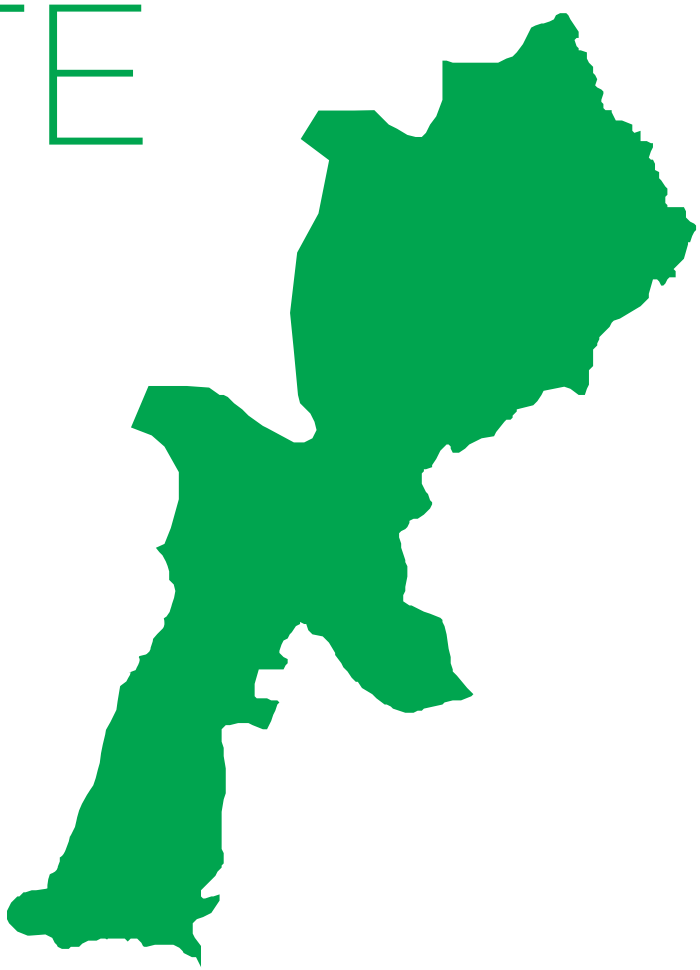
ABIA STATE



Operational Plan for Elimination of Mother-to-Child Transmission of HIV

2013 – 2015

ABIA STATE

Operational Plan for Elimination of Mother-to-Child Transmission of HIV

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Citation: Abia State Ministry of Health, FHI 360 and UNAIDS. 2013. Operational Plan for the Elimination of Mother-to-Child Transmission of HIV, Nigeria: Abia State Ministry of Health, FHI 360 and UNAIDS.

The Abia State Operational Plan for the Elimination of Mother-to-Child Transmission of HIV was supported in part by the U.S. Agency for International Development (USAID) and United Nations Joint Programme on AIDS (UNAIDS). FHI 360 and UNAIDS provided technical assistance to the Abia State Government during development of the plan. Financial assistance was provided by USAID under the terms of the Cooperative Agreement AID-620-A-00002, of the Strengthening Integrated Delivery of HIV/AIDS Services Project. This report does not necessarily reflect the views of UNAIDS, FHI 360, USAID or the United States Government.

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Foreword

Human immunodeficiency virus (HIV) continues to be a major public health issue all over the world especially in Sub-Saharan African (SSA) and other developing countries. In the year 2012, it was estimated that about 35.3 million people were living with HIV. SSA is the most affected region with 1 in 20 adults living with HIV. Furthermore 69% of people living with HIV all over the world are residing in SSA. At present HIV/AIDS has defied cure despite huge financial commitment to achieve this.

According to the 2012 National HIV/AIDS and Reproductive Health Survey Plus (NARHS-Plus) about 3.4% of Nigerians are currently living with HIV/AIDS. Nigeria now accounts for 10% of global burden of HIV/AIDS. It is estimated that about 3.5 million Nigerians are infected with the virus and 1.5 million require treatment.

The NARHS-plus 2012 reports also show that 3.3% of adults in Abia state are infected with HIV/AIDS. Furthermore the report indicates that the prevention of mother to child transmission (PMTCT) utilization (i.e pregnant women who had HIV testing during antenatal care (ANC) was 68.5% leaving a gap of 31.5%. There is also a wide gap in PMTCT coverage in the state with many areas lacking this service.

In order to achieve the goal of universal access to HIV/AIDS care and services in the state as well as meet the national PMTCT goal, the government under the leadership of Sir T.A Orji (Ochendo) is partnering with technical support from Family Health International (FHI 360) and part funding from the USAID.

The state wide rapid health facility assessment initiated and conducted in partnership with FHI 360 is therefore an important milestone towards the elimination of mother-to-child transmission of HIV (eMTCT) in the state. The state is already benefitting from the outcome of the assessment. The Assessment Report successfully guided the development of the Operational Plan.

The *Abia State eMTCT Operational Plan 2013 – 2015* is hereby recommended for use by all stakeholders that have mandate to support PMTCT in Abia State.

Dr. Okechukwu S Ogah

Honourable Commissioner for Health
Abia State

Acknowledgements

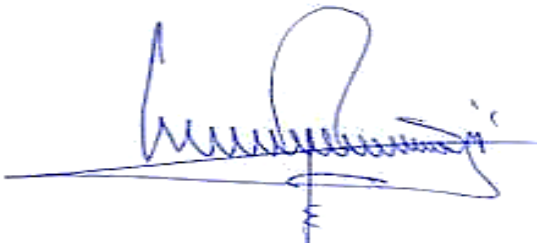
The Abia State Ministry of Health hereby thank all stakehollders whose commitment and hard work contributed to the development of of the Abia State PMTCT Operational Plan 2013 -2015. The level of commitment of the Honourable Commissioner for Health, the cooperation from the Permanent Secretary and the Directors of the Ministry of Health and the dedication of the staff of Abia State Agency for the Control of AIDS and the staff of the State AIDS/STI Control Program are highly acknowledged and appreciated.

We wish to express profound gratitude to FHI 360, the lead Implementing Partner in the state, for expert technical assistance and the United State Agency for International Development for the financial assistance.

The technical support in the review of the Plan by the National Agency for the Control of AIDS (NACA), National AIDS/STI Control Program (NASCP), UNAIDS and Implementing Partners is also immensely appreciated. This helped to ensure alignment with the National Elimination of Mother to Child Transmission (eMTCT) Plan.

Lastly we commend the efforts and contributions of all other individuals and organizations who worked tirelessly behind the scene towards the successful development of the document.

May the Almighty God bless you all abundantly.



