute 253,010,520 INH 300mg TPT for above 5years LTBI to 36+1 states	States	37	April-June, 2021	0	0	0	0		NTBLCP
Sub-activity 8.1.9.5: Orientation of Health care workers on management of latent TB infection (LTBI) at no cost	Clinicians	18652							
	OICs (PHC)	8809	Jan-Dec 2021	Jan-Dec 2022	0	0	0		NTBLCP
	Nurses/CHEWs	32,600							
Activity 8.1.10: Commence and strengthen triage (FAST strategy) of presumptive TB cases at ART sites in all facilities									
Sub-activity 8.1.10.1: Engage 1088 adhoc staff to strengthen FAST strategy at ART clinics in tertiary and high volume facilities at no cost.	Adhoc staff	1,088	Jan-Dec 2021	Jan-Dec 2022	Jan-Dec 2023	Jan-Dec 2024	Jan-Dec 2025		NTBLCP
Activity 8.1.11: Strengthen infection control committees and plan in all facilities.									
Sub-activity 8.1.11.1: Designate dedicated infection control focal persons in all facilities, who equally ensures close and routine monitoring of TB-HIV collaboration.	Infection control focal persons	Tertiary: 170 Secondary: 5478	Jan-Mar, 2021	0	0	0	0		NTBLCP
Sub-activity 8.1.11.2: Conduct 2-day residential training on IC for 5648 IC focal persons from tertiary & secondary in public and private facilities.	IC FPs	5,648	Mar-Dec 2021	0	0	0	0		NTBLCP

Sub-activity 8.1.11.3: Conduct bimonthly infection control committees' meetings in all tertiary and secondary facilities	Meetings	30	Jan-Dec 2021	Jan-Dec 2022	Jan-Dec 2023	Jan-Dec 2024	Jan-Dec 2025		NTBLCP
Sub-activity 8.1.11.4: Procurement of TBIC commodities	Latex glove mask Face N95 mask		Jan-Mar 2021		Jan-Mar 2023				
Sub-activity 8.1.11.5: Distribution of TBIC commodities to states	State	37	Mar-Dec 2021		Mar-Dec, 2023				
Sub-activity 8.1.11.6: Orientation/sensitisation of HCWs/patients on infection control at no cost at all levels	Clinicians OICs (PHC) Nurses/CHEWs	18652 8809 32,600	Jan-Dec 2021	Jan-Dec 2022	Jan-Dec 2023	Jan-Dec 2024	Jan-Dec 2025		NTBLCP
Activity 8.1.12: Institutionalise annual X-ray testing of all HCWs in all facilities									
Sub-activity 8.1.12.1: Provide yearly support for X-ray screening of 3700 HCWs working in high-risk settings in public and private facilities	Health workers	3,700	Jan-Dec 2021	Jan-Dec 2022	Jan-Dec 2023	Jan-Dec 2024	Jan-Dec 2025		NTBLCP

Strategic intervention 8.2: Reduce the burden of HIV in patients with presumptive and diagnosed TB									
Activity 8.2.1: Provision of rapid test kits (RTKs) in all DOT centers and standalone Labs (SALs)									
Sub-activity 8.2.1.1: Procure RTKs for testing of all presumptive TB cases	Rapid test kits (RTKs)	15,475,491	Jan-March 2021	Jan-March 2022	Jan-March 2023	Jan-March 2024	Jan-March 2025		NTBLCP
Sub-activity 8.2.1.2: Distribute RTKs to all DOT sites in 36+1 states	States	37	April-June, 2021	April-June 2022	April-June 2023	April-June 2024	April-June 2025		NTBLCP
Sub-activity 8.2.1.3: Provide HIV testing and counselling to presumptive and diagnosed TB patients at all DOT sites	Presumptive TB cases Notified TB cases	3,516,930 390,770	Jan-Dec 2021	Jan-Dec 2022	Jan-Dec 2023	Jan-Dec 2024	Jan-Dec 2025		NTBLCP
Activity 8.2.2: Strengthen referral services for all newly diagnosed HIV patients in low performing states									
Sub-activity 8.2.2.1: Engage adhoc staff to provide escort services for all presumptive and diagnosed TB cases who are HIV positive for early initiation on ART, CTP and TPT in Lagos, Plateau, Kano, Rivers, Akwa Ibom	Adhoc staff	100	Jan-Dec 2021	Jan-Dec 2022	Jan-Dec 2023	Jan-Dec 2024	Jan-Dec 2025		NTBLCP
Activity 8.2.3: Strengthen monitoring of co-infected patients to reduce mortality rate									
Sub-activity 8.2.3.1: Continuous sensitisation of HCWs on routine review and monitoring of all co-infected patients for ART adherence and viral load (VL) at no cost	TB-HIV Health workers	All	Jan-Dec 2021	Jan-Dec 2022	Jan-Dec 2023	Jan-Dec 2024	Jan-Dec 2025		NTBLCP

Strategic intervention 8.3: Intensify case finding among Diabetic mellitus (DM) patients at endocrinology and Geriatrics clinics									
Activity 8.3.1: Introduce TB screening on clinic days at endocrinology and Geriatrics clinics and sample collection from presumptive cases									
Sub-activity 8.3.1.1: Sensitise and build capacity of healthcare workers at the endocrinology and geriatrics clinics to develop high index of suspicion for TB among DM and elderly patients	Clinicians Nurses	170 340	Jan-Dec 2021	0	0	0	0		NTBLCP
Sub-activity 8.3.1.2: Provide communication support for 340 DM OPD nurses for screening and sample collection from presumptive DM patients on clinic days	DM OPD Nurses	340	Jan-Dec 2021	Jan-Dec 2022	Jan-Dec 2023	Jan-Dec 2024	Jan-Dec 2025		NTBLCP
Sub-activity 8.3.1.3: Disseminate IEC materials and TB desk guides to DM clinics	IEC materials TB desk guides	170 170	Jan-Dec 2021	Jan-Dec 2022	Jan-Dec 2023	Jan-Dec 2024	Jan-Dec 2025		NTBLCP
Activity 8.3.2: Improve TB diagnosis among DM patients									
Sub-activity 8.3.2.1: Conduct operational research on TB diagnosis among DM patients/Geriatrics in tertiary facilities using free X-ray services for DM patients	DM patients	1,500	300	600	900	1200	1500		NTBLCP

Objective 9: To strengthen domestic resource mobilisation with in-country funding of TB budget increasing from 8% in 2019 to 50% by 2025.									
Strategic Intervention 9.1: Strengthened Targeted High Level Advocacy									
Activity 9.1.1 Conduct Stakeholders analysis using influence and power criteria									
Sub-activity 9.1.1:1 Engage consultant to conduct Desk review of Stakeholders at all levels (including celebrities)	Consultant	1	x						NTBLCP
Activity 9.1.2: Develop and produce targeted advocacy materials for all identified levels of stakeholders									
Sub-activity 9.1.2.1 Three-days residential workshop for 16 stakeholders and Partners at the national level, to develop fact sheets and advocacy materials, for all levels of Stakeholders	Advocacy kits	1	x						NTBLCP
Sub-activity 9.1.2.2 Develop/Produce ACSM feedback form for follow-up and documentation	Feedback Form	300 booklets	x						NTBLCP
Sub-activity 9.1.2.3 Produce advocacy materials (kits, fact sheets, pen) - 2,000 copies	2 Consultants (communication & graphic artist)	2000	x						NTBLCP
Sub-activity 9.1.2.4 One-Day meeting to disseminate Advocacy kits to relevant stakeholders		1	x						NTBLCP

Activity 9.1.3 Advocacy visits to Stakeholders at National and State Levels									
Sub-activity 9.1.3.1 Conduct quarterly advocacy/courtesy visits to media houses to discuss TB and solicit for publicity support	Media Advocacy	60	x	x	x	x	x		NTBLCP, Partners
Activity 9.1.4 Conduct TB Media Chat (Electronic, Print, Social Media), Share briefs									
Sub - Activity 9.1.4.1 Conduct Quarterly Media Chat for 10 media practitioners (Electronic, Print, Social Media),	Media Chat	60	x	x	x	x	x		NTBLCP, Partners
Activity 9.1.5 Conduct advocacy visits									
Sub-activity 9.1.5.1 Quarterly advocacy visits (25) to Line Ministries - Transport, Finance, Women Affairs, Sports & Youth Dev, Education, Justice/FIDA etc), Agencies (like NOA), NAFDAC, National Assembly (Senate, House of Reps), Special Programmes (like SOML), Embassies, International Agencies, etc, using developed advocacy materials	NASS, Line Ministries Advocacy	25	x	x	x	x	x		NTBLCP, Partners

Sub-activity 9.1.5.2 Advocacy to Schools Management Boards, NYSC DG for access to schools and NYSC Camps	Boards, NYSC		x						NTBLCP, Partners
Sub-activity 9.1.5.3 Conduct 2 Courtesy visits to First Lady and Governors' Wives, using developed TB advocacy materials		37	x				x		NTBLCP, Partners State,
Activity 9.1.6. Engage corporate bodies and philanthropists for domestic resource mobilisation for in-country financing of TB programs and services									
Sub-activity 9.1.6.1 Organise Annual Breakfast Meeting for Corporate Bodies and Philanthropists for resource mobilisation	Resource Mobilisation	5	x	x	x	x	x		NTBLCP
Activity 9.1.7. Finalise and harmonise the existing ACSM/CTBC strategy/policy documents									
Sub-activity 9.1.7.1 Organise a 3-Day workshop for 20 Stakeholders and Partners to finalise and harmonise ACSM/CTBC Guidelines/policy documents	ACSM		x						NTBLCP
Sub-activity 9.1.7.2 Produce ACSM/CTBC Guidelines;	Printer	2000	x						NTBLCP

Activity 9.1.8. Establish/strengthen coordination of ACSM/CTBC Core Group in the States									
Sub-activity 9.1.8.1 Set-up/Strengthen ACSM/CTBC Units at State level (including CBOs)	State ACSM	37	x						STBLCP, NTBLCP
Sub-activity 9.1.8.2 Develop the ToR for the State Core Groups	ToR	1	x						NTBLCP
Sub-activity 9.1.8.3 Support Quarterly meeting of State ACSM/CTBC Core Groups at State level	Quarterly meeting	20	x	x	x	x	x		NTBLCP
Sub-activity 9.1.8.4 Include selected CBOs in Quarterly State Review meetings, as member of the ACSM/CTBC Core Team	Quarterly meeting	20	x	x	x	x	x		NTBLCP
Sub-activity 9.1.8.5 Quarterly 3-Days supportive supervision visits by National ACSM Unit to states	Quarterly Supervision	20	x	x	x	x	x		NTBLCP
Activity 9.1.9 Quarterly meeting of ACSM/CTBC Sub-Committee members at National Level									
Sub-activity 9.1.9.1 Support One-Day Quarterly meeting of 35 ACSM/CTBC Sub-Committee members at National Level	Quarterly Sub-Committee Meeting	20	x	x	x	x	x		NTBLCP

