Section A: USAID/Nigeria Transforming Health and Resilience For Individuals Through Vibrant Empowerment (THRIVE) Activity Program Description

List of Acronyms

AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
AO	Agreement Officer
AOR	Agreement Officer's Representative
ART	Antiretroviral Therapy
CDC	US Centers For Disease Control and Prevention
CDCS	Country Development Cooperation Strategy
CLHIV	Children living with HIV
COP	Chief of Party
DCOP	Deputy Chief of Party
DO	Development Objective
DoD	Department of Defense
ECD	Early Childhood Development
FMWA	Federal Ministry Of Women Affairs
FP	Family Planning
FSW	Female Sex Worker
GBV	Gender Based Violence
GON	Government of Nigeria
HES	Household Economic Strengthening
HIV	Human Immunodeficiency Syndrome
HIV-TB	HIV and Tuberculosis
HLMC	High Level Management Committee
HPN	Health, Population and Nutrition
ICHSSA	Integrated Child Health and Social Services Award
IP	Implementing Partner
IPT	Intermittent Preventive Treatment
IR	Intermediate Results
KM	Knowledge Management

LACA	Local Action Committee on AIDS
LAMIS	Lafiya Health Management Information System
LGA	Local Government Area
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDAs	Ministries, Departments, and Agencies
MEL	Monitoring, Evaluation and Learning Plan
MER	Monitoring, Evaluation and Reporting
MICS	Multiple Indicator Cluster Survey
NAIIS	National AIDS Indicator and Impact Survey
NEC	National Executive Council
NOA	National Orientation Agency
NOMIS	National OVC Management Information System
NPA	National Priority Agenda 2013-2020 on Vulnerable Children in Nigeria
NPC	National Planning Commission
OVC	Orphans and Vulnerable Children
PEPFAR	US President's Emergency Plan for AIDS Relief
PLHIV	People Living With HIV/AIDS
PMTCT	Prevention of Mother-To-Child Transmission of HIV/AIDS
RFA	Request for Applications
SI	Strategic Information
SRH	Sexual and Reproductive Health
TSC	Technical Steering Committee
UNAIDS	United Nations Program on HIV and AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
VACS	Violence Against Children Survey

Design Assumptions & Parameters

Instrument	Assistance: Cooperative Agreement
Solicitation	NOFO: RFA
Awards	Multiple (3 awards, based on geography)
Timing	5 years: September 2024 – September 2029
Funding	(North West -$20M), North East($15M) (South - $30M)
Annual Targets	OVC_SERV 627,099 OVC_HIV_STAT 333,50 TBD for custom indicators
Geographic Coverage	16 states where USAID provides HIV care and treatment to adults and children living with HIV (**North West** - Kano, Niger, Jigawa,Sokoto, Zamfara, Kebbi **North East** -Borno, Yobe, Bauchi, Adamawa, Taraba, **South** - Lagos, Edo, Akwa Ibom, Cross River and Bayelsa)
Target Population	Children and Adolescents living with HIV (CALHIV) Children whose caregivers are living with HIV (CPLHIV) HIV exposed infants (HEI) Children of Key Populations (CKP) Survivors of Sexual Violence Against Children (SVAC) High risk adolescent boys and girls, including out of school children

1 Introduction

USAID/Nigeria's Transforming Health and Resilience For Individuals Through Vibrant Empowerment (THRIVE) is a five-year cooperative agreement that contributes to achieving sustained epidemic control by improving the health and wellbeing of children living with HIV and reducing the risk of HIV infection among vulnerable children, adolescents, and caregivers. The activity will provide a suite of comprehensive services to build resilience and mitigate the multiple, layered vulnerabilities faced by these sub-populations. The activity will also contribute to closing gaps in Nigeria's pediatric care and treatment cascade, supporting children and adolescents living with HIV (C/ALHIV) and HIV positive caregivers to access continuous treatment, improve their quality of life, remain on HIV treatment and reduce the risk of transmission. THRIVE is USAID/Nigeria's mechanism for implementing PEPFAR funded programs for orphans and vulnerable children (OVC) and its delivery arm for community-focused health and social welfare services. THRIVE will build on previous USAID investments in improving the health, protection, and prospects of vulnerable children, with an emphasis on increasing the agency of caregivers, communities, and local authorities to mobilize resources and practice optimal nurturing care.

2 Background and Country Context

Nigeria is the most populous country in Africa, exceeding 227 million as of 2024, and projected to increase to over 377 million by 2050[1]. The population pyramid reveals a predominantly youthful demographic, with half of all Nigerians under the age of 19[2]. Despite the potential dividend of this population size and distribution, significant public health challenges persist in undermining Nigeria's development aspirations. The country has the second highest number of maternal, neonatal, and child deaths[3], the 6th highest TB burden[4], and an overall HIV prevalence of 1.4% that is notably higher among females aged 15 to 65 years (1.9%), compared to males (1.0%)[5]. Although over 80% of the estimated 1.9 million people living with HIV (PLHIV) are on antiretroviral therapy (ART), large numbers of new infections continue to be identified[6], while the pediatric cascade lags overall progress in epidemic control, with estimates of treatment coverage among children younger than 15 years as low as 41.2%[7].

[1] https://www.statista.com/statistics/1122955/forecast-population-in-nigeria/
[2] Ibid.
[3] https://von.gov.ng/who-nigeria-ranks-2nd-in-worldwide-maternal-deaths/
[4] https://www.afro.who.int/news/gearing-towards-tb-free-nigeria-who-and-partners-scale-action
[5] Nigeria HIV/AIDS Indicator and Impact Survey, 2019
[6] PEPFAR/Nigeria Country Operational Plan, 2023
[7] Ibid.

Moreover, epidemic control is threatened by the multiple, layered risks affecting vulnerable children and caregivers. An estimated 88.4 million (40%) Nigerians live in extreme poverty[8], with restricted access to healthcare and approximately 73.4% of Nigerian households experience food insecurity within a given 12-month period[9]. By not attending school, 29% of children do not benefit from education's protective effect[10]. Data also suggests that Nigeria is not safe for children, with 70% likely to experience some form of repeated physical, sexual, and/or emotional violence before they turn 18, primarily from perpetrators who are known to them and in places they should feel safe, such as home or school[11]. Further compounding these myriad of threats is a growing body of evidence that children who are HIV exposed, but uninfected, experience significantly higher rates of morbidity and mortality when compared with children unexposed to HIV[12].

USAID/Nigeria's THRIVE Activity is expected to respond to these realities to optimally contribute to HIV epidemic control. These realities, their implications for program design, and the overarching principles governing program design, are discussed in the sections that follow.

3 Principles Governing Program Design

Prevention by mitigating vulnerability. Children and caregivers are subject to multiple, layered vulnerabilities that substantially increase the risk of HIV infection, threatening progress towards sustained epidemic control. These vulnerabilities, including poverty, exposure to violence, and restricted access to health, education, and social welfare services, will be mitigated by the THRIVE Activity.

Efficient use of limited resources. Resources for programming are limited and the THRIVE activity will operate within that constraint, offering a feasible package of comprehensive services, within high burden areas, to a realistic target number of beneficiaries, adopting proven interventions and prioritizing highest-risk subpopulations.

Commitment to shared epidemic control priorities. THRIVE is one element in the overall strategic response to the HIV epidemic in Nigeria. The activity will optimize its contribution to epidemic control by committing to shared priorities such as closing the gaps in the pediatric care and treatment cascade; reflecting these shared priorities in its results framework; collaborating closely with HIV care and treatment partners; and building relevant capacity in program partners and the social workforce.

[8] 2019 Poverty and Inequality in Nigeria, National Bureau of Statistics, May 2020
[9] UNICEF Multiple Indicator Cluster Survey, 2021
[10] Nigeria Multidimensional Poverty Index 2022, National Bureau of Statistics
[11] Violence Against Children in Nigeria Survey 2014, UNICEF
[12] https://link.springer.com/content/pdf/10.1007/s13312-019-1568-5.pdf

Retaining the OVC programming model's integrity. THRIVE perpetuates those elements of the OVC programming model with proven efficacy, offering services that address vulnerabilities across the four OVC programming domains (Healthy, Stable, Safe, Schooled). Through a case management approach, THRIVE will address household and individual needs with the goal of graduating them from the need for program support.

Implementing for sustainability. THRIVE integrates those features that best strengthen prospects for sustained services and outcomes post-program exit, including interventions that reform harmful norms and practices; strengthen systems through which services to vulnerable children; develop the capacity and empower local partners, including caregivers, community service organizations, the social workforce, community leadership and structures, and local and state government; and prepare local actors for mobilizing resources external to the THRIVE activity.