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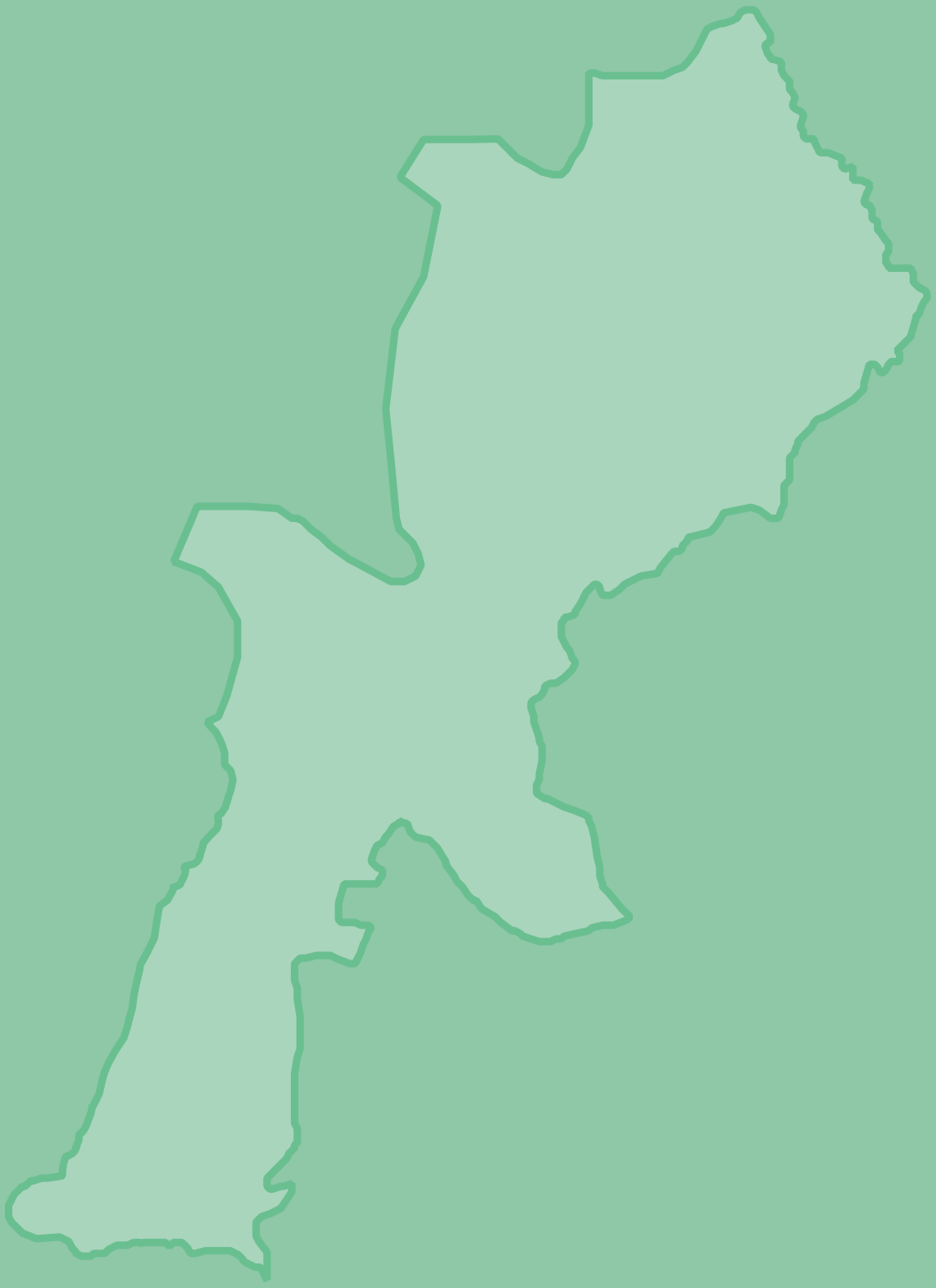
Acronyms

ABIASACA	Abia State Agency for the Control of HIV/AIDS
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
ART	Anti-Retroviral Therapy
ARVs	Anti-Retroviral Drugs
CBOs	Community Based Organizations
CDC	Centres for Disease Control
CD4	Cluster of Differentiation 4
CHEW	Community Health Extension Worker
CHOs	Community Health Officers
CLMS	Commodity Logistics Management Systems
CSOs	Civil Society Organizations
CSR	Corporate Social Responsibility
CYP	Couple-Years of Protection
DALYs	Disability Adjusted Life Years
DBS	Dried Blood Spot (Sample)
DFID	UK Department for International Development
DPRS	Department of Planning Research and Statistics
DQA	Data Question Assurance
EID	Early Infant Diagnosis
eMTCT	Elimination of Mother-To-Child Transmission
FBOs	Faith Based Organizations
FCT	Federal Capital Territory
FMOH	Federal Ministry of Health
FP	Family Planning
FSW	Female Sex Worker
GF	Global Fund
GH	General Hospital
GOPD	General Out-Patient Department
HTC	HIV Testing and Counseling
HCWs	Health Care Workers
HIV	Human Immuno-deficiency Virus
HMIS	Health Management Information System
HR	Human Resources
ICASA	International Conference on AIDS and STIs in Africa
IDU	Injecting Drug Users
IEC	Information, Education and Communication
IMAI	Integrated Management of Adolescent and Adult Illness
IMPAC	Integrated Management of Pregnancy and Childbirth
IPC	Interpersonal Communication
ISS	Integrated Supportive Supervision
JCHEWS	Junior Community Health Extension Workers
KIIs	Key Informant Interviews
LGA	Local Government Area
LMIS	Logistics Management and Information Systems
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health

MDG	Millennium Development Goal
MSM	Men Who Have Sex with Men
MSS	Midwives Service Scheme
MTCT	Mother to Child Transmission
NACA	National Agency for Control of HIV/AIDS
NASCP	National AIDS and STD Control Programme
NDHS	National Demographic and Health Survey
NGOs	Non-Governmental Organizations
NPHCDA	National Primary Health Care Development Agency
NPP	National Prevention Plan
NSF	National Strategic Framework
OPD	Out-Patient Department
PCR	Polymerase Chain Reaction
PCRP	President's Comprehensive Response Plan for HIV/AIDS in Nigeria
PEPFAR	President's Emergency Fund For AIDS Relief
PHC	Primary health care
PHC/DC	Primary Health Care/Disease Control
PMTCT	Prevention of Mother-to-Child Transmission
PSCSM	Procurement & Supply Chain Management System
RH	Reproductive Health
RHFA	Rapid Health Facility Assessment
SACA	State Agency for the Control of AIDS
SASCP	State AIDS and STD Control Programme
SBCC	Social and Behavioural Change Communication
SDPs	Service Delivery Points
SGs	Support Groups
SHC	Secondary Health Care Facilities
SIDHAS	Strengthening Integrated Delivery of HIV/AIDS Services
SIT	State Implementation Team
SMoH	State Ministry of Health
SMT	State Management Team
SOML	Saving One Million Lives
SOPs	Standard Operating Procedures
STDs	Sexually Transmitted Diseases
SURE-P	Subsidy Re-investment and Empowerment Programme
TBAs	Traditional Birth Attendants
TOTs	Training Of Trainers
TOR	Terms of Reference
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNICEF	United Nations Children Emergency Fund
USAID	United States Agency for International Development
USG	United States Government
VDRL	Venereal Diseases Research Laboratory
WHO	World Health Organization



Executive Summary

Abia State has a HIV prevalence of 7.3% and is one of the "12+1" high burden, high priority states in Nigeria. There are an estimated 139,517 people living with HIV in Abia State which makes it one of the states with the highest burden of people living with HIV in Nigeria. This has implications for mother-to-child transmission of HIV (MTCT). The increased focus on prevention MTCT aligns with the "Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive (eMTCT)" and the President's Comprehensive Response Plan for HIV/AIDS in Nigeria (PCRP) 2013-2015. These plans will ensure that 90% of HIV positive pregnant women, their babies and families have access to services that will ensure zero new HIV infections amongst children and keep their mothers alive.

There were 741,055 women of reproductive age (WRA), i.e. aged 15-49 years old, in Abia State at the end of 2012; out of these 168,422 were pregnant - 12,295 of whom (7.3%) were HIV positive. A 2011 survey showed contraceptive prevalence in the state was 20.4% while unmet need for contraception was 8.4%. The same survey reported 95.0% of pregnant women received antenatal care (ANC) from skilled personnel while 91.5% of deliveries were attended by a skilled birth attendant. Routine data showed 21% of eligible pregnant women were testing for HIV in 2012 while 14.4% of HIV positive pregnant women received anti-retroviral (ARV) drugs for prevention of mother-to-child transmission of HIV (PMTCT).

As of June 2013, 46 of the 790 ANC facilities in the state provide ARVs for PMTCT. About 631 ANC facilities which could provide comprehensive PMTCT services but did not were assessed in March 2013 and only 7% (44) of these were found to meet the nationally prescribed human resource criteria for scale-up (one doctor, one nurse/midwife, two community workers, one pharmacy staff, one laboratory staff, one medical records officer). The assessment revealed shortfalls in the human resource (HR) and infrastructure capacity of the facilities.

From June 18th to 20th 2013, a 3-day planning workshop was convened by the Abia State Ministry of Health (SMOH) and a wide range of stakeholders including representatives from HIV/AIDS Division of the Federal Ministry of Health (FMOH) and National Agency for Control of HIV/AIDS (NACA). The plan aligns with the goals and targets contained global and national eMTCT plans including the PCRP. A modelling exercise was completed to estimate the potential impact of meeting three major eMTCT targets:

- Reduce by 50% HIV incidence among women of reproductive age (WRA) by 2015
- Reduce by 90% unmet need for family planning among WRA by 2015
- Increase to 90%, ARV prophylaxis for PMTCT for all HIV-positive pregnant women and breastfeeding infant-mother pairs by 2015.