Activity 9.1.10. Build capacity of State TB ACSM/CTBC Focal Persons									
Sub-activity 9.1.10.1 Organize 3-Days training for 37 ACSM/CTBC Focal Persons	Training	37	x	x	x	x	x		NTBLCP
Activity 9.1.11 Form strong/expanded AIDS, TB, and Malaria (ATM) Resource Mobilisation Group (using harmonised advocacy tool kits and Facts-sheets)									
Sub-activity 9.1.11.1 Set-up AIDS, TB and Malaria (ATM) Resource Mobilisation Group, including Inter-Sectorial (MDAs, Special Programmes) Representatives	Expand ATM Resource Group	1	x						NTBLCP
Sub-activity 9.1.11.2 Support Bi-Annual ATM, MDAs, Special Programmes Resource Mobilisation Group Meetings	ATM DRM Meetings	10	x	x	x	x	x		NTBLCP
Strategic Intervention 9.2: Strengthened Community Systems and Structures for effective participation in TB Response									
Activity 9.2.1 Identify, create and update database of all administrative structures in communities									
Sub-activity 9.2.1.1 Engage Consultant to conduct Desk review of administrative structures, slums in 774 LGAs	Consultant	2	x			x			NTBLCP

Activity 9.2.2. Strengthen capacity of CBOs for effective engagement with community and religious leaders, key population groups and organisations in TB decision making and response									
Sub-activity 9.2.2.1 Conduct 2-day training for CBOs (15 per state) on community stakeholders' engagement, decision-making and TB response (to include Childhood TB)	CBOs	555	x						NTBLCP
Activity 9.2.3. Engage Community Health Influencers, Promoters and Services (CHIPS) Programme in TB referral									
Sub-activity 9.2.3.1 Identify and Orient 2,500 Community Health Influencers, Promoters and Services (CHIPS) members in TB referral	CHIPS	2500	x						NTBLCP
Activity 9.2.4. Engage traditional media in dissemination of appropriate TB messages in communities.									
Sub-activity 9.2.4.1 Identify and engage Traditional Media in communities for dissemination of TB messages weekly (as part of community mobilisation activity)	Traditional Media		x	x	x	x	x		CBOs
Sub-activity 9.2.4.2 Provide monthly support for megaphone battery	Traditional Media	34830	x	x	x	x	x		CBOs
Activity 9.2.5 Support CBOs on community TB implementation									
Sub-activity 9.2.5.1 Provide quarterly support to CBOs on community TB implementation	CBOs	740	x	x	x	x	x		CBOs

Activity 9.2.6 Support CSOs Networks on community TB Coordination and Implementation									
Sub-activity 9.2.6.1. Quarterly support to National CSOs for effective Coordination of community TB activities	CSOs	20	x	x	x	x	x		NTBLCP
Sub-activity 9.2.6.2 Conduct house-to-house TB sensitiisation and awareness creation and mobilisation for referral	House-to-House Mobilisation		x	x	x	x	x		NTBLCP
Sub-activity 9.2.6.3 Conduct quarterly targeted TB sensitisation and awareness creation and mobilisation for referral among key population (IDPs, Migrants/refugees, slum dwellers, Nomads, miners, Orphanage Homes, incarcerated persons like prisoners in correctional centers and police cell inmates)	Key Population	740	x	x	x	x	x		NTBLCP
Sub-activity 9.2.6.4 Organise Quarterly Community Dialogue for information sharing and feedback (50 stakeholders per LGA)	Community Engagement	15840	x	x	x	x	x		CBOs

Sub-activity 9.2.6.5 Organise Bi-Annual stakeholders forum at State level - STBLCP, TBLS, LGMoH, Supervisory Councillor for Health, HIV and Malaria Focal Persons, Social Mobilisation Officer, PHC Coordinator, Ward Health Development Committee Rep, Facility, CBO, traditional/religious leaders, Support Group representative, Traditional Healers & TBAs etc) (Include Childhood TB on Agenda)	Stakeholders Forum	370	x	x	x	x	x		NTBLCP
Sub-activity 9.2.6.6 Leveraging on and participation in public and private Primary, and Secondary Schools Health Clubs, NYSC Health Clubs (5 groups per annum)	School Engagement		x	x	x	x	x		NTBLCP, IPs

Sub-activity 9.2.6.7 Leverage on National Association of Proprietors of Private Schools (NAPPS), ANCOPSS, NUT, PTA meetings for orientation/awareness creation	School Engagement	25	x	x	x	x	x		
Sub-activity 9.2.6.8 Leverage on ANC's, Immunisation Days, RMNCAH+N and HIV services, etc for awareness creation and mobilisation	Other Health Programs		x	x	x	x	x		
Strategic Intervention 9.3 Strengthen World TB Day Campaigns									
Activity 9.3.1: Constitute Committee and plan for World TB Day									
Sub-activity 9.3.1.1 Hold partners/committee meetings to plan for World TB Day (Pre-and -Post Day)	World TB Day	30	x	x	x	x	x		NTBLCP
Sub-activity 9.3.1.2 Graphics designer/printer to produce fliers - 2000 copies	Fliers	10000	x	x	x	x	x		NTBLCP
Sub-activity 9.3.1.3 Produce WTB Day promotional materials (T-Shirts (2,500), Fez Caps (2,500), Banners (25), hand bands (2,500 - school children inclusive)	SBC for World TB day	T-Shirts - 2,500 Fez-Caps - 2,500 Hand bands - 2,500 Banners - 25	x	x	x	x	x		NTBLCP

Sub-activity 9.3.1.4 Identify 25 old/new partners and pay advocacy visits (philanthropists, media, communities, etc)	Advocacy	60	x	x	x	x	x		NTBLCP
Sub-activity 9.3.1.5 Produce Media kits for WTB Day	Media kits	150	x	x	x	x	x		NTBLCP
Sub-activity 9.3.1.6 Conduct WTB Day Road Walk	Road Walk		x	x	x	x	x		NTBCLP
Sub-activity 9.3.1.7 Media Consultant to Produce and distribute World TB Day documentaries, Jingles, social media messages	Production	5	x	x	x	x	x		NTBLCP, Social Media persons
Sub-activity 9.3.1.8 Support Airing of Jingles on Radio - Radio Nigeria, Ray Power, Human Rights Radio, Armed Forces Radio (at least once a week)	Airing TB jingles	10	x	x	x	x	x		NTBLCP
Sub-activity 9.3.1.9 Support sharing of TB Messages on Social media	Social Media	5	x	x	x	x	x		NTBCLCP
Sub-activity 9.3.1.10 Support Broadcast of TB Documentary for World TB day on 2 TV Stations	Documentary	10	x	x	x	x	x		NTBLCP
Sub-activity 9.3.1.11 Community outreaches	Outreach	5	x	x	x	x	x		NTBLCP

Sub-activity 9.3.1.12 Ministerial Press Briefing	Press Briefing	5	x	x	x	x	x		NTBLCP
Objective 10: To strengthen community involvement in provision of quality TB care with the community contribution to TB case notification increasing from 22% in 2018 to 45% by 2026									
Strategic Intervention 10.1: Community driven intervention in hard-to reach and high-risk areas									
Activity 10.1.1: Advocacy to Stakeholders in the Community									
Sub-activity 10.1.1.1: Conduct Desk review of Stakeholders at all levels (including celebrities)	Stakeholder Identification	1	x						NTBLCP
Sub-activity 10.1.1.2: Conduct Quarterly advocacy visits to Traditional, Religious Leaders, Heads of Interest Groups, Trade Unions, Influencers/Advocates, celebrities - 12,384 per year (at least 4 leaders in 774 LGAs per quarter)	Relevant Stakeholders	12384	x	x	x	x	x		CBOs
Activity 10.1.2. Mapping of the communities to reach out									
Sub-activity 10.1.2.1: Conduct Desk Review/Mapping of TB services in relation to the population in 774 LGAs at LGA level - (60 hard-to-reach LGA = 40 southern/20 northern 70 high risk LGA (30% of total LGA) - ZM, KD, Kat, BN, AD, YB, TA, NS, PL, BE, NG	Consultant	1	x						NTBLCP

Activity 10.1. 3. Selection and orientation of Community members									
Sub-activity 10.1.3.1: Identification and 2-day orientation of 260 community liaison officers (CLO) and 130 TBAs in 130 LGA on TB identification, referral and specimen collection and transport, and patient linkage to treatment	Orientation	390	x						NTBLCP
Sub-activity 10.1.3.2: Conduct 3-day training for CBOs (15 per state) on community stakeholders' engagement, decision-making and TB response (to include Childhood TB)	CBOs	555	x						NTBLCP
Sub-activity 10.1.3.3: Identify and engage Treatment Supporters for DR-TB patients enrolled in Community	Treatment Support		x	x	x	x	x		CBOs
Sub-activity 10.1.3.4: Provide Transport support for CBOs to monitor community TB activities by service providers	Supervision	37	x	x	x	x	x		CBOs

Sub-activity 10.1.3.5: Provide Quarterly Administrative support to implementing CBOs	Admin	37	x	x	x	x	x		NTBLCP
Sub-activity 10.1.3.6: Identify and orient 2,500 Community Health Influencers, Promoters and Services (CHIPS) members in TB referral	CHIPS	2500	x						NTBLCP
Sub-activity 10.1.3.7: Conduct 1-day capacity building for 40 media practitioners on basic TB facts and available services. 2 years of the NSP.	Media	40	20			20			NTBLCP
Activity 10.1. 4. Chest camps for TB screening including sputum movement									
Sub-activity 10.1.4.1 Provide monthly stipends to 70 CLO for TB case finding in high-risk areas LGA	Stipend	350	70	70	70	70	70		NTBLCP
Sub-activity 10.1.4.2: Quarterly Chest Camp for Key Target Population (PLHIVs, IDPs, Migrants/refugees, slum dwellers, Nomads, miners, Orphanage Homes, hard-to-reach population, churches, mosques - 3 Chest Camps per Zone per Annum	Key Population	160	x	x	x	x	x		CBOs