4 Realities Informing Program Design

4.1 Epidemiological Context and Child Health

Nigeria has an overall HIV prevalence of 1.4%, exacerbated by the 6th highest TB burden globally, and an estimated TB/HIV co-infection rate of 25.8%[13]. HIV prevalence is notably higher among females aged 15 to 65 years (1.9%), compared to males (1.0%)[14]. The disparity is greatest among young adults, with prevalence for females aged 20 to 24 at 1.3%, over three times the prevalence for young men of the same age at 0.4%. Although over 80 % of the 1.9 million people living with HIV (PLHIV) are on antiretroviral therapy (ART), large numbers of new infections continue to be identified[15]. The pediatric treatment cascade lags behind the overall progress towards epidemic control, with estimates of treatment coverage for children under 15 years as low as 41.2%[16], Approximately 15% of all HIV related child deaths globally occur in Nigeria[17].

HIV prevalence among key populations (KP) is also substantially higher than in the general population, potentially as high as 14.4% for female sex workers (FSW) and 22.9% among men who have sex with men (MSM)[18]. KPs and people living with disabilities (PLWD) are stigmatized

[13] 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.

[14] Nigeria HIV/AIDS Indicator and Impact Survey, 2019

[15] PEPFAR/Nigeria Country Operational Plan, 2023

[16] Ibid.

[17] https://www.who.int/data/gho/data/indicators/indicator-details/GHO/number-of-deaths-due-to-hiv-aids

[18] Federal Government of Nigeria. HIV/STI Integrated Biological and Behavioral Surveillance Survey (IBBSS) Among Key Populations in Nigeria. 2020.

and the discrimination they experience at facilities discourages health seeking behavior. In northern Nigeria, KPs avoid mainstream health services for fear of sanction under Sharia law. Instead, KPs and PLWDs tend to seek alternative care from traditional healers or to resort to self-medication[19].

Women's higher risk of infection is attributed in part to cultural norms and patterns of power that curtail their ability to negotiate terms of sexual relations with men[20]. Culturally and religiously determined attitudes also impact on health seeking behavior and outcomes, with younger women expressing reluctance to access care at public health facilities due to the discriminatory treatment they reportedly suffer, especially as unmarried women seeking SRH services[21]. Caregivers' negative views on sexuality education and reluctance to discuss these matters with children echo these restrictive norms, dissuading adolescents from SRH service access[22]. Consequently, adolescent fertility rates remain high (102 births per 1,000 women ages 15 to 19) and are increasing among 10- to 14-year-olds[23].

Figure 1: ART Coverage by Age at SNU Level 1 (FY24 Q1)

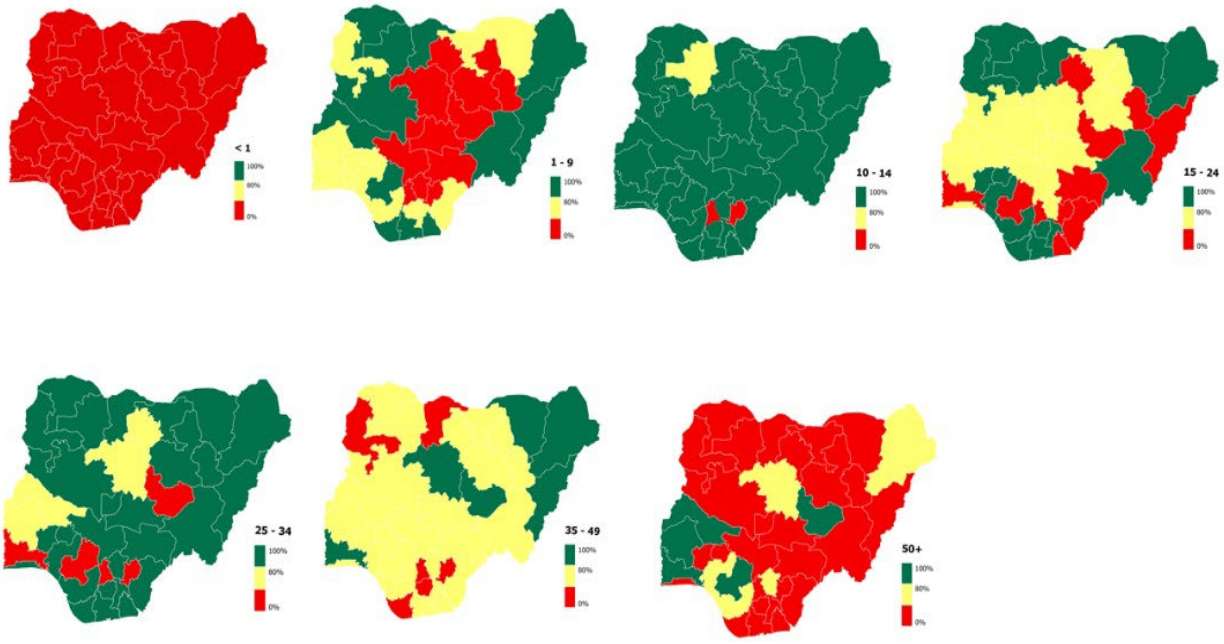
[19] USAID/Nigeria Health Sector and Inclusive Development Gender Analysis, 2023

[20] USAID/Nigeria Health Sector and Inclusive Development Gender Analysis, 2023

[21] Oduenyi, C., Banerjee, J., Adetiloye, O. *et al.* Gender discrimination as a barrier to high-quality maternal and newborn health care in Nigeria: findings from a cross-sectional quality of care assessment. *BMC Health Services Research* **21**, 198 (2021).

[22] Ezenwaka, U., Mbachu, C., Ezumah, N. *et al.* Exploring factors constraining utilization of contraceptive services among adolescents in Southeast Nigeria: an application of the socio-ecological model. *BMC Public Health* **20**, 1162 (2020)

[23] World Bank. (2022). Nigeria Development Update: June 2022 – The Continuing Urgency of Business Unusual. Washington, D.C.: World Bank



Culturally determined male dominance is such that an estimated one in ten women only are solely in control of their healthcare[24], which may be a factor in Nigeria's 40 million women of child-bearing age (15 to 49 years) suffering disproportionately negative outcomes when it comes to ante-natal and birth related health. Despite representing only 2.4% of the world's population, Nigeria currently contributes 10% of global deaths for pregnant mothers, with a maternal mortality rate of 576 per 100,000 live births, the fourth highest globally[25]. Each year approximately 262,000 babies die at birth, the world's second highest national total. Infant mortality currently stands at 69 per 1,000 live births while for under-fives it rises to 128 per 1,000 live births[26]. Up to 64% of under-five deaths are the result of preventable or treatable conditions[27], such as malaria, pneumonia, or diarrhea, suggesting that caregivers are subject to barriers hindering health-seeking behavior on behalf of the children in their care.

With high poverty and poor national health insurance coverage, cost persists as a standout barrier to care. The impact of cost is amplified for Nigerian women, whose economic participation is predominantly in informal sectors, interrupted by culturally prescribed domestic duties, and mediated by male household members who control resources and dominate

[24] WHO Nigeria Country Office Annual Report, 2019
[25] https://www.unicef.org/nigeria/situation-women-and-children-nigeria
[26] Ibid.
[27] Ibid.

decision-making[28].While the Government of Nigeria (GON) has committed to improving access to primary health care nationwide across a network of at least one PHC facility in each of the country's 10,000 administrative wards, coverage remains inconsistent and bottlenecks are severe[29]. Poor water, sanitation and hygiene services are also a factor. In 2018, a state of emergency was declared in the WASH sector due to 60 million Nigerians lacking access to potable water and 80 million lacking sanitation facilities of acceptable standard[30].

Approximately 33% of Nigerian children younger than 5 years are affected by stunting and a further 12% by wasting, both slightly higher than the average in sub-Saharan Africa[31]. Only 33% of infants aged 0 to 5 months are exclusively breastfed and only 41% of children aged 6 to 23 months are fed the minimum acceptable diet, despite multiple programs directed at improving the infant and young child feeding practices (IYCFP)[32].

4.2 Poverty and Child Vulnerability

An estimated 40% or 88.4 million Nigerians are living in extreme poverty, of which approximately 44.7 million are men and 43.7 million are women[33]. However, when factors in addition to consumption capacity[34] are considered[35], an estimated 63% of Nigerians are multidimensionally poor[36]. Critically, the Multidimensional Poverty Index (MPI) data demonstrates that poverty risk increases with the vulnerabilities afflicting specific sub-populations, such as children, people living with disabilities (PLWDs), and children forced into marriage.