If the scale-up plan is implemented to scale, 4,599 infections among WRA, 3,761 pregnancies among HIV-positive women, 7,062 infections among HIV exposed infants (HEI), 172 infant deaths, 28 maternal deaths will be prevented by meeting the PMTCT targets. Combined, this will result in 428,296 disability-adjusted life years (DALYs) saved in Abia State by 2015.

The costed "*Abia State Operational Plan for the Elimination of Mother-to-Child Transmission of HIV 2013-2015*" with an estimated cost of NGN 11,422,817,745 (USD $73,686,824) is presented in this document.

SECTION

1 Introduction

1.1 NIGERIA HIV SITUATIONAL ANALYSIS

With a population of 162, 265,000[1], Nigeria currently has one of the highest HIV and AIDS epidemic burden worldwide. It has a generalized epidemic with a prevalence of 4.1%[2], an estimated 3.1 million persons living with HIV 2, 215,130 AIDS related deaths[3] annually and 2,229,883 total AIDS orphans. By December 2012 only 491,021 out of an estimated 1.66 million people who require anti-retroviral drugs (ARVs) were receiving them[4].

New infections continue unabated in the country; in 2011 there were 281,180 new infections with more than half occurring in children (154,920). There are pockets of concentrated epidemics amongst most at risk persons which appears to feed the epidemic in the general population. Mode of transmission studies show that injecting drug users (IDU), female sex workers (FSW) and men who have sex with men (MSM) alone, who constitute about 1% of the adult population; contribute almost 25% of new HIV infections.

The national response analysis indicates that the weakest link in the national HIV/AIDS response is in the area of prevention. Access to prevention services is poor. According to the national prevention plan (NPP), the overall proportion of coverage and uptake of HIV preventive services such as HIV Testing and Counseling (HTC) and PMTCT still fall very short of national targets.

Given that 95% of the population is currently HIV negative, prevention remains the most effective means of controlling the epidemic. This is clearly articulated in the current National Strategic Framework (NSF) 2010-2015 which has an overarching priority to reposition evidence-based promotion of behavior change and prevention of new HIV infections as the major focus of the national HIV and AIDS response.

1.2 NIGERIA PMTCT SITUATION ANALYSIS

Nigeria has made some progress in the expansion of PMTCT services, yet there still exist critical bottlenecks that impede the availability as well as access to the services. Limitations within the health system (poor management, poor infrastructure, wide human resource gap, poor commodity supplies, weak health information systems and inadequate financing at all levels) hinder decentralization of PMTCT services to the primary health care levels and integration into existing maternal, neonatal & child health and reproductive health programs.

By the end of 2011, maternal HIV counseling and testing coverage was about 14% and PMTCT prophylaxis uptake was at 8% for an estimated 229,000 HIV-positive pregnant women in the country. The sub-optimal coverage of PMTCT services is evident in the fact that Nigeria has the highest burden of MTCT in the world and is among the top ten countries with poor maternal

1 National Agency for the Control of AIDS. (2012). Global AIDS Response Country Progress Report: Nigeria GAPR 2012

2 Federal Ministry of Health (2010). National HIV Sero Prevalence Sentinel Survey. FMOH Abuja Nigeria

3 National Agency for the Control of AIDS. (2011). Factsheet 2011: Update on the HIV/AIDS Epidemic and Response in Nigeria. NACA, Abuja, Nigeria

4 National Agency for the Control of AIDS. (2013). President's Comprehensive Response Plan for HIV/AIDS in Nigeria. NACA, Abuja, Nigeria

and child health indices. The country is reported to contribute up to 15% of the total number of pregnant women infected with HIV in need of ARVs for PMTCT among 20 low and middle income countries as well as 30% of the global gap to reach 80% of women needing ARVs for PMTCT. Globally, it also contributes 15% of the total number of children currently in need of antiretroviral therapy.

1.3 ACCELERATING SCALE-UP OF PMTCT IN 12+1 STATES

Following the launch of the Global Plan towards the elimination of new HIV infections among children and keeping their mothers alive (eMTCT) and the alignment of the National eMTCT Scale-up Plan to the Global elimination targets, the Nigerian response has increased its focus on the PMTCT programme. Led by the National Agency for the Control of HIV/AIDS (NACA), all stakeholders including the FMOH and the respective State Ministries of Health have re-strategized and re-focused with a view of accelerating the scale up of PMTCT services across the country.

These targets can only be achieved with the active involvement of all stakeholders including Government at federal, state and local government area(LGA) levels as well as the private sector with support of local and international partners. NACA constituted the PMTCT Scale-up Technical Committee in December 2011. The purpose was to engage these critical stakeholders in dialogue and provide technical support towards acceleration of PMTCT as well as to strengthen the State ownership and leadership for scale-up of PMTCT services within the States. The Secretariat was situated in NACA and membership of the Committee included the HIV/AIDS Division FMOH, National Primary Health Care Development Agency (NPHCDA), World Bank, DFID, UNICEF, UNAIDS, WHO, CDC and USAID.

The PMTCT Scale-up Technical Committee identified 12 states plus the FCT which account for 70% of the PMTCT burden in Nigeria for increased focus. Significant effort has been channeled towards supporting these states to mobilize additional resources, improve coordination and increase the availability as well as access to PMTCT services. Health statistics such as number of women of child-bearing age, birth rate, HIV prevalence are expected to also guide prioritization of activities between LGAs and communities within the various states. Implementation is being carried out in a phased approach that will ensure better coordination of the response with all the states of the country benefiting by 2015.

1.4 FUNDING OPPORTUNITIES

Table 1: 12+1 States arranged in order of 2010 HSS prevalence

State	HIV Prevalence	Number of PLHIV
Benue	12.7 %	242,721
Akwa Ibom	10.9 %	208,319
Rivers	9.1%	173,918
Anambra	8.7%	166,273
FCT	8.6 %	164,362
Plateau	7.7%	147,161
Nassarawa	7.5%	143,339
Abia	7.3%	139,517
Cross River	7.1%	135,694
Rivers	6.0%	114,671
Lagos	5.1 %	145,178
Kaduna	5.1%	97,470
Kano	3.4%	64,980

SOURCE: NATIONAL AGENCY FOR CONTROL OF AIDS 2013. PRESIDENT'S COMPREHENSIVE RESPONSE PLAN FOR HIV/AIDS IN NIGERIA. NACA, ABUJA, NIGERIA

Accelerating the scale up of PMTCT services requires additional resource mobilization efforts as well as effective and efficient use of these resources. A common focus of development partners is the need for ownership and sustainability of the HIV response. The President's Comprehensive Response Plan for HIV/AIDS in Nigeria (PCRP)[5] is timely as it challenges federal, state and local governments to significantly increase the resources allocated towards the HIV response in general and the PMTCT response in particular. The goal of the PCRP is to accelerate the implementation of key interventions over a two year period to bridge existing service access gaps, address key financial, health systems and coordination challenges and promote greater responsibility for the HIV response at Federal, State and local levels. In addition, multilateral and bilateral organizations such as the United Nations, World Bank, United States Government, Canadian Government and the Global Fund have increased their commitment and resource envelope for PMTCT services in Nigeria. Other opportunities that are worthy of note include the provision of midwives at PHCs under the midwifery service scheme (MSS) funded by Millennium Development Goal (MDG) mechanism and Subsidy Re-investment and Empowerment Programme (SURE-P), coordinated by the NPHCDA. There are also opportunities for increasing coverage through working with private health practitioners and investment in maternal and child health services including PMTCT through public-private partnerships (PPP).

5 National Agency for Control of AIDS 2013. President's Comprehensive Response Plan for HIV/AIDS in Nigeria. NACA, Abuja, Nigeria

SECTION

2 Abia State

2.1 STATE PROFILE

Abia, one of five South-Eastern states in Nigeria, is administratively divided into 17 LGAs. In 2012, its population was estimated to be 3,368,430 based on a 2.7% annual growth rate on 2006 census figures. It is estimated that about 70% of the population are rural dwellers and that most of the citizens are Igbo (95%).