Sub-activity 10.1.4.3 Conduct 10 chest camps/outreaches/school screening per LGA per month	High risk areas	78000	15600	15600	15600	15600	15600		CBOs
Activity 10.1.5: Implement Output-Based Approach (OBA) in TB case finding (94 cases notified in 2018 by Brass LGA of Bayelsa state. This was used as a typical hard-to-reach LGA. 94x130 LGAs=12,220 cases as baseline for 2021. increment of 50% for 2022 and 2023-2025 is 25%)									
Sub activity 10.1.5.1: Provide incentive for a positive TB case detected and case holding (Output-Based Approach)	Output - Based	99289	12220	18330	22913	22913	22913		CBOs
Activity 10.1 6. Engagement of security services during the exercise									
Sub-activity 10.1.6.1: Conduct advocacy/courtesy visits to security agencies and solicit for support	Advocacy in Crisis situation	90	x	x	x	x	x		CBOs
Sub-activity 10.1.6.2: Provide support for allowance of security personnel	Security Personnel	90	x	x	x	x	x		CBOs
Strategic Intervention 10.2: Targeted Multi-Channelled Social and Behaviour Change for TB using Media									
Activity 10.2.1: Develop and disseminate Social and Behavioural Change (SBC) materials using promotional materials (Billboards, Posters, Handbills, T-Shirts, Fez- Caps, etc).									
Sub-activity 10.2.1.1: Develop/Adapt and produce harmonised SBC materials - Posters - 200,000, Handbills - 1Million; Roll-up Banners - 50	SBC Materials	Posters - 200,000 Handbills - 1 million Banners - 50	x		x				NTBLCP

Sub-activity 10.2.1.2: Develop/Adapt and produce harmonised Childhood TB SBC materials - Posters - 20,000, Handbills - 100,000; Roll-up Banners - 50, Handbills - 500,000	Childhood TB SBC Materials	Posters - 200,000 Handbills - 100,000 Roll-up Banners - 50	x		x				NTBLCP
Sub-activity 10.2.1.3: Develop, print, and distribute SBC materials on zoonotic TB to OH unit Veterinary officers at state and LGA level	Zoonotic TB SBC materials	Posters - 2,000 Handbills - 10,000; Roll-up Banners - 15	x	x	x	x	x		NTBLCP
Sub-activity 10.2.1.4: Develop, print, and distribute Infection Control materials for health facilities	Infection Control SBC	Posters - 7,000 Roll-up Banners - 15 Handbills - 10,000	x						NTBLCP
Sub-activity 10.2.1.5: Produce and distribute TB promotional materials like (Billboards - 2, T-Shirts - 2,000, Fez- Caps - 2,000, etc)	Promotional Materials	Billboards - 2 T- Shirts - 2,000 Fez caps - 2,000	x		x				NTBLCP

Activity 10.2.2: Develop and disseminate harmonised TB documentary/Jingles/messages in local languages									
Sub-activity 10.2.2.1: Translate developed documentary/Jingles/TB messages into 3 major local languages;	Local Translation Languages	3	x		x				NTBLCP
Sub-activity 10.2.2.2: Produce and distribute translated TB documentaries, Jingles, social media messages	Production	3	x	x	x	x	x		NTBLCP, Social Media persons
Sub-activity 10.2.2.3: Support broadcast of TB documentary in major TV stations - NTA, Channels (twice a year)	Documentary Broadcast	20	x	x	x	x	x		NTBLCP
Sub-activity 10.2.2.4: Support airing of TB jingles/messages on major National radio - Radio Nigeria, Ray Power, Human Rights Radio, Armed Forces Radio (at least once a week)	Airing TB jingles	840	x	x	x	x	x		NTBLCP
Sub-activity 10.2.2.5: Support use of documentary/TB jingles/messages on social media - Facebook, Twitter, WhatsApp, Instagram etc	Social Media	280	x	x	x	x	x		NTBLCP, Partners, Social Media persons

Activity 10.2.3: Produce feature articles on TB programmes and services in print media									
Sub-activity 10.2.3.1: Support development and publication of TB Features Articles for Print, and social media	TB Newspaper Article	40	x	x	x	x	x		NTBLCP
Sub-activity 10.2.3.2: Develop/produce Quarterly TB Newsletter	Quarterly TB Newsletter	40	x	x	x	x	x		NTBLCP
Strategic Intervention 10.3: Engagement of the community in TB case finding									
Activity 10.3.1: Advocacy to state, LGA and community stakeholders									
Sub-activity 10.3.1.1: Conduct Quarterly advocacy visits to Traditional, Religious Leaders, Heads of Interest Groups, Correctional centers, Trade Unions, Influencers/Advocates, celebrities - 12,384 per year (at least 4 leaders in 774 LGAs per quarter)		12,384	x	x	x	x	x		CBOs
Objective 11: To protect and promote human rights and gender-related factors in provision of quality TB services									
Strategic Intervention 11.1: Improved access to TB services with Human Rights and Gender considerations.									
Activity 11.1.1: Conduct human rights and gender analysis to identify gaps for TB implementation									
Sub-activity 11.1.1.1 Human rights and gender analysis to identify gaps for TB implementation at State level	Consultant	1	x						NTBLCP

Activity 11.1.2: Stakeholders orientation on Human Rights and Gender Issues									
Sub-activity 11.1.2.1: Conduct 2-day workshop for 15 Stakeholders to develop policy on Human Rights and Gender Workshop for NTBLCP officers, Justice Ministry, security agencies, FIDA, Human Rights Commission, Stop TB partnership, Ministry of Women Affairs, NGOs	Human Rights & Gender Workshop on TB	1	x						NTBLCP
Sub-activity 11.1.2.2: Develop policies to address human rights and gender issues identified from Analysis									
Sub-activity 11.1.2.3: Expert to develop policy on TB Human Rights and Gender	Expert	1	x						NTBLCP
Activity 11.1.3: Patient Support to DR-TB patients (Transportation)									
Sub-activity 11.1.3.1 Provide Monthly transport support to all DR-TB patients	Transport		x	x	x	x	x		CBOs
Activity 11.1.4: Develop targeted gender-specific operational guidelines for workplaces and leisure areas									
Sub-activity 11.1.4.1: Gender Expert develop gender-specific operational guidelines on awareness creation	Gender Expert	1	x	x	x	x	x		NTBLCP

Sub-activity 11.1.4.2: Conduct Quarterly TB awareness creation activities at workplaces and leisure areas	Workplace activity	92880	x	x	x	x	x		CBOs
Activity 11.1.5: Training of DOT providers on the implementation of the Patient Charter as component of patients' pre-treatment counselling.									
Sub-activity 11.1.5.1: Leverage Training of DOT providers on the implementation of the Patient Charter as component of patients' pre-treatment counselling.	Patient's Charter	1	x						NTBLCP
Activity 11.1.6: Engage TB survivors, patients, and other key populations actively in human right-based community mobilisation, awareness creation and contact tracing of index cases.									
Sub-activity 11.1.6.1: Establish and Support Quarterly meetings of TB Support Groups (ex and current TB patients on treatment) in 774 LGAs	TB Support Groups	1 per LGA	x	x	x	x	x		NTBLCP
Sub-activity 11.1.6.2: Escort services to OPD, DOTS for DR-TB patients by Support Group Members	Escort services	DR-TB Patients on treatment	x	x	x	x	x		NTBLCP
Sub-activity 11.1.6.3: Bi-Annual contact tracing of index DR-TB cases	Contact Tracers		x	x	x	x	x		Tracers

Sub-activity 11.1.6.4: Annual TB Campaigns at State level by TB Support Groups for a human right-based TB response.	Human Rights campaign	185	x	x	x	x	x		TB Support Groups
Sub-activity 11.1.6.5: Targeted awareness and TB screening for incarcerated persons in police cell, inmates									
Sub-activity 11.1.6.6: Awareness creation for persons in police cells and correctional centers	Key population		x	x	x	x	x		CBOs
Sub-activity 11.1.6.7: Develop, use and monitor ACSM indicators to track patients' perspectives and key socio-economic factors in strategic plan (including catastrophic costs incurred by TB patients)									
Sub-activity 11.1.6.8: Develop ACSM indicators to track patients' perspectives and key socio-economic factors in strategic plan (including catastrophic costs incurred by TB patients)	ACSM Indicators	1	x						NTBLCP

Sub-activity 11.1.6.9: Monitoring/reporting of ACSM indicators	Monitoring		x	x	x	x	x		Implementers
Objective 12: Strengthen programme management and capacity at all levels for the achievement of the NSP target									
Strategic Intervention 12.1: Strengthen reporting across service delivery points.									
Activity 12.1.1: Joint National annual mop-up of data across all state.									
Sub-activity 12.1.1.1: Conduct a 5-day data mop-up in 36 States + FCT	Assessment	5	1	1	1	1	1		
Strategic Intervention 12.2: Capacity building on data management across all levels of TBLCP.									
Activity 12.2.1: Strengthen Human resource needs of the M&E unit of the NTBLCP CU									
Sub-activity 12.2.1.1: Support 2 National M&E staffs for a 2-week International training on advance data management annually	NTP M&E Staff	2	1	1	1	1	1		NTBLCP
Sub-activity 12.2.1.2: Support 3 National staff for one-week international training on impact evaluation annually									
Sub-activity 12.2.1.3 Support 3 National M&E officers annually for 2 weeks (selected at all levels to enrol in any relevant M&E course that can improve and enhance their performance towards successful implementation of the NSP)									

Sub-activity 12.2.1.4 Support participation of 4 National M&E staff at the annual Union conferences									
Sub-activity 12.2.1.5: Conduct a 2-week training of 80 persons from the CU NTBLCP, State level and Partners on advanced data management skills using relevant statistical softwares (STATA, SPSS, EPI-INFO) and data analysis, presentation/interpretation, and data use	NTP & STBLCP Staff	80		1	1				NTP
Sub-activity 12.2.1.6: Support training of 10 National Staff on Programme management and Supervisors course at NTBLTC Zaria	NTP Staff	10	1	1	1	1	1		NTP
Activity 12.2.2: Strengthen Human resource needs of state TBLCP M&E officers.									
Sub-activity 12.2.2.1: Support 10 State M&E officers to attend a 2-week training on monitoring and evaluation of public health programmes annually	STBLCP M&E Staff	37	1	1	1	1	1		NTP
Sub-activity 12.2.2.2: Support training of 10 State Staff on Programme management and Supervisors course at NTBLTC Zaria	STBLCP Staff	10	1	1	1	1	1		NTP

Activity 12.2.3: Strengthen Human resource needs at LGA and Facility levels									
Sub-activity 12.2.3.1: Conduct 2 days State level residential training on basic data management for 1548 LGTBLS and Assistants across 36 States + FCT	LGTBLS & Assistants	1548		1					NTP
Sub-activity 12.2.3.2: Conduct 6 weeks local training of 60 new LGATBLS on management and control of TB, TB/HIV, Leprosy and Buruli ulcer		60							
Sub-activity 12.2.3.3: Conduct a day LGA level non-residential training on basic data management for 30960 GHW across 36 States + FCT	GHCWs	30960		1					NTP
Sub-activity 12.2.3.4: Support training of 30 LGATBLS Supervisors course at NTBLTC Zaria	LGATBLCP Staff	30	1	1	1	1	1		NTP
Strategic Intervention 12.3: Strengthen data quality at all levels									
Activity 12.3.1: Provide mentoring and onsite data validation visit to the States, LGAs and facilities to ensure quality assurance, improve performance and establish supportive supervisory systems									
Sub-activity 12.3.1.1: Support the review and adaptation of checklist for supportive supervision and OSDV for uploading on ODK collect app	Facility supervisory visit								NTP