Well over two-thirds of children aged 0 to 17 are poor (67.5%), and 83.5% (22.9 million) of children under 5, compared to 58.7% of adults. In fact, the proportion of children under 5 living in multidimensional poverty is above 50% in all states, and greater than 95% in Bayelsa, Sokoto, Gombe and Kebbi. Over half of children under 5 lack intellectual stimulation pivotal to early childhood development. Seventy one percent of people living in households with at least one PLWD are poor, compared to the 63% MPI baseline for Nigeria. Distressingly, while 6 in 10 girls

[28] Ibid.
[29] Ibid.
[30] https://www.worldbank.org/en/news/feature/2021/05/26/nigeria-ensuring-water-sanitation-and-hygiene-for-all
[31] https://globalnutritionreport.org/resources/nutrition-profiles/africa/western-africa/nigeria/
[32] Ibid.
[33] 2019 Poverty and Inequality in Nigeria, National Bureau of Statistics, May 2020
[34] Consumption capacity is the conventional methodology for measuring poverty (consult previous reference)
[35] The Nigerian Multidimensional Poverty Index measures poverty in 5 dimensions i.e., health, education, living standards, work and shocks, and additional indicators for children under 5. The MPI provides data to report on key SDG indicators.
[36] Nigeria Multidimensional Poverty Index 2022, National Bureau of Statistics

aged 12 to 17 are poor, approximately 8 in 10 girls in child marriages are poor, and the differences in deprivations are very high[37]. The quality of participation in the economy improves with level of education, an outcome that is demonstrably gender dependent. The gender gap in schooling widens significantly from age 17 as girls, especially those from poor families and those in the north, begin to marry, have children, and exit education. The negative impact of early departure persists throughout their working lives[38].

Poverty has a direct impact on food security and children's nutritional status, which has been worsening over the last decade and a half. Between 2011 and 2022, the proportion of Nigerians regularly experiencing hunger rose from 11% to 21.3%[39], while it is projected that approximately 26.5 million Nigerians will be food insecure in 2024[40]. An even larger proportion of Nigerians are exposed to hunger intermittently, with up to 73.4% of households experiencing food insecurity within a given 12-month period[41]

4.3 Child Protection, Safety, and Vulnerability

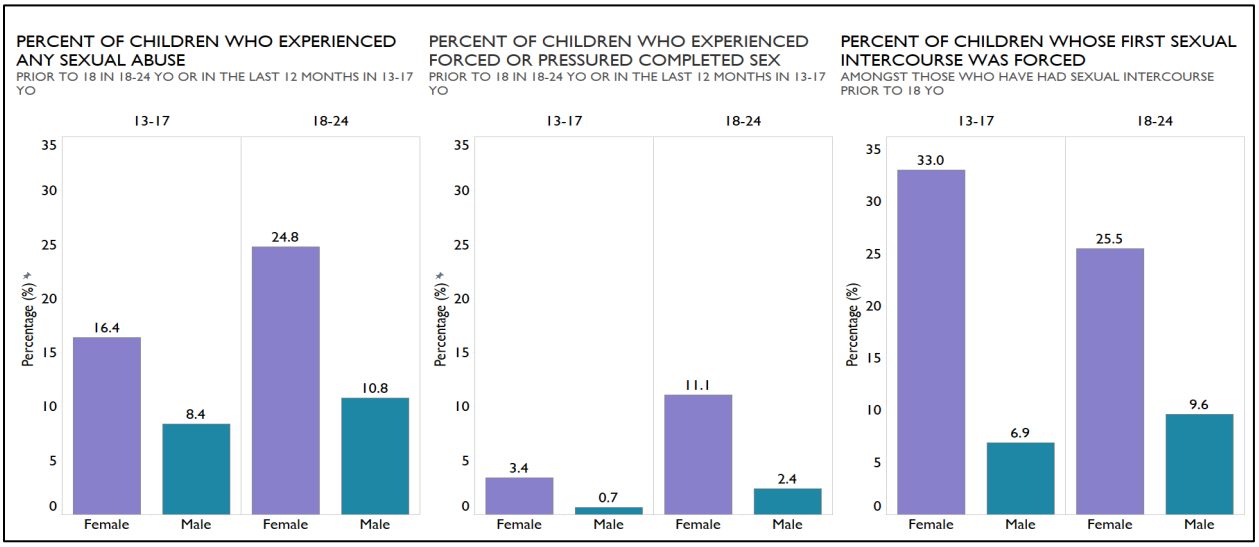
Civil registration is often an administrative prerequisite for children to access the services they are entitled to. With as much as 62% of births going unregistered in some jurisdictions[42], it is reasonable to assume that significant numbers of children are not accessing services, and that available data on child health and child protection likely underestimate the true scale of issues material to child welfare. A 2016 national campaign linked to healthcare provision resulted in the registration of about seven million children, however accelerating population growth stifles progress in this regard.

Data suggests that Nigerian children are experiencing significant child protection issues, but especially female children. Approximately 70% of all children are likely to experience some form of repeated physical, sexual, and/or emotional violence before they turn 18[43], while almost one in three (31%) women aged 15 to 49 have experienced physical violence. Both boys and girls are victims of sexual abuse, although gender disparities are striking. Nearly a quarter of women aged 18 to 24 reports having experienced some form of sexual abuse prior to turning 18; and of those who had their sexual debut before 18, 33% of girls (aged 13 to 17) and 25.5% of women claim the experience was forced[44]. Half of all girl children experiencing sexual violence were

[37] Ibid.
[38] World Bank. 2015. More, and more productive, jobs for Nigeria: a profile of work and workers. World Bank Group.
[39] WHO State of Food Security and Nutrition reports, 2011 to 2023
[40] Cadre Harmonisé analysis on food insecurity, 2023
[41] UNICEF Multiple Indicator Cluster Survey, 2021
[42] https://www.unicef.org/nigeria/reports/birth-registration-nigeria
[43] Violence Against Children in Nigeria Survey 2014, UNICEF
[44] Nigeria District Health Survey 2018

victims at home and a further 1 in 6 girls experiencing sexual violence were violated at school[45]. The preponderance of data repeatedly confirms that not only are victims of gender based violence at higher risk of HIV infection but that HIV positive women are also at higher risk of GBV[46].

Figure 2: Rates of Child Exposure to Sexual Violence by Sex



Source: Violence Against Children Survey, 2014

Rather than protect women, several legislative provisions enable violence against them. Section 16 of the Matrimonial Causes Act requires that, for abuse to be grounds for divorce, it must meet the legal criteria for attempted murder or assault with intent to cause grievous bodily harm. The perpetrator must also be criminally convicted of the alleged abuse[47]. This bias against women is repeated in sections 353 and 360 of the criminal code, which provides for more severe penalties for perpetrators of sexual assault against male victims than for perpetrators against female victims[48]. Regardless of the victim's gender however, less than 1% of sexual assault perpetrators are brought to trial and almost none are convicted[49].

Compared to their male peers, Nigerian girls are at constant, amplified risk of institutionalized exploitation and violence and the constriction of their life prospects that such vulnerability implies. Only 3% of boys are married by the age of 18, but 43% of girls are married before the age of 18 and 16% are married before their 15th birthday[50]. Only 26 states have adopted the

[45] 16 Facts About Violence Against Women and Girls in Nigeria, Spotlight Initiative, 2022
[46] https://aids2020.unaids.org/chapter/chapter-4-securing-rights/gender-based-violence/
[47] Ibid.
[48] Ibid.
[49] Ibid.
[50] Girls Not Brides Learning Resources on Child Marriage Atlas: Nigeria

Child Rights Act and with provisions against child marriage yet to be incorporated into state laws, loopholes permitting child marriage persist[51]. Moreover, section 18 of the Marriage Act enables child marriage, requiring parental consent from the father for the marriage of a minor but not from mother. Should a mother object to a child marriage, she cannot resort to the Marriage Act to prevent it[52].

With an estimated 19.9 million survivors, Nigeria accounts for the third highest number of women who have undergone female genital mutilation (FGM) worldwide[53]. Disturbingly, FGM is on the rise among girls aged 0 to 14 years, from 16.9% in 2013 to 19.2% in 2018[54].

4.4 Education and Child Vulnerability

Although education management information systems (EMIS) are robust in most sub-Saharan countries, Nigeria struggles to consistently collect and collate credible, valid, reliable, and usable education data[55]. Data submitted by states to development partners differ from that used in the states and from that supplied by states to Nigeria's EMIS, suggesting that data is adjusted to fit the purpose for which it is required[56]. Nevertheless, several approximately accurate sources of education data reveal some concerning realities.

Only 35.6% of children aged 36 to 59 months receive early childhood education[57], which has implications for the ability of the majority of Nigeria's children to benefit from primary education. In 2018 only 61% of children aged 6 to 11 years regularly attended primary school, despite it being compulsory. Although tuition fees were waived with the introduction of Universal Basic Education, costs such as transport, uniforms, textbooks, learning materials, and examination fees remain prohibitive for vulnerable households[58]. If these costs cannot be met a child's education might be interrupted and data shows that if they miss school, even for a short period, there is only about a 25% likelihood that the child will ever return.