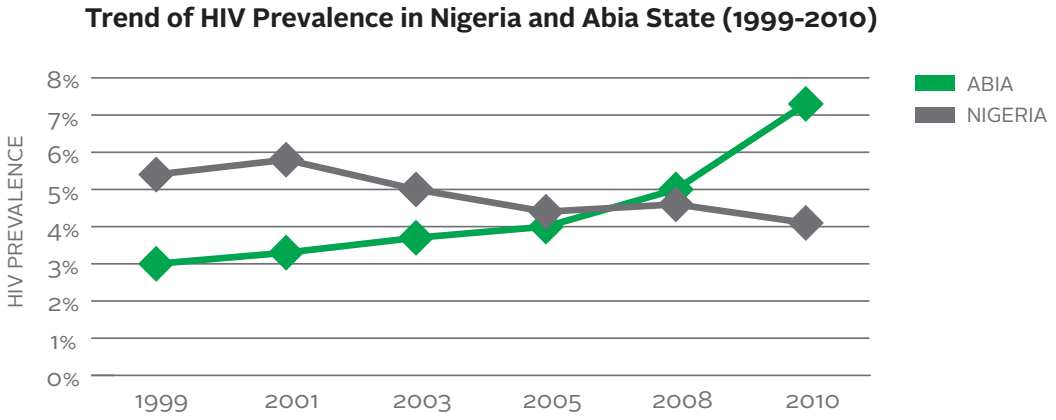
At the end of 2012, there were an estimated 741,055 women of reproductive age (15-49) in Abia, of these, 168,422 were pregnant women , while children under five years and below one year of age were 666,751 and 133,350, respectively. A 2011 survey showed contraceptive prevalence in the state was 20.4% while unmet need for contraception was 8.4%[6]. The same survey reported 95.0% of pregnant women received antenatal care (ANC) from skilled personnel while 91.5% of deliveries were attended by a skilled birth attendant.

Abia State reports a total of 1,100 health facilities, 790 (71%) of which provide ANC services.

2.2 HIV PREVALENCE IN ABIA STATE

Figure 1 illustrates the trend in HIV prevalence among pregnant women in Abia State based on ANC sentinel surveillance from 1999 to 2010

Figure 1: Trend of State HIV Prevalence among Pregnant Women Compared to the National[7]



ABBREVIATION: G6PD — Glucose-6-phosphate dehydrogenase. Source: Federal Ministry of Health Technical Report, 2010 National HIV Sero-prevalence Sentinel Survey

6 National Bureau of Statistics (NBS) 2011. Nigeria Multiple Indicator Cluster Survey 2011 Main Report, ABUJA NIGERIA

7 Source: Federal MOH Technical Report 2010

in comparison with those obtainable nationally during the same period. There was a consistent increase from 3% in 1999 to the highest proportion of about 7.3% in 2010, which was significantly higher than the national average of 4.1%. The high HIV prevalence is of particular relevance to vertical transmission of HIV within the state.

2.3 PMTCT IN ABIA STATE

With a prevalence of 7.3%, about 12,295 pregnant women are projected to be HIV positive out of an estimated population of 168,422 pregnant women within the state in 2012. In the absence of PMTCT, about one third of these infected pregnant mothers would transmit HIV to their babies translating into an estimated 3,824 preventable HIV infections among infants in the state in 2012 alone. Only 46 of the 790 ANC facilities in the state currently provide ARVs for PMTCT.

SECTION

3 Process

This operational plan for eMTCT was developed under the leadership of the Abia State Ministry of Health (SMOH) and the Abia State Agency for the Control of HIV and AIDS (ABIASACA).

In February 2013, with support from UNAIDS and HIV/AIDS Division FMOH, Abia State developed the first draft of its eMTCT operational plan. The plan was however, quite generic and was not widely circulated.

In order to specifically identify the health system challenges to be addressed to meet Abia State's eMTCT targets, FHI 360 with support from USAID, provided technical assistance to Abia State to conduct a state-wide rapid health facility assessment (R-HFA). The assessment was done in all facilities in all eight LGAs identified as providing ANC services but not PMTCT services. The assessment covered seven domains: facility health linkages, health human resource complement, client flow, scope of services provided, community support systems, current infrastructure and future prospects for expansion. The results of the assessment informed the priority areas chosen as well as scale-up targets required to meet the eMTCT goal.

From June 18th to 20th 2013, a 3-day planning workshop was convened by the Abia SMOH and a wide range of stakeholders including representatives from HIV/AIDS Division of the FMOH and NACA. The meeting was funded by USAID through FHI 360. The initial draft plan earlier developed by the SMOH was reviewed in line with findings from the RHFA and the Ministers deep dive team. The outcome of the meeting was a costed eMTCT scale up plan which aligned with the goals and targets contained in the national eMTCT scale up plan. State specific challenges were identified and a comprehensive package with appropriate interventions to address the specific needs within the state.

To make a stronger argument for investment towards eMTCT, projections of impact based on assigned annual scale-up targets were developed. These targets and projected outputs are presented in Chapter 6. Details of calculations and assumptions made for the projections are presented in the appendix.

With the completion of all of these processes, the Abia SMOH and SACA disseminated Abia State's eMTCT Scale-up Plan 2013-2015 to His Excellency, Governor Theodore Orji on June 21st 2013. The dissemination meeting was attended by all major stakeholders in the HIV/AIDS response in Abia, including FHI 360 (lead PEPFAR implementing partner for Abia State).

SECTION

4 State-wide Rapid Health Facility Assessment

4.1 METHODOLOGY

Both quantitative and qualitative methodologies were used in R-HFA to determine the status of the health system to deliver PMTCT services in all 17 LGAs of Abia State.

A complete list of all health facilities in the state was provided by the Department of Planning, Research and Statistics (DPRS) of the Abia SMOH. All public and private health facilities which met defined criteria were assessed. A total of 651 health facilities provided ANC but had no support to provide ARVs for PMTCT at the time of the survey. These were fully assessed and the full "Report of the Abia State-wide Rapid Health Facility Assessment: in preparation for the elimination of mother-to-child- transmission of HIV 2013" is available as a separate document. A summary of assessment findings is presented below.

Box 1: Site selection

Site Inclusion Criterion

1. Providing ANC

Site Exclusion Criteria

1. Specialist hospitals such as neuropsychiatry, dental and maxillofacial hospitals.
2. Facilities already providing ARVs for PMTCT or planned for 2013 (PEPFAR/Global Fund)

Table 2: Characteristics of facilities providing ANC with no PMTCT ARV support

OWNERSHIP	FACILITY TYPE		TOTAL
	PRIMARY LEVEL	SECONDARY LEVEL	
Private			
Faith-based	6	7	13
Private for profit	115	98	213
Sub-total (private)	121	105	226
Public			
Federal government	1	1	2
State government	1	3	4
LGA	418	1	419
Sub-total (public)	420	5	425
Overall total	**541**	**110**	**651**

4.2 FINDINGS

4.2.1 Facility Ownership and Healthcare Level

About a third of assessed facilities were privately owned while the rest were publicly owned (see Table 3.)

4.2.2 Human resources and service utilization

Human resources for health and uptake of health services for the 12 month preceding survey were assessed. Findings showed fewer staff and wider coverage gaps in primary compared to secondary health centres. As expected secondary facilities on the average had a higher number of every category of health workers compared with the primary level. Out of the 541 primary level facilities assessed, 16.8% reported having at least one doctor (vs. 95.5% in secondary level), 52.5% reported having at least one nurse midwife (vs. 83.6% at secondary level) while community health workers were available at 87.2% of primary level facilities (vs. 82.7% of facilities at secondary). Records officers and pharmacy technicians/pharmacists were the least likely to be available at per facility. The averages were better for private level facilities at both primary and secondary levels.

The average number of outpatient department (OPD) and ANC attendees as well as deliveries in the last 12 months also revealed a much higher utilization of secondary facilities compared to the primary level health services in the state. Overall, 94.5% of facilities assessed had at least one ANC client in the 12 months preceding the assessment. In public sector facilities, however, 56% of women did not return to deliver at the health facility. While at private facilities 38% did not return to deliver at the health facility.

4.2.3 Other domain summaries

Facilities were also assessed for the following domains: services available, infrastructure, enabling environment for ANC, community delivery options and community health support systems.