Sub-activity 12.3.1.2: Support 5 days joint national DQA of 3 persons/state to 1 challenged/weak State per zone (to visit at least 6 LGAs) biannually		720	4	4	4	4		
Sub-activity 12.3.1.3: Conduct a 5 day quarterly integrated supportive supervision and mentoring visit from National to the States	Assessment	20	4	4	4	4	4	NTP
Sub-activity 12.3.1.4: State TBLCF M&E to conduct a 5day quarterly on-site data verification visit to 5 challenging LGA/ facilities	Assessment	20	4	4	4	4	4	STBLCP
Sub-activity 12.3.1.5: Support all TBLS and assistants to conduct mentoring and supervisory visits to all facilities within the LGA								
Sub-activity 12.3.1.6: Conduct a 6-day quarterly integrated supportive supervision and mentoring visit from State to the LGA/facilities	Facility supervisory visit	44400	12	12	12	12	12	STBLCP
Sub-activity 12.3.1.7: Conduct a 5-day data mop-up in 36 States + FCT	Assessment	5	1	1	1	1	1	NTP

Activity 12.3.2: Development and dissemination of quarterly and annual National and State programme reports.									
Sub-activity 12.3.2.1: Identify and designate NTBLCP staff to collate quarterly supervisory reports from National, Zonal and State levels	NTP Staff	1	4	4	4	4	4		NTP
Sub-activity 12.3.2.2: Place quarterly supervisory reports from National, Zonal and State levels on the NTBLCP website	Report	20	4	4	4	4	4		NTP
Sub-activity 12.3.2.3: Disseminate reports of State quarterly visits to the NTBLCP Zonal coordinator, WHO Zonal NPOs and partners (at no cost during quarterly meetings)	Report	20	4	4	4	4	4		NTP
Sub-activity 12.3.2.4: Hold a 4-day meeting of 15 participants to produce National annual TBL report									
Sub-activity 12.3.2.5: Print and distribute 1500 copies of National annual TBL report (distribution to States, LGA, Partners)									
Sub-activity 12.3.2.6: Upload all National and State annual reports on the NTBLCP website									

Sub-activity 12.3.2.7: Print and distribute 100 copies of State score cards and annual TBL report.	State score card and annual TBL Report	100 Copies	1	1	1	1	1		NTP
Sub-activity 12.3.2.8: Upload all National and State annual reports on the NTBLCP website (at no cost)	Report	41	1	1	1	1	1		NTP
Activity 12.3.3: Availability of R&R tools									
Sub-activity 12.3.3.1: Convene a 5-day meeting of 30 persons (lab and programme) to review all recording and reporting tools used in TB programme in years 1, 3 and 5 of the NSP	NTP Staff		1		1		1		
Sub-activity 12.3.3.2: Convene a 5-day meeting of 15 persons (lab and programme) to finalise all recording and reporting tools used in TB programme in years 1, 3 and 5 of the NSP			1		1		1		
Sub-activity 12.3.3.3: Printing and distribution of R&R Tools									
Strategic Intervention 12.4: Optimise NETIMS (etb-manager, Gx alert/GxAspect, DHIS TB module, and MATS)									
Activity 12.4.1: Procure Tablets and Android phones for LGAs and facilities.									
Sub-activity 12.4.1.1: Procure tablets and android phones for LGAs and facilities									

Activity 12.4.2: Scale up eTB Manager to capture community TB activities.									
Sub-activity 12.4.2.1: Annual subscription for bucket data	Data subscription		1	1	1	1	1		NTP
Sub-activity 12.4.2.2 Procure SIM cards.									
Sub-activity 12.4.2.3: Develop eTB Manager mobile app to capture community TB activities.	e-TB Manager app		1						NTP
Sub-activity 12.4.2.4: Develop and activate TB module on DHIS.	TB Module		1						NTP
Sub-activity 12.4.2.5 Integrate eTB Manager with DHIS			1						NTP
Sub-activity 12.4.2.6: Integrate GxAlert with DHIS	GxAlert		1						NTP
Sub-activity 12.4.2.7: Install GxAlert on newly procured GeneXpert machines	GxAlert		1	1	1	1	1		NTP
Activity 12.4.3: Establish and maintain a central data bank system for the NTBLCP									
Sub-activity 12.4.3.1: Upgrade server and annual subscription			1	1	1	1	1		NTP
Activity 12.4.4: Recruit 2 IT Specialist to manage NETIMS									
Sub-activity 12.4.4.1: Advertise position on national newspaper	Advert	1	1						NTP

Sub-activity 12.4.4.2: interview and engagement of 2 IT Specialists (at no cost)	IT Specialists	2	1						NTP
Sub-activity 12.4.4.3: Payment of monthly salary to 2 IT Specialists	IT Specialists	2	12	12	12	12	12		NTP
Strategic Intervention 12.5: Unlinked private facilities report to the NTBLCP									
Activity 12.5.1: Expand TB notification App to unlinked Private facilities									
Sub-activity 12.5.1.1: Download and activate TB notification app (at no cost)	TB Notification APP								
Strategic Intervention 12.6: Improve data analysis at all levels									
Activity 12.6.1: Procure Statistical and Data visualisation software (SPSS, STATA, Tableau, 2Epi Info, Arc GIS).									
Sub-activity 12.6.1.1: Procure Statistical and Data visualisation software (SPSS, STATA, Tableau, Epi Info, Arc GIS).			1						
Activity 12.6.2: Programme Review at all levels									
Sub-activity 12.6.2.1: Conduct a 3 day annual Programme review meeting	NTP Staff, SPMs, Partners	480	1	1	1	1	1		NTP
Sub-activity 12.6.2.2: Conduct a 3-day quarterly zonal review meeting across the 6 zones.	NTP & STBLCP staff, IPs		4	4	4	4	4		NTP
Sub-activity 12.6.2.3: Conduct a 2-day quarterly State review meeting across the 36 states + FCT.	NTP & STBLCP Staff, IPs	1218	4	4	4	4	4		STBLCP
Sub-activity 12.6.2.4: Day residential National biannual planning cell meeting.	Meeting	8	2	2	2	2	2		NTP

Activity 12.6.3: Capacity building on Data analysis and visualisation for national M&E staff.									
Sub-activity 12.6.3.1: Conduct a 2-week training of 80 persons from the CU NTBLCP, State level and Partners on advanced data management skills using relevant statistical softwares (STATA, SPSS, EPI-INFO) and data analysis, presentation/interpretation, and data use	NTP & STBLCP Staff	80		1	1				NTP
Activity 12.6.4: Produce and disseminate fact sheets, score cards and annual report									
Sub-activity 12.6.4.1: Print and distribute 100 copies of State score cards and annual TBL report.	State score card and annual TBL Report	100 Copies	1	1	1	1	1		NTP
Sub-activity 12.6.4.2: Upload all National and State annual reports on the NTBLCP website (at no cost)	Report	41	1	1	1	1	1		NTP
Strategic Intervention 12.7: Strengthen M&E systems at all levels									
Activity 12.7.1: Conduct National quarterly M&E Technical working group meeting.									
Sub-activity 12.7.1.1: Day non-residential National quarterly M&E Technical working group meeting.	Meetings	16	4	4	4	4	4		NTP

Sub-activity 12.7.1.2: Support participation of 20 programme staff across all levels of programme management to attend annual international conferences	NTP, STP&LGA TP Staff	20	1	1	1	1	1		NTP
Activity 12.7.2: Quarterly data validation and harmonisation									
Sub-activity 12.7.2.1: Conduct 3 days quarterly data harmonisation meeting at National level	meeting	20	4	4	4	4	4		NTP
Sub-activity 12.7.2.2: Conduct 1-day non-residential quarterly data harmonisation meeting at LGA level	Meeting	15480	4	4	4	4	4		STBLCP
Activity 12.7.3: Develop National and State Strategic and operational plans									
Sub-activity 12.7.3.1: Identify and Train pool of experts to support the development of state TB Strategic plan (5days training for 37 Experts)	EXPERTS	37	1						NTP
Sub-activity 12.7.3.2: Conduct Expert/stakeholders meeting at the state level to develop draft state strategic plan (5 days meeting of 20 participants per state including the expert)	Meetings	37	1						NTP

Sub-activity 12.7.3.3: Conduct Expert meeting to finalise draft state strategic plan (3 days meeting of 10 participants per state including the expert)	Meetings	37	1						NTP
Sub-activity 12.7.3.4: Conduct 3 days non-residential meeting of STBLCP staff, SASCP, SACA and partners to develop annual operational plan from the State Strategic Plan	State Annual workplan	37	1						NTP
Sub-activity 12.7.3.5: State team to present the annual work plan at the state quarterly review meeting (no cost)	State Annual workplan	37	1						NTP
Sub-activity 12.7.3.6 State team to develop template for LGA work plan and share with TBLS during state review meetings (at no cost)	Template	774	1						STBLCP
Sub-activity 12.7.3.7: State team to introduce the LGA annual work plan template to the LGA TBLS during one of the State TBL quarterly meetings	Template	774	1				2		STBLCP
Sub-activity 12.7.3.8: Meeting of LGA TBLS, State team to develop annual plan for the LGAs (to be developed during the state programme review meeting)	work plan	774	1						STBLCP

Activity 12.7.4: Provide adequate equipment for M&E operations									
Sub-activity 12.7.4.1: Procure Laptops for National M&E officers, State Programme managers and State M&E Officers	NTP Staff								
Sub-activity 12.7.4.2: Procure 38 hard drives for NTPLCP (1) and STBLCP (37)	NTP Staff								
Sub-activity 12.7.4.3: Procure multiple users Antivirus for National and State Programmes	NTP Staff								
Sub-activity 12.7.4.4: Procure 37 routers for internet services	NTP Staff								
Sub-activity 12.7.4.5: Support monthly data bundle	Data bundle		12	12	12	12	12		NTP
Activity 12.7.5: Support data visualisation at National level									
Sub-activity 12.7.5.1: Procure 2 LG 43 inches full HD digital LED television	LG 43 inches full HD digital LED television	2	1						NTP
Strategic Intervention 12.8: Include Operational Research session in NSP									
Activity 12.8.1: Support operational research									
Sub-activity 12.8.1.1: Recruit 3 staff for the operation research unit of the central unit	OR staff	3	1						NTP