While there were no significant gender disparities in primary education participation rates, the difference between urban and rural attendance is significant (71% urban, 51% rural)[59].

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[51] World Bank. (2022). Nigeria Development Update: June 2022 – The Continuing Urgency of Business Unusual. Washington, D.C.: World Bank.

[52] https://thebrainbuilders.org/wp-content/uploads/2022/10/COMPENDIUM-OF-DISCRIMINATORY-LAWS-AND-PRACTICES-AGAINST-WOMEN-IN-NIGERIA.pdf

[53] https://www.unicef.org/nigeria/press-releases/unicef-warns-fgm-rise-among-young-nigerian-girls

[54] Ibid

[55] Reviewed National Policy on EMIS and Implementation Guidelines, 2021

[56] Ibid.

[57] https://www.unicef.org/nigeria/education

[58] USAID/Nigeria Stakeholder Engagement Report, 2024

[59] Ibid.

Significant gender disparities are evident in secondary school attendance however, with an attendance rate of 65% for males aged 12 to 17, compared with only 54% for females in the same age range[60]. The urban/rural divide in attendance is echoed at secondary level, with a 20% difference in average attendance between the two[61]. The layering of gender and poverty substantially disadvantages females, with only 9% of Nigeria's poorest girls attending secondary school compared to 81% from the wealthiest quintile[62]. Overall, 29% of school-aged children are not attending school, and 94% of out-of-school children are poor[63].

In addition to poverty, gender parity is dependent on geography, with marked attendance discrepancies in 10 states in the north and dropping in a further 15 states[64]. Conflict substantially affects attendance, with 935 schools in Northeast Nigeria having to close in 2020 because of insurgency attacks[65].

4.5 Government of Nigeria's Response and Priorities

Nigeria features a robust policy landscape that articulates consistent priorities and programmatic responses for vulnerable children, youth, and their families:

The Government of Nigeria (GON), mainly through the Federal Ministry of Women Affairs and Social Development (FMWASD), leads the process of mainstreaming the concerns of gender, child development, the aged, and persons with disabilities into the national development process. The Ministry is the primary custodian of the 2013-2020 National Priority Agenda (NPA) on vulnerable children in Nigeria, which promotes an equity-based approach towards reducing child vulnerability. Equity, which is embedded in the national development framework, is reflected in the NPA through six commitments to children and families, as follows:

- Commitment 1: All poor and vulnerable children have equitable access to and benefit from comprehensive social protection services
- Commitment 2: All vulnerable children have access to HIV/AIDS and other health services, including nutrition support and mental health services.
- Commitment 3: All children are safe from abuse, violence, exploitation and neglect

[60] https://www.statista.com/statistics/1124489/secondary-school-attendance-ratio-in-nigeria-by-area-and-gender/

[61] Ibid.

[62] World Bank. (2022). Nigeria Development Update: June 2022 – The Continuing Urgency of Business Unusual. Washington, D.C.: World Bank.

[63] Nigeria Multidimensional Poverty Index 2022, National Bureau of Statistics

[64] National Bureau of Statistics & UNICEF. (2017). Multiple Indicator Cluster Survey 2016-17, Survey Findings Report. Abuja: NBS & UNICEF

[65] https://www.brookings.edu/articles/education-in-emergency-in-nigeria-creating-gender-equitable-policies-so-all-girls-have-an-uninterrupted-right-to-learn/

- Commitment 4: Vulnerable children have equitable access to and benefit from quality basic education, including early childhood development (ECD), primary and junior secondary
- Commitment 5: Vulnerable children have access to social protection services in order to improve their quality of life
- Commitment 6: All children have a legal identity

Operationally, the NPA provides the framework for engaging public and private sector players to increase funding for OVC programs and to build local capacity in the budgetary planning and advocacy process at the federal and state levels to direct more funding towards social welfare services. The NPA also provides for building a comprehensive response for vulnerable children through strengthening, linking, and integrating systems of service delivery across all relevant sectors for children. Technical coordination of the NPA for vulnerable children is assigned to a Technical Steering Committee (TSC) and the newly established High Level Management Committee (HLMC), both of which are housed in the Child Development Division of the FMWASD (the secretariat) and co-led with the National Planning Commission (NPC). Relevant ministries, departments, and agencies (MDAs) are represented within the committees. These committees are accountable to the National Executive Council (NEC) through the NPC.

Once promulgated, the National Social Protection Policy Framework will feature prominently as a key policy affecting the well-being of children in the country. In addition to government pensions, the administration of the proposed National Insurance Fund, the Subsidy Reinvestment Program, and all other instruments of social safety, will be framed by this policy document.

4.6 United States Government's Response and Priorities

USAID, the US Department of Defense (DOD) and the US Centers for Disease Control and Prevention (CDC) work closely together to implement a coordinated portfolio of technical assistance and service-delivery interventions for OVC. This includes an overall strategy and priority interventions for OVC, with distinct geographical areas assigned to each agency and USAID funded technical assistance partners that work on cross-cutting OVC systems for all three agencies.

USAID's Country Development and Cooperation Strategy lays out key assistance priorities for the period while several global initiatives also shape USAID priorities and investments in Nigeria. The goal of USAID's 2020-2025 CDCS is to support a healthier, more educated, prosperous, stable, and resilient Nigeria. USAID/Nigeria will make progress towards this goal through three Development Objectives (DO) and one Special Objective (SpO) that prioritize the core approaches needed to advance Nigeria's self-reliance. These objectives are: 1) broadened

and inclusive economic growth; 2) a healthier, better educated population; 3) accountable, inclusive, and responsive governance strengthened; and 4) greater stability and early recovery advanced in targeted states. Each of these Objectives incorporates four cross-cutting strategic priorities - good governance, conflict sensitivity and mitigation, resilience, and inclusion - that serve as foundational principles for making lasting progress toward self-reliance. THRIVE contributes to DO 2 but also includes activities that support DO1. THRIVE also works to achieve USAIDs Special Objectives in conflict affected areas.

5 Activity Description

5.1 Activity Goal

To improve the health and wellbeing of children living with HIV and reduce HIV related risk among uninfected children, adolescents, and young people by providing a suite of social welfare and related services that mitigate the multiple, layered vulnerabilities they are subject to, and in so doing contribute to sustained HIV epidemic control and resilience.

5.2 Geographic Focus and Saturation

Activities under this RFA will be implemented in three clusters:

North West - Kano, Niger, Jigawa, Sokoto, Zamfara, and Kebbi

North East- Borno, Yobe, Bauchi, Adamawa, Taraba

South - Lagos, Edo, Akwa Ibom, Cross River, and Bayelsa

5.3 Population Focus

THRIVE will target the most vulnerable children and youth for service provision, prioritizing:

- Children and Adolescents living with HIV (C/ALHIV);
- Children whose caregivers are living with HIV (CPLHIV);
- HIV exposed infants (HEI);
- Children of key populations prioritized in Nigeria's PEPFAR Country Operational Plan;
- Survivors of Sexual Violence Against Children (SVAC);
- High risk Adolescent boys and girls, including out of school children, and adolescent mothers.

Priority should be given to C/ALHIV populations at enhanced risk such as: children with advanced HIV disease (AHD), children with poor viral suppression, a history of interrupted treatment or having been returned to care, children newly initiating treatment, infants of mothers at risk of interrupting treatment in the PMTCT cascade or missing EID (especially

adolescent mothers during and after pregnancy), adolescents transitioning to adult treatment, and biological children of adult index clients.

5.4 Anticipated Targets

Targets are assigned per required PEPFAR Monitoring, Reporting, and Evaluation (MER) OVC indicators (OVC_SERV and OVC_HIVSTAT), as presented below, and specified by State in Table 1. Additional targets may be determined for select custom indicators specified in Table 2 in the Appendix.