The assessment showed that basic clinical services were available in most of the facilities assessed (70%) with the exception of HTC and TB services. HTC services were available in less than half of the primary facilities surveyed while TB services were available in about a fifth of facilities.

The enabling environment assessment looked at access to available support for ANC through projects such as Millennium Development Goal (MDG) funds for MCH services, the Midwives Service Scheme (MSS) or Subsidy Reinvestment and Empowerment Program (SURE-P), provision of subsidised ANC services to the community and whether regular community outreaches were conducted. Community outreach was the most frequently observed activity in this domain. Over 60% of facilities engaged in community outreach although only 8.2% of secondary facilities. However, only (14%) provide free/subsidised ANC in the state, less than a quarter had access to MDG support for MCH and less than 10% had access to midwife staffing support programs

4.2.4 Summary of qualitative findings

Key informant interviews were conducted with health workers to explore factors that determine demand for facility-based PMTCT services. Health workers reported many women prefer to deliver with traditional birth attendants (TBAs), private clinics and churches. Some of the reasons proffered for this observation include a firm traditional belief in the abilities of the TBA, perceived cost of services at the health facilities, the long distance to the facilities and unavailability of staff especially at night.

For the facilities which were well patronized, reasons given by respondents' include good relationship that health workers have with the community including the village development committee (VDC), good relationship amongst community members and continuous education on the reason why women should deliver in the facilities.

Health workers interviewed were of the opinion that better staffing of facilities, improved capacity building for staff as well as provision of infrastructure and social amenities would motivate health care workers to work to their full capacity thus, improving quality of services and patronage.

4.2.5 Scenarios for eligibility of PMTCT services

About 7% (44) of the assessed facilities met the minimum national standard (one doctor, one nurse, two other health workers, one pharmacy staff, one lab technician, one records officer) for PMTCT service provision. Of these, 39 (6%) were in the private sector. In order to ensure more equitable coverage of PMTCT services, a total of 455 doctors, 275 nurses, 464 CHEWs/CHOs, 561 pharmacists or pharmacy technicians, 428 records officers and 453 laboratory scientists or technicians are needed to bring all assessed public facilities to national standard for PMTCT service provision.

Table 3 shows PMTCT burden and service coverage gap by LGA. LGAs are ranked 1 to 17 for each variable; 17 for those with the highest gap or burden and 1 for the lowest. The scores for PMTCT burden and service coverage gap are then combined to give the rank sum. The LGAs are arranged from those with the highest rank sum to those with the lowest. The LGAs with higher rank sums have the greatest need for PMTCT services.

While Aba South LGA has the highest MTCT burden, the lack of PMTCT services in Umuahia South LGA and relatively high MTCT burden makes the LGA with the highest unmet need for PMTCT services.

4.2.6 Recommendations

Scale-up priority should be given to LGAs with the highest PMTCT service coverage gap and burden of HIV positive pregnant women. Scale-up efforts must attempt to close the gap in human resource and infrastructure that exists almost 93% of facilities assessed. Private sector involvement in PMTCT service provision is also another critical area which should be addressed to ensure universal coverage of PMTCT services. Community systems should be strengthened to improve community involvement and ownership by establishing and strengthening existing ward and village development committees as well as community-based organizations.

Table 3: PMTCT Burden and Coverage Gap by LGA in Abia State

LGAS	MTCT BURDEN			PMTCT SERVICE COVERAGE GAP			RANK SUM [RANK 1 + RANK 2]
	HIV prevalence	Estimated number of HIV+ pregnant women	Rank 1 (number of HIV+ pregnant women)	Number of sites with ANC services	Proportion without PMTCT services	Rank 2 (service gap)	
Umuahia South	12.00%	995	15	37	100%	17	32
Ikwuano	7.30%	600	8	39	100%	17	25
Obingwa	7.30%	792	12	51	98%	12	24
Aba South	7.00%	1785	17	64	88%	6	23
Arochukwu	7.30%	737	11	49	98%	12	23
Osisioma	7.30%	961	14	65	97%	9	23
Umuahia North	12.00%	1597	16	64	89%	7	23
Bende	7.30%	839	13	62	95%	8	21
Ugwunagbo	7.30%	372	3	52	100%	17	20
Ukwa East	7.30%	253	2	20	100%	17	19
Isiala Ngwa South	7.30%	595	7	39	97%	9	16
Aba North	7.00%	446	5	60	97%	9	14
Nneochi	7.30%	710	10	37	84%	3	13
Ohafia	4.70%	690	9	44	82%	2	11
Isuikwuato	7.30%	504	6	44	84%	3	9
Isiala Ngwa North	1.30%	119	1	44	86%	5	6
Ukwa West	7.30%	380	4	19	68%	1	5
Total	**7.30%**	**12,377**		**790**	**93%**		

SECTION

5 Abia State HIV/AIDS Operational Plan

5.1 RATIONALE

Research has shown that MTCT is preventable, though currently responsible for virtually all new infections among children, thereby significantly contributing towards infant morbidity and mortality. The risk of MTCT can be reduced from an average of 30 – 45% to less than 2% by comprehensive interventions that include the use of anti-retroviral drugs (ARVs) either as prophylaxis or therapy given to women in pregnancy, during labour and while breastfeeding. Consequently, the prevention of vertical transmission of HIV is one of the critical pillars for attaining the Millennium Development Goals 4 (reduced child mortality), 5 (improved maternal health) and 6 (HIV and AIDS, malaria combated).

5.2 GOAL AND OBJECTIVES

This Operational Plan was developed in partnership with various actors/ stakeholders on the response and, aligning to the National *Scale-up Plan towards Elimination of Mother to Child Transmission of HIV in Nigeria 2010 – 2015,* as well as the *National Health Sector Strategic Plan & Implementation Plan for HIV/AIDS 2010 – 2015*.

5.2.1 Goal

The goal of this operational plan is to improve maternal health and child survival by 2015 through the accelerated provision of comprehensive services for elimination of mother-to-child transmission of HIV.

5.2.2 Objectives

The State objectives, by end of the year 2015, are to:

1. Reduce HIV incidence among 15-49 year old women by at least 50% by 2015
2. Reduce the unmet need for family planning among women living with HIV by 90%
3. Increase access to quality HIV counselling and testing to at least 90% of pregnant women by 2015
4. Provide ARV prophylaxis for PMTCT to at least 90% of all HIV positive pregnant women and breastfeeding infant-mother pairs
5. Increase provision of early HIV diagnosis services to at least 90% of all HIV exposed infants
6. Increase provision of life-long ART to at least 90% of the pregnant, infected women requiring treatment for their own health
7. Ensure effective management: coordination, resourcing, monitoring and evaluation, of the eMTCT elimination plan

5.3 SCALE UP TARGETS

Table 4: State Level Targets for the Operational Plan

	BASELINE	2013	2014	2015	DATA SOURCE
Estimated Number of Women of Reproductive Age (WRA)	741,055	761,336	782,172	803,578	NPC 2006 Projections
Estimated Number of Pregnant Women of Reproductive Age	168,422	173,031	177,766	182,631	NPC 2006 Projections
Projected ANC Attendance (95% of pregnant women from MICS)	28,718 (28%)	164,379 (95%)	168,878 (95%)	173, 500 (95%)	Routine State Data and MICS4 2011 Based Projections
Estimated Number of HIV-positive Pregnant Women (7.3% of preg. WRA projection 12,295)	1817 (14.8%)	12,631	12,977	13,332	National HIV Sero-prevalence Sentinel Survey
50% reduction in HIV incidence among 15-49 year old women	0.64%	0.53%	0.43%	0.32%	Prevalence Based Estimates
90% reduction in unmet need for family planning among women living with HIV	8.9%	7%	5%	1.80%	MICS4 2011 Based Projections
90% of all pregnant women have access to quality HIV counselling and testing services	21552 (21%)	82,190 (50%)	126,658 (75%)	156,150 (90%)	State Routine Health data on DHIS
90% of all HIV-positive pregnant women and breastfeeding infant-mother pairs have received ARV prophylaxis for PMTCT	1659 (13.4%)	6,316 (50%)	9,733 (75%)	11,999 (90%)	State Routine Health data on DHIS
90% of all HIV-exposed infants have access to Early HIV diagnosis services	86 (0.40%)	6,316 (50%)	9,733 (75%)	11,999 (90%)	State Routine Health data on DHIS
90% of HIV-infected women pregnant requiring treatment for their own health will have access to life-long ART (Based on 50% of HIV positive pregnant women requiring ART)	983 (16%)	3,158 (50%)	4,866 (75%)	6,666 (90%)	State Routine Health data on DHIS
Number of health facilities that provide ANC plus PMTCT services (790 ANC facilities at R-HFA)	46	82 (10%)	287 (36%)	355 (45%)	eMTCT scale-up plan development workshop