Sub-activity 12.8.1.2: Organise a 3-week master training for 10 persons on epidemiology and biostatistics (include cost for 2 external TAs)	OR staff	10	1					2		NTP
Sub-activity 12.8.1.3: A 3-day non-residential meeting to develop operation research plan.	Meeting	5	1	1	1	1	1	1		NTP
Sub-activity 12.8.1.4 Finalise and print the OR agenda.	Agenda	5	1	1	1	1	1	1		NTP
Sub-activity 12.8.1.5: Conduct quarterly OR task force meeting	Meeting	20	4	4	4	4	4	4		NTP
Sub-activity 12.8.1.6: Set up an OR network with research institution and academia for capacity building (at no cost)			1							NTP
Sub-activity 12.8.1.7: Conduct a 5-day capacity building on research for both National and State TB control programme team.	NTP&STBLCP Staff	47	1							NTP
Sub-activity 12.8.1.8: Conduct 4 ORs annually	Research	20	4	4	4	4	4	4		NTP
Sub-activity 12.8.1.9: 1-day dissemination meeting and publication of research findings.	Meeting	1		2	2	2	2	2		NTP

Strategic Intervention 12.9: Conduct specific TB surveys and studies									
Activity 12.9.1: Conduct specific TB surveys and reviews									
Sub-activity 12.9.1.1: Conduct TB Catastrophic survey	Survey	1		1					NTP
Sub-activity 12.9.1.2: Conduct KAP Survey	Survey	1		1					NTP
Sub-activity 12.9.1.3: Conduct a 2-day meeting to agree on NETIMS to be assessed	meeting	1	1						NTP
Sub-activity 12.9.1.4: Conduct 5-day stakeholders meeting to develop protocol for system assessment	meeting	1	1						NTP
Sub-activity 12.9.1.5: Conduct assessment of agreed NETIMS	assessment	1	1						NTP
Sub-activity 12.9.1.6-day dissemination meeting of findings from assessment	meeting	1	1						NTP
Sub-activity 12.9.1.7: Drug resistant survey	Survey	1							NTP
Sub-activity 12.9.1.8: Conduct TB prevalence survey.	survey	1	1						NTP
Sub-activity 12.9.1.9: Develop concept for the midterm review and identify TA support (no cost)	Meeting	1			1				NTP
Sub-activity 12.9.1.10: Conduct 2 preparatory 3-day meetings to develop and finalise tools for the mid-term review of the NSP	Meeting	1			1				NTP

Sub-activity 12.9.1.11: Conduct Mid-term review of the NSP (50 internal participants and 20 external TAs for 2 weeks)	Assessment	1			1				NTP
Sub-activity 12.9.1.12: Conduct a 1-day dissemination meeting to share result of the mid term review	Meeting	1			1				NTP
Sub-activity 12.9.1.13: Conduct End Term review of NSP 2021-2025.	Assessment	1					1		NTP
Strategic Intervention 12.10: Strengthen coordination mechanism for delivering integrated TB and HIV services at the national, state and health facilities									
Activity 12.10.1: Biannual TB-HIV Technical Working Group meetings at national level									
Sub-activity 12.10.1.1: Conduct 2-day non-residential biannual meeting of TB-HIV working group of 26 participants	Meetings	10	44348	44713	45078	45444	45809		NTBLCP
Activity 12.10.2: Joint supportive supervision to 6 states annually									
Sub-activity 12.10.2.1: Conduct a 5-day TB-HIV MSV of 12 persons to 6 states annually	National TB-HIV programs/partners	72	44186	44187	44188	44189	44190		NTBLCP
Activity 12.10.3: Quarterly State TB-HIV Technical Working Group meeting									
Sub-activity 12.10.3.1: Conduct 2-day non-residential quarterly meeting of State TB-HIV TWG of 20 participants	Meetings	20	X	X	X	X	X		NTBLCP

Activity 12.10.4: Joint supportive supervision to health facilities quarterly									
Sub-activity 12.10.4.1: Conduct a 5-day TB-HIV MSV of 11 persons each in the 36+1 states	TB-HIV MSV	20	X	X	X	X	X		NTBLCP
Activity 12.10.5: Enhance TB-HIV collaboration in all facilities									
Sub-activity 12.10.5.1: DOT Officer and Lab FP participation (at no cost) in the existing monthly HIV clinical meetings to strengthen TB-HIV collaboration in comprehensive tertiary/secondary facilities	Monthly clinical meetings participated by DOT Officer and Lab FP	60	Jan-Dec 2021	Jan-Dec 2022	Jan-Dec 2023	Jan-Dec 2024	Jan-Dec 2025		NTBLCP
Activity 12.10.6: Incentivise and recognise facilities that meet and sustain NSP target for TB-HIV indicators									
Sub-activity 12.10.6.1: Quarterly payment of incentives and recognition of 10 best tertiary/secondary/primary public and private facilities that meet and sustain 100% of TB-HIV NSP low performing indicators in each state	Tertiary/Secondary/primary facilities	7400	X	X	X	X	X		NTBLCP
Activity 12.10.7: Procure a service provider for this activity									
Sub-activity 12.10.7.1: 2 days engagement meeting with the developers of the tool	NTP and 3pl	13	1						NTBLCP

Activity 12.10.8: Roll-out of this service to cover all locations for LMDs									
Sub-activity 12.10.8.1: 2 days training of 3PL on the use of the geospatial tool	NTP Staff and 3pl	18	1						NTBLCP
Strategic Intervention 12.11 Upgrade of facilities with minimum requirements for good storage									
Activity 12.11.1: Provision of Temperature regulating and monitoring devices, cooling systems shelves and pallets for all Federal, Zonal and State stores									
Sub-activity 12.11.1.1: Procurement of thermometers/hygrometers, Air conditioners, shelves, and pallets	NTP Staff			1		1			NTBLCP
Activity 12.11.2.: Develop storage SOPs for DOT facilities that are less dependent on electronic devices									
Sub-activity 12.11.2.1: Conduct a 2-day meeting for the development of SOPs.	NTP Staff		1						NTBLCP
Sub-activity 12.11.2.2 Printing of SOPs		12000	1						NTBLCP
Activity 12.11.3: Advocacy to State governments to upgrade and insure storage facilities in their States.									
Sub-activity 12.11.3.1: 1-day advocacy visit to States	NTP Staff		1	1	1	1	1		NTBLCP
Activity 12.11.4: Relocation of TB commodities to the State CMS; where applicable									
Sub-activity 12.11.4.1: Memo to the affected States MoH	NTP Staff		1	1	1	1	1		NTBLCP
Activity 12.11.5: Provision of funding for the insurance for FCMS									
Sub-activity 12.11.5.1: Inclusion of funds for insurance as cost item in the current grant	NTP Staff		1	1	1	1	1		NTBLCP

Strategic Intervention 12.12: Expansion of the scope of the NHLMIS									
Activity 12.12.1: Engagement of the stakeholders to develop a robust system for logistics data reporting on the NHLMIS platform									
Sub-activity 12.12.1.1: 3-day meeting of stakeholders on the expansion of the scope of TB section of the NHLMIS	NTP Staff	1	1						NTBLCP
Activity 12.12.2: Engage NPSCMP based on the outcome of the stakeholders meeting on the expansion of the NHLMIS platform									
Sub-activity 12.12.2.1: 1-day (non-residential) Engagement meeting.	NTP Staff		1						NTBLCP
Activity 12.12.3: Quarterly NHLMIS TB data entry meeting (Zones Pharmacists and State team- SLO, M&E, DRTB FP and QAO)									
Sub-activity 12.12.3.1: 2 days meeting for data entry by zonal and state officers.	NTP Staff	20	4	4	4	4	4		NTBLCP
Activity 12.12.4: Roll out of the expanded NHLMIS across the relevant levels									
Sub-activity 12.12.4.1: 2-day orientation on the expanded version of the NHLMIS	NTP Staff	1	1						NTBLCP
Strategic Intervention 12.13 Develop a robust system for PV and aDSM in-country									
Activity 12.13.1: Use of electronic reporting platforms that allow for instantaneous reporting and sharing of reports (Electronic Pharmacovigilance Monitoring System). Setup of TB expert aDSM committee to conduct causality assessment and signal detections. Setup of TB expert aDSM committee to conduct causality assessment and signal detections.									
Sub-activity 12.13.1.1: Meeting with relevant stakeholders on the adoption of the Pvims and constitution of a National aDSM committee	NTP Staff	1	1						NTBLCP
Sub-activity 12.13.1.2: Provide server to host the PViMS	NTP Staff	1	1						NTBLCP

Activity 12.13.2: Provision of tablets/devices for reporting on the electronic platforms									
Sub-activity 12.13.2.1: Provision of tablets for treatment centers and OPD sites.	NTP Staff	1500	1500						NTBLCP
Activity 12.13.3: Quarterly meeting to conduct causality assessment and signal detection on the ADR reported									
Sub-activity 12.13.3.1: conduct 2-day causality assessment and signal detection meeting	NTP Staff	20	4	4	4	4	4		NTBLCP
Activity 12.13.4: Designation of a Pharmacovigilance officer at the NTBLCP to drive and monitor reporting.									
Sub-activity 12.13.4.1: Develop a ToR for the PV officer	NTP Staff	1							NTBLCP
Activity 12.13.5: Support aDSM and pharmacovigilance committees in the states and facilities									
Sub-activity 12.13.5.1: Conduct 2 days visit to treatment centers to set up aDSM committees. The State programmes will do same for the OPD sites	NTP Staff	25	1						NTBLCP
Activity 12.13.6: Capacity building of FPs at the facilities on PV and aDSM reporting on the electronic platforms									
Sub-activity 12.13.6.1: Carry out one-day advocacy visit to Stakeholders at the State level on the importance of Community engagement in TB Control	NTP Staff		1						NTBLCP
Sub-activity 12.13.6.2: 2 days step-down PViMS training of users at the facilities	NTP Staff	2	1						NTBLCP
Strategic Intervention 12.14 Central level support for the retrieval and destruction of expired medicines across all levels									
Activity 12.14.1: Collection of data of expired and unusable TB medicines and commodities from all Stores and SDPs in accordance with the National waste disposal policy									
Sub-activity 12.14.1.1 Inclusion of cost for reverse logistics in the grant PSM cost.	NTP Staff	5	1	1	1	1	1		NTBLCP