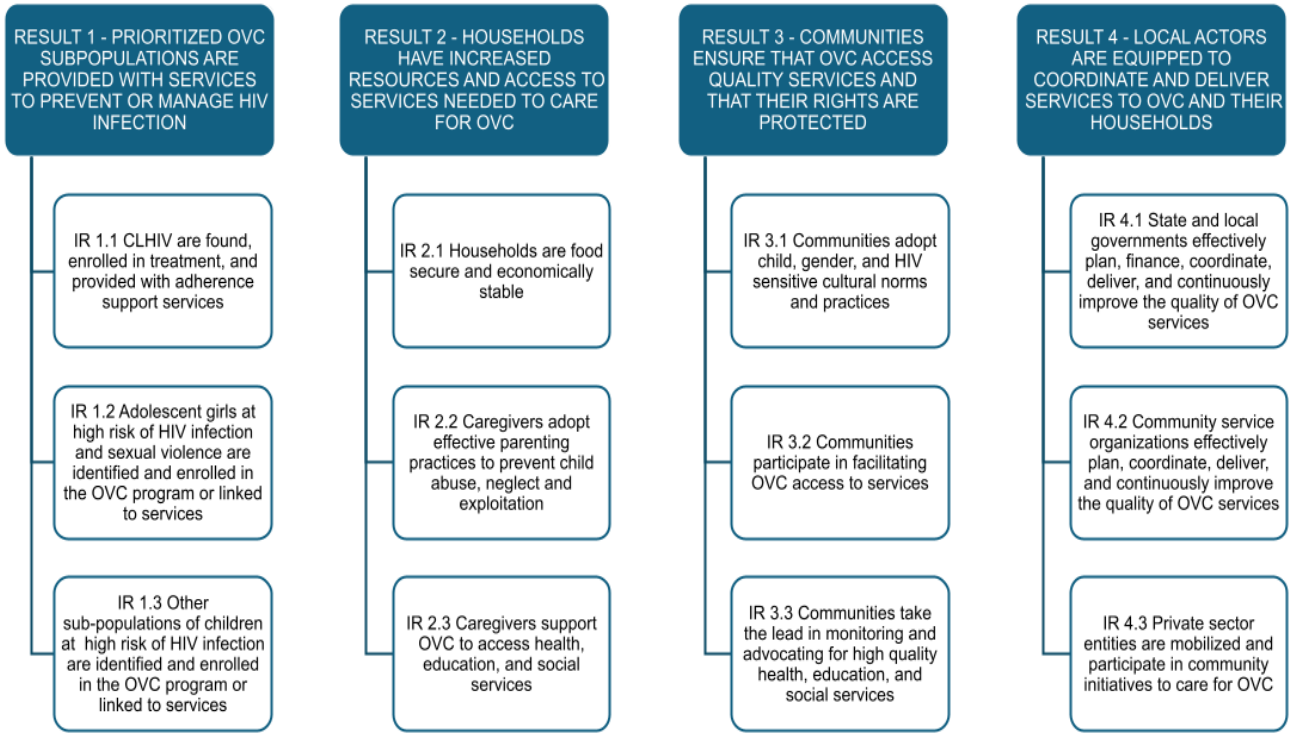
OVC_SERV	**Number of beneficiaries served by PEPFAR OVC programs for children and families affected by HIV**
OVC_HIVSTAT	**Percentage of orphans and vulnerable children (<18 years old) enrolled in the OVC Comprehensive program with HIV status reported to implementing partner**

Table 1: Targets for MER OVC Indicators per State

REGION	STATE	OVC_SERV	OVC_HIVSTAT
THRIVE NORTH-EAST	Adamawa	32,452	19,376
	Bauchi	32,263	20,227
	Borno	27,179	12,495
	Taraba	11,517	5,791
	Yobe	12,732	7,153
	Total	**116,143**	**65,042**
THRIVE NORTH-WEST	Jigawa	12,236	6,841
	Kano	123,730	57,560
	Kebbi	10,999	5,767
	Niger	44,136	21,779
	Sokoto	15,286	7,861
	Zamfara	6,934	3,607
	Total	**213,321**	**103,415**
THRIVE SOUTH	Akwa Ibom	151,243	89,937
	Bayelsa	4,923	2,906
	Cross River	56,064	25,210
	Edo	21,228	11,021
	Lagos	64,177	35,972
	Total	**297,635**	**165,046**
AGENCY	**Total**	**627,099**	**333,503**

5.5 Intended Results

Figure 3: The THRIVE Activity Results Framework



5.5.1 RESULT 1 - PRIORITIZED OVC SUBPOPULATIONS ARE PROVIDED WITH SERVICES TO PREVENT OR MANAGE HIV INFECTION

Recognizing that the THRIVE Activity is one element in PEPFAR's overall strategic response to the HIV epidemic in Nigeria, activities under this result will address shared epidemic control priorities, contributing directly to closing gaps in the pediatric treatment cascade, and focusing the limited OVC program resources on serving the sub-populations at highest risk.

IR 1.1 CLHIV are found, enrolled in treatment, and provided with adherence support services.

Activities under this intermediate result will strengthen the program's capacity to (i) support case finding in the pediatric and adolescent populations, and (ii) find and enroll all CLHIV in the geographies where the program is being implemented. These efforts will contribute directly to ramping up diagnosis, enrollment in and adherence to ART, of CLHIV and HIV positive caregivers, closing gaps in the pediatric treatment cascade, and reducing the risk of HIV transmission. Achieving this result will require close coordination with care and treatment partners and the health facilities they support, joint planning of case finding efforts, and the appropriate capacity development and equipping of the OVC program's social workforce.

<u>Illustrative activities:</u>

- Setup enrolment committees at local level that include care & treatment IPs, health facilities, and local CSOs to coordinate enrolment of households with C/ALHIV.
- Deploy linkage facilitators to health facilities to support continuous enrolment of C/ALHIV.
- Equip the social workforce with SOPs, tools, and training to screen, identify, and enroll households with C/ALHIV.
- Setup adherence support groups for C/ALHIV and equip the social workforce to facilitate these groups.
- Setup parenting groups to mentor and support caregivers of C/ALHIV.

IR 1.2 Adolescent girls at high risk of HIV infection and sexual violence are identified and enrolled in the OVC program or linked to services.

Activities under this intermediate result will strengthen the program's capacity to find and enroll AGYW who are at highest risk of sexual violence, exploitative sexual relations, and HIV infection, including girl survivors of sexual violence and adolescent mothers. These efforts will maximize THRIVE's prevention contribution by ensuring that its comprehensive services are provided to the sub-population most in need of its protective effects. After C/ALHIV, at risk AGYW represent the priority sub-population for enrolment and should constitute a substantial proportion of program clients, as dictated by enrolment targets. Achieving this result will require soliciting meaningful participation from community leadership; methodologies for effectively distinguishing the most vulnerable AGYW from a universe of girls that will all meet at least some of the eligibility criteria for enrolment; and developing the capacity and equipping the OVC program's social workforce to support targeted identification and enrolment.

<u>Illustrative activities:</u>

- Setup enrolment committees at local level that include community leadership and local CSOs to coordinate enrolment of households with highest at risk AGYW.
- Develop an effective strategy and tools for identifying and enrolling AGYW at highest risk.
- Equip the social workforce with SOPs, tools, and training to screen, identify, and enroll AGYW at highest risk.
- Setup procedures for identifying and immediately linking AGYW who are victims of abuse to violence response and counseling services.

IR 1.3 Other sub-populations of children at high risk of HIV infection are identified and enrolled in the OVC program or linked to services.

Activities under this intermediate result will strengthen the program's capacity to find and enroll children at highest risk of HIV infection in addition to AGYW, including children of HIV positive caregivers or caregivers in key populations such as female sex workers (FSW) and men

who have sex with men (MSM), boy survivors of sexual violence, HIV exposed infants (HEI), and children living with a disability or in households with people liviing with a disability (PLWD). These efforts will maximize the THRIVE Activity's prevention contribution by ensuring that its comprehensive services are provided to sub-populations of children most in need of its protective effects. After CLHIV and at risk AGYW, these children represent the priority sub-population for enrolment and should constitute the remaining proportion of program clients, as dictated by enrolment targets. Achieving this result will require soliciting meaningful participation from community leadership; methodologies for effectively distinguishing the most vulnerable from a universe of children that will all meet at least some of the eligibility criteria for enrolment; and developing the capacity and equipping the OVC program's social workforce to support targeted mass identification and enrolment.

Illustrative activities:

- Setup enrolment committees at local level that include community leadership and local CSOs to coordinate enrolment of households with highest at-risk children.
- Develop an effective strategy and tools for identifying and enrolling children at highest risk.
- Equip the social workforce with SOPs, tools, and training to screen, identify, and enroll children at highest risk.
- Setup procedures for identifying and immediately linking survivors of abuse to violence response and counseling services.

5.5.2 RESULT 2 - HOUSEHOLDS HAVE INCREASED RESOURCES AND ACCESS TO SERVICES NEEDED TO CARE FOR OVC

Acknowledging their role at the forefront of nurturing care, the THRIVE Activity will empower caregivers to meet children's basic needs and ensure that they access available services according to their rights and requirements. Activities under this result will mitigate their constrained economic means, limited knowledge, and harmful attitudes, norms, and practices that hinder optimal parenting and that compromise the welfare of the child.

IR 2.1 Households are food secure and economically stable.