5.4 IMPLEMENTATION APPROACHES

The primary consideration will be integration of PMTCT into the existing health programmes including the maternal, neonatal, child and adolescent health, the nutrition-related services as well as the other HIV-related services. Successful implementation of the Operational Plan will be dependent upon the following major strategic outcomes:

- PMTCT guidelines, manuals and related standards produced and widely disseminated;
- Advocacy for PMTCT with gate keepers and influential people within the community strengthened;
- Community education on PMTCT including promoting the utilization of the available services enhanced;
- Social mobilization at community level for PMTCT strengthened;
- The human resource capacity for delivery of quality PMTCT services strengthened;
- Medicines, related commodities and supplies as well as the procurement supplies management system strengthened;
- Physical infrastructure and equipment for provision of quality PMTCT services rehabilitated;
- PMTCT programme coordination, management and resource mobilization strengthened; and
- PMTCT programme monitoring and evaluation as well as operational research strengthened.

Based on the implementation approaches outlined above, five focus areas guided the themed group work. These are PMTCT service supply; PMTCT Health Care Commodities Supply; PMTCT Demand Creation; Monitoring and Evaluation and Programme Management.

5.4.1 PMTCT Service Supply Systems

The PMTCT service supply systems include but are not limited to; training of health care workers, site activation for PMTCT service provision, distribution of guidelines, standard operating procedures (SOPs), job aids and information, education, communication (IEC) materials and providing support to PMTCT sites through routine mentoring and technical supportive supervision.

Trainings

To ensure that quality PMTCT services are provided at the health facilities, it is essential to expand the pool of health care workers trained in integrated PMTCT and Integrated Management of Pregnancy and Childbirth (IMPAC) in the context of HIV.

Health care workers in secondary health facilities will be trained using the national five-day Integrated PMTCT curriculum which includes early infant diagnosis (EID), reproductive health/HIV integration, malaria in pregnancy and gender. The IMAI/IMPAC curriculum will be used for training health care workers in PHC facilities as this is targeted at lower cadre health care staff including community health extension workers (CHEWs) and junior community health extension workers (JCHEWs).

Activation of selected facilities for PMTCT service provision

PMTCT services will be set up at selected health facilities after completion of trainings. This service activation exercise involves setting up service delivery points at the in the facility as well as a multi-disciplinary team at the facility level.

Distribution of National guidelines, SOPs, Job aids and IEC materials for PMTCT

National guidelines and SOPs are critical in service delivery to ensure that health care providers deliver quality PMTCT services to clients according to national recommendations and

protocols. Job aids and IEC materials will provide the needed information for service provision.

Mentoring and supportive supervision

A multidisciplinary team composed of LGA, state level officers as well as implementing partners will provide hands-on mentoring and supportive supervision of the service provision at the site. Mentoring visits provide feedback from program data and assure quality service delivery and documentation and ensure timely supply of medical commodities. Joint supportive supervision with State teams will be conducted on a quarterly basis and will utilize the integrated supportive supervisory (ISS) checklist developed by the NPHCDA.

5.4.2 PMTCT Health Care Commodities supply

To ensure a succesful and rapid scale up of PMTCT services,there is need for a strenthened supply chain management system for PMTCT commodities. These would include test kits ARVs, laboratory commodities as well as consumables. There is need to: establish a supply chain management system to ensure prompt and efficient supply of PMTCT commodities; assess the existing state supply chain management systems; and integrate donor supported and state owned supply systems to ensure ownership and sustainability.

5.4.3 PMTCT Demand Creation

The Abia State demand creation strategy is aligned with the national strategic approach, which involves positioning of PMTCT Centres as places of Confidence Building and Empowerment. The PMTCT centres will be branded with appropriate and acceptable logos/mascots (to be determined at the national level) – friendly care, healthy babies. The centres would be promoted as places to access trained and qualified 'friends' (facility workers) whom you can chat with about your life plans, especially your health and that of your baby, i.e. providing 'caring services tailored to your needs'.

Pregnant women will receive health talks at the community level on the benefits of ANC/ PMTCT services and where they can be accessed. Incentives will be provided for the uptake of ANC services through provision of happy birth packs. Furthermore, program implementers will improve IPC skill of healthcare workers so as to facilitate friendly services for women seeking ANC/PMTCT. Implementers would also facilitate partnerships between HCWs, TBAs and faith houses through orientation, trainings, dialogues and "be the best" campaign for healthcare workers (badges etc.). They would address issues of HIV related stigma and disclosure by working with directly influencing audiences such as husbands, community and religious leaders to support and encourage pregnant women to seek ANC/PMTCT services.

In order to ensure that issues around PMTCT are effectively and efficiently kept topical, journalists will be trained on the benefits of ANC/PMTCT and supported to mainstream PMTCT/ANC messages in their media programs.

5.4.4 Monitoring and Evaluation

A strong and functional monitoring & evaluation (M&E) system is a critical factor for tracking, measuring and estimating the progress made towards eMTCT in Abia State. The established strong M&E system and standard data management processes will ensure that: a) inefficiencies in data collection and reporting is minimized or eliminated, b) PMTCT intervention process, outputs and outcomes are better tracked for the purpose of evaluating the impact of the program and c) answers to operational questions are provided to the stakeholders.

To this end, the M&E system proposed for the scale-up will address identified deficiencies in the areas of M&E coordination at all levels including maintenance of a central database; systems for mentoring and supportive supervision and data quality assurance (DQA) system, and human resource capacity for M&E as well as information use and data sharing.

At the inception phase, the major key players in implementing program M&E system and HMIS at both the state and LGA level will be engaged to agree on the seamless way of strengthening M&E coordination and assignment of roles & responsibilities. Monthly program coordination and data review meetings will be established to facilitate strategic direction for the scale up. Central database, standard data management protocol and relevant HR will be put in place to facilitate the process of obtaining up-to-date routine service statistics and logistics management and information systems (LMIS) reports across the state. Capacity of Medical Records and M&E/HMIS Officers at community, health facilities, LGAs and state level will be built. Systems for routine mentoring and supportive supervision and data quality auditing will be instituted to ensure that high quality data is generated for analysis and use in decision making.

5.4.5 General Program Management, Stakeholders Consensus Building, Resource Mobilization and Coordination Mechnism (Program Management, Coordination and Resource Mobilization)

The program management, coordination and resource mobilization thematic area aims at strengthening the strategies and activities that contribute to the efficient management, coordination and mobilization of the available resources.

The State Management Team (SMT) will support site assessments, set criteria for site selection during scale-up of PMTCT services. The SMT will be responsible for budgeting PMTCT scale-up activities, mobilizing resources and ensuring counterpart funding from the government to ensure ownership and sustainability of the activated sites. A state PMTCT task team will be created to work with the lead PEPFAR implementing partner, FHI 360 and other implementing partners. The PMTCT task team will comprise SMOH staff: Departments of Public Health and Disease Control, Planning Research and Statistics and Ministries of Information, Women Affairs and other related ministries. In addition, key personnel from the LGA level will also be part of the task team. Heads of hospitals as well as implementing partners will be part of the team.

SECTION

6 Benefits & Impact of Expanded Access to PMTCT Services in Abia

To estimate the potential impact of meeting PMTCT targets in Abia State, a modelling exercise was completed. In the exercise, the number of HIV infections averted in women of reproductive age and infants, the number of infant and maternal deaths averted, as well as the disability-adjusted life year (DALY) saved from meeting three of the four main PMTCT targets were estimated (targets listed below). The methods for estimation are described in below. Briefly, though, the infections and deaths that would result from maintaining current levels (maintaining the status quo) compared to meeting PMTCT targets were estimated. The difference between the two was taken as the estimate of programmatic impact (see table below).