Sub-activity 12.14.1.2: Annual reverse logistics of expired commodities to zonal hubs.	NTP Staff	5	1	1	1	1	1		NTBLCP
Activity 12.14.2; Transportation and destruction of all expired commodities to at Zonal Destruction sites in collaboration with NAFDAC.									
Sub-activity 12.14.2.1: Annual zonal destruction of expired commodities.	NTP Staff	5	1	1	1	1	1		NTBLCP
Strategic Intervention 12.15: Ensuring availability of good quality TB medicines in the pipeline									
Activity 12.15.1: Provision of packaging/kitting materials for DRTB medicines									
Sub-activity 12.15.1.1: Procurement of packaging materials for DRTB medicines	NTP Staff	5	1	1	1	1	1		NTBLCP
Activity 12.15.2: Monitoring and supervising patient specific kitting of DRTB medicines at CMS Oshodi									
Sub-activity 12.15.2.1: 5 days visit to FCMS to supervise kitting of DRTB medicines Hiring of labour for kitting	NTP/ZONAL/STATE	20	4	4	4	4	4		NTBLCP
Activity 12.15.3: Orientation of samplers									
Sub-activity 12.15.3.1: 3-day meeting for training of samplers for the survey	NTP Staff /NAFDAC	4	1	1	1	1	1		NTPLCP
Activity 12.15.4: Sample collection									
Sub-activity 12.15.4.1: 5 day visit to various level of commodity storage for sample collection.	NTP Staff /NAFDAC	10	2	2	2	2	2		NTBLCP

Activity 12.15.5: Testing of collected samples									
Sub-activity 12.15.5.1: Payment for testing by NAFDAC	NTP Staff /NAFDAC	10	2	2	2	2	2		NTBLCP
Activity 12.15.6 Report writing and dissemination									
Sub-activity 12.15.6.1: 3-day meeting for report writing and dissemination	NTP Staff /NAFDAC	10	2	2	2	2	2		NTBLCP
Activity 12.15.7: Procurement of laboratory equipment, reagents and Consumables for Xpert MTB/RIF, Microscopy, LPA, Culture, C/DST, new molecular tools etc.									
Sub-activity 12.15.7.1: Procure additional equipment for the BSL2 laboratories for 14 RLs in 2021 and 14 RLs in 2024)	1	14	1		1				NTBLCP
Sub-activity 12.15.7.2: Activate the BSL2 for culture and DST for 10 days for 4 new TB RLs (2 in 2021 and 2 in 2023)	10	2	2		2				NTBLCP
Sub-activity 12.15.7.3: Provide for infrastructural and equipment upgrade of Line Probe Assay for 5 TB LPA labs (2 in 2021; 1 in 2022; 2 in 2023)	1	5	2	1	2				NTBLCP
Sub-activity 12.15.7.4: Purchase and install generators, inverters, and stabilizers for TB reference labs 12 in 2021, 13 in 2022, 14 in 2023).	1	1	12	13	14				NTBLCP

Sub-activity 12.15.7.5: Procure and install 5KVA solar panels and inverters for all GeneXpert sites for GeneXpert sites in 2021 (200) in 2022 (200) and 2023 (200)	1	1	200	200	200				NTBLCP
Sub-activity 12.15.7.6: Procure GDF TB lab Consumable kits (e.g. Strong carbol fuchsin, Acid alcohol 3% v/v, Methylene Blue (3g/l), Industrialised methylated spirit (95% methanol), Immersion oil, _Lysol_ 5% solution, Slides, etc.) for the 605,792 smears in 2021, 642104 in 2022, 679986 in 2023, 729630 in 2024 and 781540 in 2025.	1	781540	1	1	1	1	1		NTBLCP
Sub-activity 12.15.7.7: Procure additional laboratory equipment starter kit required for effective microscopy (e.g. Applicator sticks, lime-soda-glass, pack of 50, Diamond pen, pack 2021 for 100 sites, 2022 for 56 sites, 2023 for 50 sites and 2024 for 50 sites	1	256	100	56	50	50			NTBLCP
Sub-activity 12.15.7.8: Procure, Lens tissue paper, Liquid soap for hands, etc) for the 22021- 3206; 2022 - 3262; 2023- 3312, 2024- 3362 microscopy sites	1	3362	1	1	1	1			NTBLCP

Sub-activity 12.15.7.9: Procure Sputum containers required for effective microscopy (605,792 containers in 2021, 642104 in 2022, 679986 in 2023, 729630 in 2024 and 781540 in 2025.	1	781540	1	1	1	1	1		NTBLCP
Sub-activity 12.15.7.10: Procure microscope spare parts (bulbs, stages, X100 and X 10 objective lenses and X10 eyepiece lens, microscope maintenance kit , stage and condenser) for 30% of the newly procured microscopes 2021- 100; 2022 -56; 2023- 50 2024-50	1	256	1	1	1	1			NTBLCP
Sub-activity 12.15.7.11: Procure cartridges for the conduct of 12,036,682 GeneXpert tests assuming 70% of presumptive TB patients tested using GeneXpert; (2,120,272 in 2021, 2,247,364 in 2022, 2,379,951 in 2023, 2,553,705 in 2024 and 2,732,390 in 2025)	1	2732390	1	1	1	1	1		NTBLCP

Sub-activity 12/15/7.12: Procure additional equipment (see attached list) for TB Reference labs 10 in 2021, 12 in 2022, 14 in 2023, 14 in 2024 and 14 in 2025)	1	14	1	1	1	1	1		NTBLCP
Sub-activity 12.15.7.13: Maintenance of generators and inverters for TB Reference labs 10 in 2021, 12 in 2022, 14 in 2023, 14 in 2024 and 14 in 2025)	1	14	1	1	1	1	1		NTBLCP
Sub-activity 12.15.7.14: Procure supplies for 193,152 cultures (32,763 in 2021, 35,643 in 2022, 38,712 in 2023, 41,538 in 2024 and 44,496 in 2025)	1	44496	1	1	1	1	1		NTBLCP
Sub-activity 12.15.7.15: Procure supplies for 193,152 patients for FLD using solid culture on LJ for 193,152 cultures (32,763 in 2021, 35,643 in 2022, 38,712 in 2023, 41,538 in 2024 and 44,496 in 2025)	1	44496	1	1	1	1	1		NTBLCP
Sub-activity 12.15.7.16: Procure supplies for 193,152 patients for FLD using MGIT liquid culture; for (32,763 tests in 2021, 35,643 in 2022, 38,712 in 2023, 41,538 in 2024 and 44,496 in 2025)	1	44496	1	1	1	1	1		NTBLCP

Sub-activity 12.15.7.17: Procure supplies to conduct 193,152 TB molecular test (LPA) for (32,763 tests in 2021, 35,643 in 2022, 38,712 in 2023, 41,538 in 2024 and 44,496 in 2025)	1	44496	1	1	1	1	1		NTBLCP
Sub-activity 12.15.7.18: Procure office equipment for the TB reference laboratories (see attached list)	1	4	1	1	1	1	1		NTBLCP
Sub-activity 12.15.7.19: Procure additional equipment for the BSL2 laboratories for 14 RLs in 2021 and 14 RLs in 2024)	1	14	1			1			NTBLCP
Sub-activity 12.15.7.20: Activate the BSL2 for culture and DST for 10 days for 4 new TB RLs (2 in 2021 and 2 in 2023)	1	2	1		1				NTBLCP
Sub-activity 12.15.7.21: Provide for infrastructural and equipment upgrade of Line Probe Assay for 5 TB LPA labs (2 in 2021; 1 in 2022; 2 in 2023)	1	1	2	1	2				NTBLCP

Sub-activity 12.15.7.22: Purchase routers and other accessories (TP link adaptor and sims) and expansion of data plan to new GeneXpert sites for the installation of GX alert system for all GeneXpert machines (269 in 2021, 60 in 2022, 40 in 2023, 40 in 2024 and , 30 in 2025)	1	1	269	60	40	40	30		NTBLCP
Sub-activity 12.15.7.23: Procure and install 5KVA solar panels and inverters for all GeneXpert sites for GeneXpert sites in 2021 (200) in 2022 (200) and 2023 (200)	1	200	1	1	1				NTBLCP
Sub-activity 12.15.7.24: Purchase and install generators, inverters and stabilizers for TB reference labs 12 in 2021, 13 in 2022, 14 in 2023).	1	14	1	1	1				NTBLCP
Sub-activity 12.15.7.25: Procure and install 5KVA solar panels and inverters for all GeneXpert sites for GeneXpert sites in 2021 (200) in 2022 (200) and 2023 (200)	1	200	1	1	1				NTBLCP

Sub-activity 12.15.7.26: Procure solar refrigerators for collection centres in all the 774 LGAs for storage of specimens prior to transportation to culture/DST centres (774 in 2021)	1	774	1						NTBLCP
Sub-activity 12.15.7.27: Procure laboratory consumables for preparation of panels for AFB Microscopy labs (100 in 2021; 156 in 2022; 256 in 2023; 256 in 2024 and 256 in 2025) for AFB sputum smear microscopy twice a year for 5 years.	1	256	2	2	2	2	2	2	NTBLCP
Sub-activity 12.15.7.28: Procure laboratory consumables (see list) for preparation of panels LPA and culture DST sites (12 in 2021, 12 in 2022, 14 in 2023, 14 in 2024 and 14 each in 2025)	1	14	2	2	2	2	2	2	NTBLCP
Sub-activity 12.15.7.29: Procure e-PT reporting platform by system one for sites to submit results online	1	14	1						NTBLCP
Sub-activity 12.15.7.30: Procure 6 panels for culture, ID, and DST for first- and second-line anti-TB drugs SRL to NRLs and ZRLs once annually	1	6	1	1	1	1	1	1	NTBLCP

Sub-activity 12.15.7.31: Procurement, clearing and distribution of American Type Culture Collection (ATCC) strains for quality control to all the TB Reference laboratories (14 in 2021, 14 in 2022, 14 in 2023, 14 in 2024 and 14 in 2025). 1 set per established laboratory throughout the period of the NSP	1	14	1	1	1	1	1	NTBLCP
Sub-activity 12.15.7.32: Procure and install 4 desktops for each of the TB reference laboratories for TBLIS 2 in 2021 and 2 in 2022, Procure same number back up system for data	1	2	1	1				NTBLCP
Sub-activity 12.15.7.33: Procure 932 LED microscopes (30% of existing bright field microscopes that are damaged) in year 1 of the NSP.	1	932	1					NTBLCP
Sub-activity 12.15.7.34: Procure and install 256 LED microscopes for additional 256 new microscopy sites activation (100 in 2021, 56 in 2022, 50 in 2023 and 50 in 2024, maintain functionality in 2025	1	256	1	1	1	1	1	NTBLCP