Activities under this intermediate result will offer an integrated strategy that enables caregivers to meet the nutritional needs of their households, mitigate economic shocks, smooth household consumption, and meet the costs of accessing basic services and care. In addition to identifying and linking those requiring emergency nutritional support to required care, case plans will prescribe household participation in activities that support nutritional self-sufficiency, such as interventions that provide training and inputs to cultivate household, school, and community kitchen gardens and feeding programs. On a foundation of minimal food security, THRIVE will systematically strengthen household economic capacity by training, mentoring, and

supporting caregivers and eligible youth to form savings groups, manage funds, and achieve financial goals. As their financial literacy matures, groups will be assisted to increase their economic participation through viable income generating activities, exploiting opportunities offered through other USAID funded programs where these are available. Besides implementing its own repertoire of evidence-based food security and economic strengthening interventions, THRIVE will continuously link eligible households and individual clients to existing nutrition and consumption support services and ensure that the financial literacy it offers encourages prioritizing and providing for the costs of accessing OVC services and care.

Illustrative activities:

- Implement household, school, and community kitchen garden activities.
- Map available government, development partner, and other donor food security, livelihoods, and household economic strengthening programs, and integrate these into referral networks.
- Implement social behavior change communication (SBCC) to increase production, consumption of, and income from safe and nutritious foods, including appropriate intra-household food distribution.
- Adopt and implement evidence-based savings group methodology for caregivers and youth.
- Implement viable income generating activities based on market assessment.
- Implement comprehensive, evidence-based youth livelihoods intervention.

IR 2.2 Caregivers adopt effective parenting practices.

Activities under this intermediate result will equip caregivers with the knowledge and skills to effectively manage the relationships within their households, to best support the development of very young children in their care, and to guide older children to make choices that better secure their current and future welfare. Interventions will be sensitive to water, sanitation, and hygiene (WASH) concerns; infant and young child feeding (IYCF) practices; the specific knowledge and skills caregivers of C/ALHIV and children living with disabilities require; and the particular circumstances of caregivers in key populations, such as female sex workers. The content of parenting programs will be reinforced by community-wide social and behavior change communication programs that challenge harmful perspectives on gender and child discipline in favor of practices that respect children's rights and prioritize their welfare (IR 3.1).

Illustrative activities:

- Adopt and implement an evidence-based, PEPFAR approved parenting program, such as Parenting for Lifelong Health, Family Matters Program .

- Adopt and/or design and implement activity that improves early childhood development practices in the home.
- Deliver gender norms sessions to address harmful gender norms and cultural practices.

IR 2.3 Caregivers support OVC to access health, education, and social services.

Activities under this intermediate result will improve responsive caregiving, by encouraging caregivers to value services that promote the rights, meet the needs, and improve the prospects of children in their care; equipping caregivers with the knowledge they require to access services children are entitled to; and supporting caregivers to overcome the barriers hindering their efforts to access services on behalf of their children. Reinforced by community-wide social and behavior change campaigns (IR 3.1) and parenting programs (IR 2.2) that reframe harmful cultural and religious norms and practices, THRIVE's community workforce will continuously screen households to identify needs across all OVC program domains, raise awareness of available services with caregivers, and link clients appropriately. To strengthen responsive care, health screening and referral will be sensitive to CALHIV specific needs and comprehensive, integrating ante- and post-natal care, nutrition, immunization, and sanitation, as well as emerging priorities such as child and caregiver mental health. THRIVE will also implement interventions that address and resolve administrative and cost barriers confronting caregivers, facilitating birth registration and setting up mechanisms for initially covering health and education fees that household economic strengthening interventions (IR 2.1) will ultimately empower caregivers with the means to meet. In addition to securing access, education interventions will support consistent attendance at, progression through, and completion of schooling, as well as reintroduce out of school youth to education opportunities. THRIVE's community workforce will also be trained and equipped to identify children in need of protection, to initiate the appropriate, comprehensive response, and facilitate child protection services through the referral pathway to completion. Activities under this intermediate result will be complemented by interventions to address and resolve poor service quality that at times dissuades caregivers from seeking care for children, including interventions that improve the safety of service locations, the receptiveness of service personnel (IR 4.1 and 4.2), and the accountability of providers to the communities they serve (IR 3.3).

<u>Illustrative activities:</u>

- Train and equip the community workforce to deliver behavior change messaging in households that strengthens responsive caregiving.
- Train and equip the community workforce to screen for priority health needs and facilitate completed referrals.
- Train and equip the community workforce to screen for child protection needs and facilitate a comprehensive response.

- Implement a comprehensive education intervention that facilitates parental involvement and supports children to access, consistently attend, and complete school.
- Implement education support services for out-of-school youth.

5.5.3 RESULT 3 - COMMUNITIES ENSURE THAT OVC ACCESS QUALITY SERVICES AND THAT THEIR RIGHTS ARE PROTECTED

Progress towards epidemic control and child wellbeing is constrained or enabled by the norms, attitudes, and behaviors sanctioned by communities. To ensure that the social environment becomes conducive to the welfare of children and other vulnerable sub-populations, and that this transformation is sustained after program exit, activities under this result will empower community members, structures, and institutions to lead de-stigmatization, child protection, violence prevention, and violence response efforts; encourage and facilitate access to services; and ensure that the demand for quality, accountable services and increases over time.

IR 3.1 Communities adopt child, gender, and HIV sensitive cultural norms and practices.

Under this intermediate result, THRIVE will collaborate with community leadership and structures to implement social behavior change communication campaigns that target and transform attitudes, norms, and practices harmful to the wellbeing of children and other vulnerable sub-populations. In addition to inculcating rights-based values in its social workforce and equipping its cadres to model and reinforce norms change, THRIVE will target community authority figures and authoritative institutions with SBC interventions that complement its work with caregivers (IR2.2). Acknowledging their significant influence, THRIVE will work with religious leaders, organizations, and institutions, to transform harmful norms and practices. Community leadership, traditional authorities, and community structures with a role in community welfare (such as child protection committees) will receive culturally sensitive rights-based messaging in small group settings; educators will receive rights-based messaging as a component of THRIVE's interventions to improve school safety (IR4.1); and THRIVE will work with care and treatment and prevention partners to address the attitudes and behaviors of providers' that dissuade clients from seeking care in health facilities. Rights-based messaging will be integrated into THRIVE's interventions to improve violence protection and response services, and its comprehensive strategy for combatting child marriage and FGM.

<u>Illustrative activities:</u>

- Design and implement a comprehensive SBC campaign integrating THRIVE's messaging priorities (de-stigmatization of PLHIV, children's rights, eliminating child marriage and FGM).
- Design and implement an evidence-based safe school's intervention.
- Design and implement a culturally sensitive SBCC intervention targeting traditional and religious leadership and structures.

- Work with care and treatment partners to implement SBC at health facilities.
- Develop and implement a comprehensive strategy for combatting child marriage and female genital mutilation.

IR 3.2 Communities participate in facilitating OVC access to services.

Activities under this intermediate result will leverage THRIVE's SBC interventions (IR3.1) by mobilizing communities to participate directly in nurturing care. Existing community structures with a role in community welfare (such as ward development committees) will be revived where necessary, and trained, equipped, and mentored to improve their efficacy. THRIVE will also integrate these structures into the social services referral network at community level. The program will avoid setting up parallel structures. Through a program of consistent community engagement - including community meetings, workshops, and small group sessions - THRIVE will equip community members with the knowledge to identify children in need, notify community structures and/or THRIVE's community workforce, and facilitate referrals to services. The value that community members and structures contribute to nurturing care depends on the effectiveness of the systems THRIVE institutes to facilitate referrals and linkages. In addition to supporting GON by continuously refining case management and referrals tools and procedures (see sections 6.1 and 6.2), THRIVE will operationalize community participation through systems strengthening efforts such as mapping referral pathways, disseminating guidance to direct community action (posters, job aids, standard operating procedures), and strengthening routine engagement between communities, service points, and local authorities.

Illustrative activities:

- Assess and strengthen the effectiveness of referrals and linkages at community level, integrating community participation.
- Implement an intervention to strengthen community structures such as Ward Development Committees, Community Child protection committees and other faith-based, youth and women groups contributing to social welfare.
- Formulate and implement a plan for educating and mobilizing community members to participate in nurturing care.
- Develop and disseminate guidance for community members to link those in need with the services they require.

IR 3.3 Communities take the lead in monitoring and advocating for high quality health, education, and social services.

Activities under this intermediate result will empower communities to drive the continuous improvement of health and social welfare services due to them and the children in their care by rights, and guaranteed by law. THRIVE will establish community monitoring platforms, whereby community representatives are trained and equipped to systematically and routinely assess the quality of services provided at service points and use those findings to engage providers to improve service accessibility, palatability, and quality. In consultation with local authorities, THRIVE will establish community monitoring of education, social welfare, and child protection services, while community monitoring of health services will be developed in collaboration with PEPFAR's care and treatment partners. In addition to developing monitoring tools and training community monitoring teams, THRIVE will institute procedures and facilitate community-provider engagements, as well as develop and disseminate templates for quality improvement agreements and tracking of commitments to support mutual accountability. Community monitoring will be designed and implemented to maximize prospects for sustaining these activities beyond program exit.