TARGETS:

- Reduce HIV incidence among women of reproductive age (WRA) 50% by 2015
- Reduce unmet need for family planning among HIV-positive women 90% by 2015
- Increase ARV prophylaxis for PMTCT to 90% of all HIV-positive pregnant women and breastfeeding infant-mother pairs by 2015

Table 5: Potential Impact of Meeting PMTCT Targets in Abia State by 2015

TARGETS	2012	2013	2014	2015	TOTAL
1. Decrease HIV incidence among WRA	*0.64%*	*0.53%*	*0.43%*	*0.32%*	
2. Reduce unmet need for FP among HIV+ women	*8.90%*	*9%*	*5%*	*2%*	
3. Increase prophylaxis for HIV+ pregnant women	*21.0%*	*50%*	*75%*	*90%*	
OUTCOMES					
Status Quo Maintained: New HIV infections among WRA	4,397	4,486	4,578	4,671	18,132
Targets Achieved: New HIV infections among WRA	4,397	3,739	3,055	2,343	13,534
HIV infections averted among WRA	-	748	1,523	2,328	**4,599**
Status Quo Maintained: Pregnancies among HIV+ WRA	12,295	12,377	12,461	12,547	49,680
Targets Achieved: Pregnancies among HIV+ WRA	12,295	11	11,277	11,369	46,171
Pregnancies averted among HIV+ WRA	-	1,147	1,185	1,178	**3,509**
Status Quo Maintained: HIV infections among HEI	3,824	3,849	3,875	3,902	15,451
Targets Achieved: New HIV infections among HEI	3,824	2,246	1,410	910	8,389
HIV infections averted among HEI	-	1,603	2,466	2,993	**7,062**
Status Quo Maintained: Infant mortalities	602	606	611	615	2,434
Targets Achieved: Infant mortalities	602	550	553	557	2,262
Infant mortalities averted among HEI	-	56	58	58	**172**
Maternal mortalities averted among HIV+ women	-	9	9	10	**28**
DALYS saved	-	94,885	147,613	185,798	**428,296**

IN SUMMARY:

4,599
infections among WRA

3,761
pregnancies among HIV-positive women

7,062
infections among HIV exposed infants (HEI)

172
infant deaths

28
maternal deaths will be prevented by meeting the PMTCT targets.

Combined, this will result in

428,296
DALYs saved in Abia State by 2015 if the scale-up plan is implemented to scale.

Impact Estimation Methodology and Assumptions

1. **Infections averted among women of reproductive age (15-49 years)** were calculated based on state specific estimates of HIV incidence, prevalence, and population growth as well as the size of population of women of reproductive age in 2012. Prevalence estimates are based on levels ANC sentinel surveillance for each state, which is the most reliable and accepted. True incidence is difficult to measure at the state level. There is a national estimate of incidence (1%)[8], and it was used to derive state level estimates of incidence. The national estimate was adjusted for each state based on the size of the difference between the national prevalence and State specific prevalence[9] (state prevalence – national prevalence /100). Estimates of population growth[10] varied by state and are referenced accordingly as are estimates of the size of the population of women of 15-49 years by state.

2. **The number of pregnancies prevented among HIV + women** was estimated by subtracting the number of pregnancies expected if unmet need was reduced by 90% from the number of expected pregnancies among HIV + women if unmet need was not reduced. The number of expected pregnancies in each scenario was based on a couple-years of protection (CYP) conversion factor produced by MSI[11]. CYPs in each scenario were estimated based on the current contraceptive

8 National Incidence of HIV Nigeria UN Development Report http://unstats.un.org/unsd/mdg/SeriesDetail.aspx?srid=801

9 Federal Ministry of Health (2010). National HIV Sero Prevalence Sentinel Survey. FMOH Abuja Nigeria

10 National Population Commission [Nigeria] InterCensus Population Growth Rate. Abuja: National Population Commission 2009.

11 Corby N, Boler T, and Hovig D. The MSI Impact Calculator: methodology and assumptions. London: Marie Stopes International, 2009

mix observed in each state[12] and assumed 1 year of use for new adopters. The CYPs for a minimum of year of use of each method were based on region-specific standards[13]. The World Health Organization estimates of HIV transmission from mother-to-child were also based on accepted standards: transmission with ARVs is expected be 5%, and without ARVs 35%[14].

3. **The reduction in HIV infection among HIV exposed infants (HEI)** expected from meeting the PMTCT targets was estimated based on

   a. reductions in the number of infections estimated to be averted among women of reproductive age (in step 1),

   b. the number of pregnancies prevented among HIV + women due to reductions in unmet need for FP, and

   c. estimates of expected transmission rates in the presence/ absence of ARV prophylaxis during pregnancy and 1 year of breastfeeding.

4. **The estimated number of deaths averted in the first year of life** is based on

   a. reductions in the number of infections estimated to be averted among women of reproductive age (in step 1),

   b. the reduction in HIV infections among HIV exposed infants (in step 2), as well as expected mortality among infected children in the first year of life (35.2%) compared to un-infected infants (4.9%)[15].

5. **The maternal mortalities averted through PMTCT** were estimated to have been produced solely through reducing unmet need for family planning (and not through reductions in maternal mortality due to reductions in HIV incidence among WRA). The estimated CYPs that correspond to reductions in unmet need for family planning were calculated in step 2. Maternal mortalities averted were estimated for Nigeria based on the MSI calculator that converts CYPs to estimated reductions in maternal mortalities.

6. **Disability-adjusted life disability (DALYs)[16]** were estimated from several sources:

   a. reduction in HIV incidence among women of reproductive age, 2.

   b. reduced unmet need for family planning,

   c. reduced HIV infections and loss of life among infants of HIV-positive women.

12 National Bureau of Statistics (NBS). Nigeria Multiple Indicator Cluster Survey, Summary Report (2011). ABUJA NIGERIA. Last referenced (October 23, 2013): http://www.childinfo.org/files/MICS4_Nigeria_SummaryReport_2011_Eng.pdf

13 Measure Evaluation. Couple Years Protection. Website accessed October 25th 2013 http://www.cpc.unc.edu/measure/prh/rh_indicators/specific/fp/cyp

14 WHO estimates of transmission HIV with and without ART http://www.who.int/hiv/pub/mtct/PMTCTfactsheet/en/index.html

15 Newell ML et a. Mortality of infected and un-infected infants born to HIV-infected mothers in Africa: a pooled analysis. The Lancet 2004;364: 1236-1243. Last reference (October 16, 2003): http://www.ncbi.nlm.nih.gov/pubmed/15464184

16 Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990–2010: a systematic analysis for the Global Burden of Disease Study 2010. The Lancet. 2012 Dec 13; 380: 2197–2223

SECTION

7 Implementation Plan

Prong 1: Primary Prevention of HIV among women of reproductive age

Objective 1: Reduce HIV incidence among 15-49 year old women by at least 50% by 2015

Key interventions and activities	Target	Timeline			Responsible party	Funding source
		2013	2014	2015		
FOCUS AREA: PMTCT SERVICE SUPPLY SYSTEMS						
Training & capacity						
Conduct 10-day HTC training for health care workers in 342 health facilities (non-residential)	2 HCWs/facility x 10 days	Q3-Q4	Q1-Q4	Q1-Q4		
Conduct 10 day training for 2 CBOs and 1 Community Pharmacists per LGA to provide HTC services within the communities (non-residential)	51 CBOs and CPs. (3/LGA) x 10 days	Q4				
Conduct 10 day training for Community Volunteers to provide HTC services within the communities (non-residential)	5 CVs per LGA x 10 days	Q3-Q4	Q1-Q4			
Sensitization						
Conduct a bimonthly 1-day sensitization workshop for TBAs on HIV prevention activities including referrals and linkages for care	50 TBAs and 1 facilitator/ senatorial zone.	Q3-Q4	Q1-Q4			
Mentoring & supervision						
Conduct quarterly 1 day sensitization and advocacy meetings at the state, LGA and ward level to engage community resources persons for PMTCT service delivery	100 persons/meeting per zone x 3 zones	Q3-Q4	Q1-Q4			
Conduct weekly community outreach to increase awareness for PMTCT services (integrate into immunization clinics) (2 CVs to conduct 1 outreach per week per ward)	2 CVs x 291 wards (1 outreach/week/ ward)	Q2-Q4	Q1-Q4	Q1-Q4		
IEC materials						
Procure copies of the National HTC guidelines, SOPs, job aids and IEC materials for 342 facilities	342 facilities	Q3	Q1	Q1		
Distribute copies of the National HTC guidelines, SOPs, job aids and IEC materials for 342 facilities (tie to site activation/mentoring visits)	342 facilities	Q2-Q4	Q1-Q4	Q1		