Sub-activity 12.15.7.35: Procure additional equipment for the BSL2 laboratories for 14 RLs in 2021 and 14 RLs in 2024)	1	14	1			1			NTBLCP
Sub-activity 12.15.7.36: Procure laboratory consumables (see list) for preparation of panels LPA and culture DST sites (12 in 2021, 12 in 2022, 14 in 2023, 14 in 2024 and 14 each in 2025)	1	66	1	1	1	1	1		NTBLCP
Sub-activity 12.15.7.37: Purchase of software and training materials for continuous Medical education	1	14	1	1	1	1	1		NTBLCP
Sub-activity 12.15.7.38: Procure consumables for Health Care Workers and MDR TB Patients in the treatment Centers: Local Procurement	1		1	1	1	1	1		NTBLCP
Sub-activity 12.15.7.39: Consumables for MDR TB Patients in the Ambulatory Phase and Health Care Workers: Direct Importation	1		1	1	1	1	1		NTBLCP
Sub-activity 12.15.7.40: Procure consumables for MDR TB Patients in the Ambulatory Phase and Health Care Workers: Local Procurement	1		1	1	1	1	1		NTBLCP

Sub-activity 12.15.7.41: Procure consumables for Health Care Workers and MDR TB Patients in the treatment Centers: Direct Importation	1		1	1	1	1	1		NTBLCP
Sub Activity 12.15.7.42. Procure supplies and equipment (cold boxes, glycerol, packaging box) for cold chain transportation of clinical specimen: Local Procurement	1		1	1	1	1	1		NTBLCP
Strategic Intervention 12.16 Advocacy to the government to include key PSM activities in the budget and release requisite funds									
Activity 12.16.1 Deploy advocacy tools to facilitate FG, SG and LG buy-in to support PSM activities within their scope. (e.g. HR support)									
Sub-activity 12.16.1.1: 1-day advocacy visit to FG, SG and LGs to HR support for PSM activities	NTP Staff		2	2	2	2	2		NTBLCP
Strategic Intervention 12.17: Advocacy to government and partners to ensure prompt release of budgeted funds for procurement of TB medicines/commodities									
Activity 12.17.1: Engage the ACSM team to provide TA on the package to use for advocacy to government and partners									
Sub-activity 12.17.1.1: 1-day meeting to develop advocacy tool with the ACSM team	NTP Staff		1	1	1	1	1		NTBLCP
Activity 12.17.2: Regular communication with key MoH staff and partners and ensure their involvement in relevant National PSM activities									
Sub-activity 12.17.2.1: Memo communicating funding gaps/ needs MoH/ partners	NTP Staff		2	2	2	2	2		NTBLCP

Strategic Intervention 12.18: Funding Support to hold regular PSM TWG meetings & Onsite LMIS Data Validation									
Activity 12.18.1.: Quarterly PSM TWG meetings									
Sub-activity 12.18.1.1: 1-day meeting	NTP Staff	20	4	4	4	4	4		NTBLCP
Activity 12.18.2: Quarterly 3PL performance monitoring (facilities-To the last mile)									
Sub-activity 12.18.2.1: 4 Spot-Check visit to 4 States per Quarter	NTP Staff	20	4	4	4	4	4		NTBLCP
Activity 12.18.3: Quarterly LMIS validation meeting (FCMS, Zonal, State stores and treatment centers)									
Sub-activity 12.18.3.1: 3 days meeting	NTP Staff	20	4	4	4	4	4		NTBLCP
Strategic Intervention 12.19: Partner coordination for laboratory activities at sub-national level									
Activity 12.19.1. Quarterly CGAT meetings in collaboration with partners and stakeholders									
Sub-activity 12.19.1.1. Conduct 2 days quarterly Country Coordinating GeneXpert Advisory Team (CGAT) meetings of 35 participants throughout the NSP	2	35	4	4	4	4	4		NTBLCP
Activity 12.19.2. Quarterly TB laboratory technical working group meetings in collaboration with partners and stakeholders									
Sub-activity 12.19.2.1: Conduct 3 days quarterly laboratory technical working group (LTWG) meetings of 30 participants	3	30	4	4	4	4	4		NTBLCP

Activity 12.19.3. Quarterly state Quality Assurance (QA) officer's coordination meeting									
Sub-activity 12.19.3.1: Conduct 2 days state quarterly Quality Assurance (QA) officer's coordination meeting of 52 participants per state	2	52	4	4	4	4	4		NTBLCP
Strategic Intervention 12.20. Improved human resource and capacity development of TB laboratory personnel at all levels of laboratory services									
Activity 12.20.1. Review policy on human resource acquisition and retention									
Sub-activity 12.20.1.1: Conduct a 3 days meeting of 28 participants to review TB laboratory policy for the human resource acquisition and retention	3	28	1						NTBLCP
Activity 12.20.2. Develop TB laboratory training, materials, programmes, plan an manuals/SOPs for all facilities									
Sub-activity 12.20.2.1: Conduct a 5-day meeting of 28 participants to review the existing TB laboratory training materials, programmes plans and SOPs for smear microscopy, Xpert, LPA and C/DST	5	28	1						NTBLCP
Activity 12.20.3. Develop a national TB diagnostic Manual of operation									
Sub-activity 12.20.3.1: Conduct a 5 day meeting of 28 participants to develop the national TB diagnostic and QA Manual of operations including review after 2 years	5	28	1		1				NTBLCP

Sub-activity 12.20.3.2: Conduct two time 3 days review meeting of 15 participants on the national TB diagnostic and EQA operations manual	3	15	1		1				NTBLCP
Sub-activity 12.20.3.3: Print 5,500 TB laboratory policy manual for all TB laboratories (AFB-LED, GeneXpert and Culture lab and new WHO approved molecular diagnostics) including buffer	1	5500	1		1				NTBLCP
Sub-activity 12.20.3.4: Distribute TB laboratory policy manual to all TB laboratories (AFB-LED, GeneXpert and Culture lab). 5,500 in 2021 and 5500 in 2024	1	5500	1		1				NTBLCP
Activity 12.20.4. Conduct annual training and retraining of TB laboratory personnel on diagnostics and management at all levels									
Sub-activity 12.20.4.1: Conduct a 5 day ToT workshop of 25 participants and 3 facilitators for the national TB diagnostic and QA Manual of operations	5	28	1						NTBLCP

Sub-activity 12.20.4.2: Conduct a 5 day zonal training for 256 new smear microscopy sites (100 in 2021; 56 in 2022; 50 in 2023; 50 in 2024) 2 participants per site, 24 participants and 3 facilitators including secretariat staff per batch of 18 trainings	5	27	100	56	50	50			NTBLCP
Sub-activity 12.20.4.3: Conduct a 5 day training for each of the 256 new GeneXpert sites (100 in 2021; 56 in 2022; 50 in 2023; 50 in 2024) 5 participants per site (1280 participants) and 2 facilitators per site (512)	5	7	100	56	50	50			NTBLCP
Sub-activity 12.20.4.4: Conduct a 21-day refresher training of two participants per site and 5 facilitators for each of the LPA, C/DST sites at the NRL (27 in 2021, 33 in 2023 and 33 in 2025)	21	7	11		14		14		NTBLCP
Activity 12.20.5: Laboratory Information System									
Sub-activity 12.20.5.1: Conduct a 3-day training of 20 (15 lab and 5 M&E) on optimal utilisation of GxAlert information for action (monitoring of KPIs) in 2021, 2023 & 2025.	3	20	1		1		1		NTBLCP

Sub-activity 12.20.5.2: Upgrade the existing TB laboratory information system (TBLIS) software for the 6 TB reference laboratories. 6 in 2021	1	6	1						NTBLCP
Sub-activity 12.20.5.3: Procure and install laboratory information system (TBLIS) software for the 8 TB reference laboratories (6 in 2021, 2 in 2022)	1	8	1		1				NTBLCP
Sub-activity 12.20.5.4: Procure, install and maintain central server laboratory information system (TBLIS) software at NTBLCP	1	14	1						NTBLCP
Sub-activity 12.20.5.5: Maintain central server laboratory information system (TBLIS) software at NTBLCP	1	14	1	1	1	1	1		NTBLCP
Sub-activity 12.20.5.6: Provide for maintenance and support costs for TBLIS in all 14 TBRL (6 in 2022, 8 in 2023, 14 in 2024 and 14 in 2025)	1	14	1	1	1	1	1		NTBLCP
Sub-activity 12.20.5.7: Provide for annual internet subscriptions for TBLIS central server and all TBRL	1	14	1	1	1	1	1		NTBLCP

Sub-activity 12.20.5.8: Conduct 2-day training of GeneXpert focal persons on how to troubleshoot for connectivity, inventory entry and custom data collection. Biannually in South and Northern zones	2	537	1	1	1	1	1		NTBLCP
Sub-activity 12.20.5.9: Follow up quarterly supervision visits to resolve issues of connectivity in the field by QAOs.	1	500	4	4	4	4	4		NTBLCP
Sub-activity 12.20.5.10: Conduct training on upgrade of GxAlert to Aspect	1	500	1						NTBLCP
Strategic Intervention 12.21: Develop operational research capacity (Evaluate use of good quality data to determine TB burden (DS-TB, DR-TB, and TB-HIV), result delivery, Client satisfaction, and laboratory performance indicators)									
Activity 12.21.1: Evaluate use of good quality data to determine TB burden (DS-TB, DR-TB, and TB-HIV), result delivery, Client satisfaction, and laboratory performance indicators									
Sub-activity 12.21.1.1: Evaluate use of good quality data to determine burden of TB and drug resistant TB nation-wide	1	1	4	4	4	4	4		NTBLCP
Sub-activity 12.21.1.2: Conduct Annual country-specific operational research that improves laboratory services	2	20	1	1	1	1	1		NTBLCP

Sub-activity 12.21.1.3: Evaluate the acceptability and impact of over-the-phone laboratory results reporting to TAT	1	14	1	1	1	1	1		NTBLCP
Sub-activity 12.21.1.4: Introduction to data analysis and research methods for laboratory personnel	1	28	1		1		1		NTBLCP
Strategic Intervention 12.22: Strengthen Operational Research for Child TB									
Activity 12.22.1: Institute operational research on incidence and prevalence of child TB									
Sub-activity 12.22.1.1: The prevalence and incidence of TB in children in Nigeria	Operational research on child TB	3	1		1				
Activity 12.22.2: Institute operational research on assessing different diagnostic options for child TB									
Sub-activity 12.22.2.1: Assess for measures to improve the utilisation of Xpert MTB/RIF assay for extra-pulmonary TB samples in diagnosing TB in children	Operational research on child TB diagnosis	2			1		1		
Sub-activity 12.22.2.2: The utility of chest x-ray support in addition to other parameters for diagnosing TB in children/adolescents									
Activity 12.22.3: Institute operational research on accessing the outcome of TB treatment in children									
Sub-activity 12.22.3.1: Assessment of treatment outcomes in children accessing treatment for drug susceptible and Drug Resistant TB	Operational research on outcome of child TB	2		1		1			