Illustrative activities:

- Consult with local authorities and service providers to secure buy-in for community monitoring.
- Consult with communities and CSOs to develop or adapt procedures for mobilizing community monitoring teams.
- Develop or adapt community monitoring tools and training materials.
- Develop or adapt tools and procedures for facilitating community-provider engagements, developing joint quality improvement plans, and tracking quality improvement commitments.

5.5.4 RESULT 4 - LOCAL ACTORS ARE EQUIPPED TO COORDINATE AND DELIVER SERVICES TO OVC AND THEIR HOUSEHOLDS

To ensure that all children in need are reached during the implementation cycle, and continue to be reached after program exit, the OVC program must invest in developing and refining social service systems at local level. Key local actors to be prioritized under this result include Government of Nigeria at National and sub national levels, CBO's/FBOs, Local CSO networks (such as the Association of OVC NGOs in Nigeria, AONN), Networks of people Living with HIV/AIDS ,Youth and women groups, Child protection committees and private sector players.The OVC program also needs to develop the capacity of local partners with the skills to implement systems and deliver services. Finally, the OVC program needs to establish additional resource streams to meet the costs of continued service delivery after OVC program resources are withdrawn.

IR 4.1 State and local governments effectively plan, finance, coordinate, deliver, and continuously improve the quality of OVC services.

Empower local government to effectively implement their mandates and to continue to do so after program exit. Local governments should also be equipped to effectively coordinate their own efforts with those of non-government partners to optimize the delivery of services within their SNU.

IR 4.2 Community service organizations effectively plan, coordinate, deliver, and continuously improve the quality of OVC services.

Empower CSOs to effectively deliver services to OVC and caregivers during the implementation cycle and to continue to do so after OVC program exit. CSOs should also be equipped to manage relationships with local government and other actors and to coordinate the joint delivery of services to optimize impact within the SNU in which they operate. To build sustainability, OVC implementers are encouraged to work with CSO networks that work in the OVC area (such as the Association of OVC NGOS in Nigeria, AONN). The application should describe how the role of AONN and related CSO networks will be maximized and local capacity built using this platform.

IR 4.3 Private sector entities are mobilized and participate in community initiatives to care for OVC.

The private sector should be mobilized to assume a role in community development and to offer additional resources to meet the costs of services, or improve the accessibility and affordability of services, particularly after the exit of the OVC program.

6 Further Considerations for Implementation

Applications will be assessed on the extent to which the interventions proposed respond convincingly and are judged most likely to deliver the results presented in the results framework. Equally material to a successful application, however, is the extent to which it integrates proposed interventions in a coherent, evidence-based program model, sensitive to the implementation context and committed to strengthening prospects for sustained services and outcomes post-program exit. A credible program model will be founded on case management arrangements that efficiently exploit all available resources, both within and external to THRIVE, to deliver outcome directed, comprehensive care; will utilize, strengthen, and/or introduce systems, tools, and procedures that facilitate coordinated actions across role-players; and will institute monitoring, evaluation, research and learning (MERL) arrangements that consistently account for and adapt program implementation to improve performance. All applications are also expected to integrate inclusion priorities and describe provisions for

safeguarding children and immediately responding to child welfare emergencies encountered during routine operations.

6.1 Case Management for Graduation

All households will receive case management services with a view to graduating them out of program support. Case plans are formulated for each household based on an assessment conducted at enrolment, with the intent of achieving PEPFAR's graduation benchmarks for OVC programs, as they apply to the household being served. Benchmark or graduation focused case management allows case managers to differentiate service delivery based on household needs, introducing a framework for efficient deployment of limited program resources, ensuring that defined benefits are realized within a reasonable period, and potentially freeing up slots for subsequent enrollment of new households. Applicants are expected to describe how case management will be refined and implemented to both align with, as well as strengthen the national case management system, support program efficacy, and accommodate innovations being introduced in the new activity.

6.2 Tracking Layered Comprehensive Services

To ensure that the effectiveness of comprehensive services and differentiated case management can be monitored and usefully analyzed, it is critical that recipients provide for the tracking of layered services delivered directly through THRIVE, those facilitated through referrals and linkages, and the aggregation of the data. As service providers contributing to broader child welfare efforts, recipient's are expected to adopt and, where necessary, adapt nationally mandated case management tools and procedures. In addition to reporting into the National OVC Management Information System (NOMIS) in compliance with GON requirements, recipients' management information system (MIS) should warehouse case management data that is identifiably linked to individuals and the households to which they belong. Reports from the MIS should comprehensively present clients' receipt of all layered services, while clearly distinguishing between those delivered within THRIVE and those provided externally. Applicants are expected to explain how their monitoring, evaluation, research, and learning (MERL) arrangements and systems will meet client and household level service tracking requirements, the aggregation of case management data for reporting, and the use of data for continuously improving program effectiveness.

6.3 Strategic Collaboration and Coordination

THRIVE will achieve its intended results by delivering services and by linking clients and households to services delivered by external providers. Consequently, recipients will collaborate with community leadership, community structures, and local authorities mandated

to ensure the welfare of children, strengthening their capacity and strengthening shared systems. Recipients are also expected to work closely with care and treatment and prevention implementing partners to effectively address shared epidemic control priorities. It is anticipated that this collaboration will result in harmonized tools and processes; strengthened systems for case management, referrals, and linkages; improved implementation and enhanced impact.

Additionally, recipients are expected to explore opportunities for collaboration with USAID mechanisms outside of PEPFAR, as well as programs funded by other development partners and donors, that are geographically co-located, to better layer services and enhance outcomes for shared beneficiaries. Applicants should offer feasible proposals to accomplish this, including potential USAID funded mechanisms and external programs with which to collaborate, as well as the structures and procedures they would institute to facilitate collaboration.

6.4 Post Award Performance Management

The performance of the successful applicant will be monitored by USAID/Nigeria, based on service criteria detailed in the signed agreement, including target based performance criteria. Targets and performance criteria are subject to annual review and adjustable according to the emergent priorities of PEPFAR and USAID for Nigeria. Consistent failure to meet performance criteria may result in performance improvement agreements being negotiated.

6.5 Gender and Identity Responsive Programming

Gender and identity responsive programming will be integrated in all THRIVE activities. The recipient will be expected to implement SBCC interventions to address and transform the harmful cultural and religious norms that discriminate against vulnerable sub-populations and undermine progress towards epidemic control. Building on the accompanying activity level gender analysis, applicants are expected to conduct in-depth state level gender and identity analyses to identify issues more specific to the implementation context. At this stage, applicants' submissions should reflect an understanding of how gender, identity, and inclusion are relevant and likely to influence OVC programming, specifying approaches to addressing these issues in-line with USAID's Gender Equality and Female Empowerment Policy and Nigeria's national gender policies.

6.6 Diversity, Equity, Inclusion and Accountability (DEIA)

USAID Nigeria Actively encourages a workplace culture that embodies, values, and respects: 1) the variety of similarities and differences within Nigeria's diverse socio cultural and religious environment and the unique contributions of all individuals; 2) the consistent treatment of all individuals with dignity and respect; and 3) the ability for everyone to contribute to their fullest potential in a respectful,inclusive, and safe environment without fear of discrimination,

harassment, or retaliation. USAID will consider applicants who reflect this diversity in organizational policies, management and staffing plans and program inclusion of minority groups.

1. 6.6 Disability Inclusion

Recipients' are expected to ensure that routine HIV prevention, care, and treatment services are accessible for people with disabilities, which may include: vision impairment, hearing impairment, mental health conditions, intellectual disabilities, acquired brain injury, autism spectrum disorders, and physical disabilities. Recipients' must work with government, Disabled People's Organizations (DPOs), advocates, partners and communities, to regularly identify and remove barriers prohibiting clients with disabilities - including C/ALHIV and PLHIV with disabilities - from accessing HIV and other services, in line with recommendations in USAID/Nigeria's project level inclusion analysis. Linkages to services for clients with disabilities should be planned for and completed. Recipients' are also expected to link to USAID, PEPFAR and non-PEPFAR rehabilitation services, to enable people living with HIV and who have disabilities to remain virally suppressed and improve their quality of life. Recipients will be expected to integrate inclusion commitments across operations, including affirmative provisions in human resource policies and practices, applying inclusion relevant analysis to program data, and promoting inclusion in all forums in which they participate. At this stage, applicants' submissions should reflect an understanding of how disability and inclusion are relevant and likely to influence programming, specifying approaches to addressing these issues.