Activity 12.22.4: Institute operational research on assessing the impact of task shifting and different models of child TB integration									
Sub-activity 12.22.4.1: Assess the impact of task shifting in improving childhood/adolescent TB notification and management									
Sub-activity 12.22.4.2: Evaluate the impact of different models of integrating childhood TB with RMNCAH, nutrition and orphan and vulnerable (OVC) services									
Sub-activity 12.22.4.3: Assess the Impact/evaluation of current childhood /adolescent TB integration with HIV service									
Strategic Intervention 12.23: Strengthen Coordination and Governance of Child TB Control									
Activity 12.23.1: Strengthen Coordination of Child TB Control in Nigeria									
Sub-activity 12.23.1.1: Develop annual operational plans for child TB control at the National level	Child TB Annual operational plan		1	1	1	1	1		NTBLCP
Sub-activity 12.23.1.2: Print Annual operational plan	Printed operational plan	500	100	100	100	100	100		NTBLCP
Sub-activity 12.23.1.3: Conduct 2- day quarterly meetings of National Child TB Steering Committee	Quarterly meeting of child TB committee		4	4	4	4	4		NTBLCP

Sub-activity 12.23.1.4: Integrate Child TB sub-committees into existing committees at the State Level									NTBLCP
Sub-activity 12.23.1.5: Appoint focal paediatricians for child and adolescent TB for the six geo-political zones	Focal Paediatrician appointed per health facility								NTBLCP
Sub-activity 12.23.1.6: Create a WhatsApp forum for all 36 States and the FCT for regular communications	WhatsApp forum								NTBLCP
Activity 12.23.2: Ensure provision of guidelines and SOPs on child TB									
Sub-activity 12.23.2.1: Print copies of National TB guidelines	National TB guidelines	30000	30000						NTBLCP
Sub-activity 12.23.2.2: Distribute copies of National TB guidelines	National TB guidelines	30000	30000						NTBLCP
Sub-activity 12.23.2.3: Print copies of Child TB desk guide	Child TB desk guide	30000	30000						NTBLCP
Sub-activity 12.23.2.4: Distribute copies of Child TB desk guide	Child TB desk guide	30000	30000						NTBLCP
Sub-activity 12.23.2.5: Print copies of SOP on child-friendly medicines for drug susceptible TB	SOP on child-friendly medicines for DS TB	30000	30000						NTBLCP

Sub-activity 12.23.2.6 Distribute copies of SOP on child-friendly medicines for drug susceptible TB	SOP on child-friendly medicines for DS TB	30000	30000						NTBLCP
Sub-activity 12.23.2.7: Print 5,000 copies of SOP on child-friendly medicines for drug resistant TB	SOP on child-friendly medicines for DR TB	5000	5000						NTBLCP
Sub-activity 12.23.2.8 Distribute copies of SOP on child-friendly medicines for drug resistant TB	SOP on child-friendly medicines for DR TB	5000	5000						NTBLCP
Sub-activity 12.23.2.9: Print copies of guidelines on Latent TB Infection Management	Guidelines on Latent TB Infection Management	20000	20000						NTBLCP

Sub-activity 12.23.2.10 Distribute copies of guidelines on Latent TB Infection Management	guidelines on Latent TB Infection Management	20000	20000						NTBLCP
Sub-activity 12.23.2.11 Print copies of SOP on gastric aspiration/lavage	SOP on gastric aspiration/lavage	20000	20000						NTBLCP
Sub-activity 12.23.2.12 Distribute copies of SOP on gastric aspiration/lavage	SOP on gastric aspiration/lavage	20000	20000						NTBLCP
Activity 12.23.3: Strengthen collaboration with Paediatric associations and other professional bodies									
Sub-activity 12.23.3.1 Support the conferences of 2 associations (Paediatric Association of Nigeria (PAN) and NISPID) annually (one session during the conferences)	Conference support of paediatric association meetings	5	1	1	1	1	1		
Sub-activity 12.23.3.2: Support the participation of 2 persons to 2 local conferences of Paediatric associations (NISPID and any other) annually	Local conference support of individuals	10	2	2	2	2	2		NTBLCP

Sub-activity 12.23.3.3: Support the participation of 2 persons to 2 international conferences of Paediatric associations (NISPID and any other) annually	Participation at international conference	10	2	2	2	2	2		NTBLCP
Activity 12.23.4: Strengthen the capacity of the NTBLCP in child TB control									
Sub-activity 12.23.4.1: Support 2 NTBLCP staff to attend annual meeting of child and Adolescent working group	NTBLCP Participation at child and adolescent working group	10	2	2	2	2	2		NTBLCP
Sub-activity 12.23.4.2: Support 2 child TB Staff for international M & E training to improve recording and reporting as well as measurement of impact of interventions		4	2				2		NTBLCP
Sub-activity 12.23.4.3: Support 2 STBLPM to attend Union courses on Childhood drug susceptible and drug resistant TB.			2	2	2	2	2		NTBLCP
Sub-activity 12.23.4.4: Support 2 NTBLCP staff to attend a 5-day Union Conference on Lung Health.			2	2	2	2	2		NTBLCP

Strategic Intervention 12.24: Integrate child TB care into RMNCAH + N as well as HIV Services									
Activity 12.24.1: Strengthen collaboration with Child health and nutrition stakeholders									
Sub-activity 12.24.1.1: Support the participation of 2 NTBLCP staff in quarterly meetings of National Core Technical Committee of RMNCAH + N services	Quarterly meeting	20 meetings	4	4	4	4	4		NTBLCP
Sub-activity 12.24.1.2: Conduct 3- day expert meeting to develop training materials for MCH staff on identification and referral of presumptive child TB	Expert meeting								NTBLCP
Sub-activity 12.24.1.3: Conduct 2- day orientation of 120 nutrition service providers (2 per facility) in 60 tertiary facilities across the country on identification and referral of presumptive child TB	Orientation meeting in tertiary facilities								NTBLCP
Sub-activity 12.24.1.4: Conduct 2- day orientation of 740 nutrition service providers (2 per facility) in 370 high burden secondary facilities across the country on identification and referral of presumptive child TB	Orientation meeting in secondary facility facilities		0.5	0.5					NTBLCP

Sub-activity 12.24.1.5: Conduct 3-day child TB training including contact investigation and TPT for 2,870 health care workers (2 from all 1,435 ART sites) across the country	Child TB + TPT training for ART sites								NTBLCP
Sub-activity 12.24.1.6: Conduct a hub and spoke mapping of health facilities in a senatorial fashion across the country									NTBLCP
Sub-activity 12.24.1.7: Support 109 paediatricians/medical officers to provide mentorship and follow-up to MCH sites (1 per senatorial zone) on child TB	Engagement of Focal paediatricians	109	1						NTBLCP
Strategic Intervention 12.25: Strengthen DR-TB surveillance system									
Activity 12.25.1: Update recording and reporting tools for DR-TB									
Sub-activity 12.25.1.1 Printing of recording and reporting tools for DR-TB patients treatment card	NTP Staff	64384	10921	11881	12904	13846	14832		NTBLCP
Sub-activity 12.25.1.2: DR-TB referral form - (3640 in 2021; 3960 in 2022; 4301 in 2023; 4615 in 2024; 4944 in 2025) and 44 per year (for treatment centres)	NTP Staff	21461.33	3640.33	3960.33	4301.33	4615.33	4944		NTBLCP
Sub-activity 12.25.1.3 Patient identity card - (in 2015; in 2016; 1 in 2017; in 2018; in 2019; in)	NTP Staff	64384	10921	11881	12904	13846	14832		NTBLCP
Activity 12.25.2: Quarterly supervision of DR-TB programme management at all levels									

Sub-activity 12.25.2.1: Conduct supervision by 3 persons per State per year for 5 days	NTP staff		37	37	37	37	37		NTBLCP
Activity 12.25.3 Conduct National Drug Resistant Tuberculosis Survey.									
Sub-activity 12.25.3.1: Stakeholders meeting to plan for the survey - 4 days, 25 persons	NTP Staff	1	1						
Sub-activity 12.25.3.2: Two external TAs for DRS. Two weeks in each quarter throughout the period of the survey, including protocol development	TA	1	1						
Sub-activity 12.25.3.3 Printing of protocol - 50 copies of survey report	NTP Staff	1	1						
Sub-activity 12.25.3.4 Meetings of 5 different committees monthly for 6 months (7 people/committee; 3 days)	NTP Staff	30	30						
Sub-activity 12.25.3.5 National DRS committee meeting (quarterly, 25 people, 2 days)	NTP Staff	4	4						
Sub-activity 12.25.3.6 Procure, reagents and consumables for the DR survey for 5,000 cases (10,000 tests)	NTP Staff	1	1						
Sub-activity 12.25.3.7 Train Survey supervisors - (30 states; 4 people per state; 2 days training); 50 clusters with 120 sites (240 field workers), 14 TB Ref labs (28 staff) and 30 LGA supervisors; 2 days training)	NTP Staff	9	9						

Sub-activity 12.25.3.8 Communication	NTP Staff	2280	2280						
Sub-activity 12.25.3.9: Develop, print, and distribute IEC materials on zoonotic TB to OH unit Veterinary officers at state and LGA level.	Move to ASCM and PSM Groups to develop and print the materials								
Sub-activity 12.25.3.10: Provision of seed stock of anti-TB medicines and R & R tools for newly engaged sites	seed stock of FL anti-TB medicines and R & R tools	PSM group to quantify pls.							
Sub-activity 12.25.3.11: Provision of R & R tools for referral health facilities	provision of R & R tools for referral HF	PSM group to quantify pls.							
Sub-activity 12.25.3.12: Development and printing of CTBC training manual									NTBLCP
Activity 12.25.4: Review National PMDT guidelines scale-up plans and training documents and manuals									
Sub-activity 12.25.4.1: Conduct a 5-day expert meeting of 20 participants and 10 IPs to review national PMDT guidelines and training manual	NTBLCP	3	1		1				NTBLCP
Sub-activity 12.25.4.2: Print and distribute 1800 copies of PMDT guideline	NTBLCP	3	1		1		1		
Sub-activity 12.25.4.3: Conduct a 2 day meeting of 10 participants and to review the PMDT expansion plan	NTBLCP	2	1		1		1		

Sub-activity 12.25.4.4 Print and distribute 1000 copies of PMDT scale-up plan	NTBLCP	2	1		1				
Sub-activity 12.25.4.5: Procurement of Novel regimen and new drugs (Pretomanid, Clofazimine, Bedaquilline and all other 2nd line regimen drugs oral)									
Strategic Intervention 12.26 Pre-service curriculum updated to include current TB control strategies									
Activity 12.26.1 Engagement of umbrella bodies of healthcare professionals e.g. MDCN and other bodies for the introduction of TB into their training curriculum									
Sub-activity 12.26.1.1									
Sub-activity 12.26.1.2									
Activity 12.26.2: Advocacy to the school of Medicine, Nursing and Health tech for the inclusion of TB in the training curriculum									
Sub-activity 12.26.2.1									
Sub-activity 12.26.2.2									