6.6 Child Safeguarding

Award recipients must conduct a comprehensive assessment of potential risks likely to threaten child safety during THRIVE's implementation, and must formulate and implement appropriate measures to prevent, mitigate, and respond to child abuse by project personnel. A child safeguarding plan describing risks and risk management measures should be submitted with the recipients' first annual workplan for approval by USAID.

6.7 Emerging Leaders

In recognition of USAID's dedication to meaningful youth engagement across all programming, the Applicant/Offeror is encouraged to include an **Emerging Leaders Program** as part of project implementation in which youth will be hired as emerging leaders into jobs, fellowships and/or paid internships within the project or directly linked to specific job or remunerated internship opportunities outside the project (such as with local government or private sector providers). Emerging Leaders are defined as those with less than two (2) years of financially compensated experience and yet demonstrate potential for advancing the work activities as well as bringing

in diverse perspectives of youth. The inclusion of Emerging Leaders in USAID programming has multiple rationale including but not limited to: support for localization and sustainability; strengthening the capacity of youth in public health and human resources for health, which strengthens the health systems for decades to come; and supporting economic opportunities for youth as a protective factor against poverty and HIV. The Emerging Leaders program should consider national youth policies when developing programming. The Applicant/Offeror should include concrete and practical approaches to address the capacity development of such Emerging Leaders and, in line with USAID's agency-wide Positive Youth Development approach, integrate the voice of such leaders into programmatic approaches.

6.8 Conflict Sensitivity

In striving to reduce conflict and to exemplify Do No Harm principles, the applicant must design and implement interventions in a manner consistent with a conflict sensitive approach. The applicant must: (1) demonstrate an understanding of the context in which the intervention is working; (2) recognize how the proposed interventions interact with the context; and (3) continually revisit the programming approach to ensure that no harm is being done and that interventions have positive outcomes that contribute to increased community cohesion and resilience. A context or conflict analysis, including a mapping of key stakeholders and “dividers and connectors,” should be completed at the outset of Activity implementation, usually within 90 days after award, and continuously updated as part of the ongoing CLA process.

7 Appendix

Table 2: THRIVE Custom Indicators

No	Indicator	Indicator Definition	Indicator Detail	Reporting Frequency
1	OVC_ENROLLED	Number of enrolled beneficiaries (OVC, caregivers, or parents) who are receiving services within the reporting period, disaggregated by sex, age, Enrollee Status (New enrolled or Re- enrolled)	Number of enrolled beneficiaries (OVC, caregivers, or parents) who are receiving services within the reporting period in PEPFAR OVC programs for children and families affected by HIV	Quarterly
2	OVC_HIVRISKASS	Percent of OVC<18 who were of unknown HIV status or HIV-negative, risk assessed and determined to be at risk for HIV	**Numerator:** Number of OVC (<18 years old) determined of unknown status or HIV-negative, who were assessed to be at risk for HIV using a risk assessment tool **Denominator:** Number of unknown/undisclosed or HIV- negative OVC (<18 years old)	Semi- annually
3	OVC_PROTECT	Percentage of demonstrated and/or documented cases of violence, exploitation or neglect that have been linked to Government of Nigeria Social Welfare and other post violence and child protection services	**Numerator:** Number of OVC <18 with a demonstrated and/or documented case of violence, exploitation or neglect who have been successfully referred to Government of Nigeria Social Welfare and other post-violence and child protection services **Denominator:** Number of OVC_SERV <18 with a demonstrated and/or documented case of violence, exploitation or neglect	Quarterly

No	Indicator	Indicator Definition	Indicator Detail	Reporting Frequency
4	OVC_HTSLINK	Percent of OVC (<18 years old) with unknown HIV status referred for testing who got tested and received result, disaggregated by result/confirmed status [ESI]	**Numerator:** Number of OVC with unknown HIV status referred for testing who got tested and received result **Denominator:** Number of unknown/undisclosed or HIV- negative OVC (<18 years old)	Quarterly
5	OVC_TXLINK	Percent of OVC (<18 years old) newly tested positive and successfully linked to treatment	**Numerator:** Number of HIV+ OVC successfully linked to treatment **Denominator:** Number OVC newly tested positive	Quarterly.
6	OVC_ART_SUPP	Percentage of HIV+ OVC on treatment who self-reported [or caregiver -reported] adherent to treatment regimen for the last six months, disaggregated by age, sex	**Numerator:** Number self-reporting adherent to treatment regimen for the last six months **Denominator:** Number of HIV+ OVC on treatment	Semi- annually
7	OVC_NUTRITION	Percentage of Malnourished OVC (<18 years old) identified through quarterly nutrition assessment and linked to the appropriate nutrition services. Number of Referrals that received the services needed.	**Numerator**: Number of malnourished OVC linked to appropriate Nutrition services (disaggregated by Type: Clinical; Counseling; Others)	Quarterly

No	Indicator	Indicator Definition	Indicator Detail	Reporting Frequency
			Denominator: Number of Malnourished OVC identified through quarterly nutrition assessment	
8	OVC_BIRTHCE RT	Percent of OVC with a birth certificate [Nigeria Benchmark, ESI]	**Numerator**: Number OVC (<18) with a birth certificate. **Denominator**: Number of OVC (<18) enrolled in the program	Quarterly
9	OVC_EDU	Percent of OVC regularly attending school or vocational training (not missing more than 5 days in a month of uninterrupted academic or vocational training session) [NG benchmark]	**Numerator**: Number of school aged children enrolled in the OVC program who are regularly (defined as not missing more than 5 days in a month of uninterrupted academic or vocational training session) attending school or vocational training **Denominator**: Number of school aged children enrolled in the program	Quarterly
10	OVC_ECON	Percent of active HHs that have access to money to pay for unexpected household expenses, school fees and other important expenses [ESI]	**Numerator**: Number of active HHs that have access to money to pay for unexpected household expenses, school fees and other important expenses [ESI] **Denominator**: Number of active HHs	Quarterly

No	Indicator	Indicator Definition	Indicator Detail	Reporting Frequency
11	OVC_HIVPREV	Percent of OVC (aged 10 -17) that received adolescent HIV prevention and sexual reproductive health services	**Numerator**: Number of OVC (aged 10-17) that received adolescent HIV prevention and sexual reproductive health services **Denominator**: Number of OVC (aged 10-17)	Quarterly
12	OVC_OFFER	Number of children and adolescents on ART in PEPFAR clinical settings offered enrollment in the OVC program, as counted through family-based enrollment as the number of children and adolescents on ART who are in enrolled households	Number of children and adolescents on ART in PEPFAR clinical settings whose households are offered enrollment in the OVC program PLUS the number of children and adolescents already in the OVC Program who are HIV+ and on ART.	Quarterly
13	OVC_ENROLL (OHA CI)	Percentage of HIV-positive children and adolescents on ART at a PEPFAR clinical setting whose households are enrolled in the OVC comprehensive program after having been offered enrollment. This is counted through family based enrollment as the number of children and adolescents on ART who are in households enrolled in the OVC comprehensive program.	**Numerator:** Number of HIV-positive children and adolescents on ART at a PEPFAR clinical setting whose households are enrolled in the OVC comprehensive program after having been offered enrollment **Denominator:** Collected under OVC_OFFER Custom Indicator	Quarterly
14	OVC_VL_ELIGIBLE	Percentage of HIV-positive OVC on ART, active or graduated, who are served by an OVC comprehensive program, who are eligible for viral load testing	**Numerator:** Number of HIV-positive children and caregivers on ART (active or graduated) who are served by an OVC	Quarterly

No	Indicator	Indicator Definition	Indicator Detail	Reporting Frequency
			comprehensive program who are eligible to have a viral load test **Denominator:** Collected under the "On ART" disaggregate of OVC_HIVSTAT_POS MER indicator	
15	OVC_VLR	Percentage of HIV-positive OVC on ART, active or graduated, who are served by an OVC comprehensive program with a known documented viral load test result in the previous 12 months	**Numerator:** Number of HIV-positive OVC and caregivers on ART (active or graduated) who are served by an OVC comprehensive program with a known documented viral load test result in the previous 12 months **Denominator:** Collected under OVC_VL_ELIGIBLE Custom Indicator	Quarterly
16	OVC_VLS	Percentage of HIV-positive OVC on ART, active or graduated, who are served by an OVC comprehensive program who are virally suppressed (<1000 copies/ml)	**Numerator:** Number of HIV-positive OVC (required)on ART (active or graduated) who are served by an OVC comprehensive program and whose most recent viral load test result in the last 12 months was virally suppressed (<1000 copies/ml). **Denominator:** Collected under OVC_VLR Custom Indicator	Quarterly