Prong 1: Primary Prevention of HIV among women of reproductive age

Objective 1: Reduce HIV incidence among 15-49 year old women by at least 50% by 2015 *(continued)*

Key interventions and activities	Target	Timeline			Responsible party	Funding source
		2013	2014	2015		
FOCUS AREA: HEALTH CARE COMMODITIES						
Procurement						
Consumables						
Procure and distribute HIV test kits and consumables in line with national algorithm	2,310,554	Q4	Q3	Q2	SIT, SACA, SASCP	State Govt., Donor Partners
Confirmatory tests	462,111	Q4	Q3	Q2	SIT, SACA, SASCP	State Govt., Donor Partners
Tie Breaker	46,211	Q4	Q3	Q2	SIT, SACA, SASCP	State Govt., Donor Partners
Procure male condoms for HIV prevention	241,499,104	Q4	Q3	Q2	SIT, SACA, SASCP	State Govt., Donor Partners
Procure female condoms for HIV prevention	12,074,955	Q4	Q3	Q2	SIT, SACA, SASCP	State Govt., Donor Partners
Procure gloves, goggles, sharps boxes, etc. and commodities for Elisa screening for blood transfusion	342	Q4	Q1-Q4	Q1-Q4	SIT, SACA, SASCP	State Govt., Donor Partners
Procure ARVs for post exposure prophylaxis (TDF, 3TC, AZT, EFV, LPV/r) - Already costed	342		Q1-Q4	Q1	SIT, SACA, SASCP	State Govt., Donor Partners
Equipment						
Procure ANC equipment (autoclave and sterilization, etc.)	342		Q1-Q4	Q1	SIT, SACA, SASCP	State Govt., Donor Partners
Distribution						
Drugs						
Distribute drugs (TDF, 3TC, AZT, EFV, LPV/r) - Already costed	342		Q1-Q4	Q1-Q4	SIT, SACA, SASCP	State Govt., Donor Partners
Consumables						
Distribution of commodities	342	Q4	Q1-Q4	Q1-Q4	SIT, SACA, SASCP	State Govt., Donor Partners
Linkages/referrals						
Link clients to emergency contra-ceptives and psychosocial support	linkages	Q4	Q1-Q4	Q1-Q4	SIT, SACA, SASCP	State Govt., Donor Partners
IEC materials						
Print STI syndromic management IEC Materials	342		Q1-Q3		SIT, SACA, SASCP	State Govt., Donor Partners

Prong 2: Prevention of unintended pregnancies in women living with HIV

Objective 2: The unmet need for family planning among women living with HIV reduced by 90%

Key interventions and activities	Target	Timeline			Responsible party	Funding source
		2013	2014	2015		
Focus area: PMTCT Service Supply Systems						
Training & capacity						
Conduct 5 days non-residential training of HCW on SRH/ HIV integration (1 HCW to be trained per facility, 1 RH coordinator per LGA and 1 state coordinator)		Q4				
IEC materials						
Procure copies of the National SRH guidelines, SOPs, job aids and IEC materials for 342 facilities	342 facilities	Q2-Q4	Q1-Q4	Q1		
Distribute copies of the National SRH guidelines, SOPs, job aids and IEC materials for 342 facilities (tie to site activation/mentoring visits)	342 facilities	Q2-Q4	Q1-Q4	Q1		
Service Delivery						
Provide family planning services to 5,000 HIV positive non-pregnant women/annum (no cost)		Q2-Q4	Q1-Q4	Q1		
Focus area: Health Care commodities						
Procurement						
Consumables					SIT, SACA, SASCP	FMOH/UNFPA
Procurement of FP commodities (Condoms, COC, POP, Injectables - Depo, Noristerat, Implants - Jadelle, Implanon, IUCD)	0	Q4	Q1-Q4	Q1	SIT, SACA, SASCP	State Govt., Donor Partners
Procurement of FP consumables (needles & syringes, cotton wool, gloves, methylated spirit, Jik)	33,734	Q4	Q1-Q4	Q1	SIT, SACA, SASCP	State Govt., Donor Partners
Procure emergency contraception	-	Q4	Q1-Q4	Q1		
Equipment						
Procure Equipment for Family Planning (clinic couches, angle lamp, sterilization units, IUCD insertion kits, weighing scale, BP apparatus, stethoscope, Jadelle insertion kits, sharps boxes, furniture etc) -Already costed under Equipment procurement & Maintenance	342	Q4	Q1-Q4	Q1	SIT, SACA, SASCP	State Govt., Donor Partners

Prong 2: Prevention of unintended pregnancies in women living with HIV

Objective 2: The unmet need for family planning among women living with HIV reduced by 90% *(continued)*

Key interventions and activities	Target	Timeline			Responsible party	Funding source
		2013	2014	2015		
Focus area: Health Care commodities *(continued)*						
Distribution						
Consumables						
Distribution of commodities through cluster review and resupply meeting	342	Q4	Q1-Q4	Q1-Q4	SIT, SACA, SASCP	State Govt., Donor Partners
Stock management (CLMS)						
Capacity building on CLMS (Contraceptive Logistic Management System) for nurses and CHEWS	30	Q4			SIT, SACA, SASCP	State Govt., Donor Partners
FP Models e.g. penile, pelvis, gynaecological models	342	Q4	Q1-Q4		SIT, SACA, SASCP	State Govt., Donor Partners
Focus area: PMTCT demand creation systems						
Training on IPC						
Conduct a 10 day training for 40 select communication officers in Social & behaviour change communication at state and local government levels	40 communication officers.					
Conduct 21 community outreaches to carry-out HCT and generate demand for PMTCT	21 outreaches to over 300 market women.				ABSACA, SMOWASD, SMOH, LACA	
Conduct 3-day residential trainings for 105 Ward Development Committee members as agents to develop talking points and also create demand for PMTCT services (35 wards per LGA)	105 WDC members x 3 days (35 Wards per LGA)					
Conduct 3 day training for 3 community resource persons (CORPS) on PMTCT/HCT.	21 CORPs (3/ LGA x 17 LGAs)				FMoH/SMoH, SMoWASD	
Support with training materials					ABMOH/ABPHCB/ LACA	
Conduct training for 50 TBAs and FBOs/LGA in 17 LGAs on PMTCT,MNCH and providing referrals to new PHCs						
Sensitization						
Conduct one day sensitization meeting with stakeholders on importance of PMTCT services, 50 persons from each of the 3 senatorial zones.	150 persons				ABMOH/ SMOWASD, ABPHCB/LACA	SMOH
Conduct community sensitization in wards for community influencers and gatekeepers					ABMOH/ SMOWASD, ABPHCB/ LACA	

Prong 2: Prevention of unintended pregnancies in women living with HIV

Objective 2: The unmet need for family planning among women living with HIV reduced by 90% *(continued)*

Key interventions and activities	Target	Timeline			Responsible party	Funding source
		2013	2014	2015		
Focus area: PMTCT demand creation systems *(continued)*						
IEC materials						
Print and provide the Ward Development Committees with appropriate tools to advocate for increased uptake and integration of PMTCT services within the community and the facilities. (This budget includes production of IEC, radio, TV, job aids, etc.)					ABMOH/ABPHCB/ SMoI	SMOH
Adapt and translate IEC materials for the general population	General population				ABMOH/ABPHCB	
Production of IEC materials for (market) women of reproductive age (15-49 years old)	Women of reproductive age				ABMOH/ABPHCB/ LACA	
Media engagement						
Radio and TV jingles generating demand for PMTCT service uptake developed					ABMOH/ABPHCB/ SMoI	SMOH
Radio and TV jingles aired 180 times per month on major radio stations to target women of reproductive age (15-49)	TV and radio Jingles x 180 times				ABMOH/ABPHCB/ SMoI	SMOH
Radio jingle on PMTCT male involvement and safe disclosure developed					ABMOH/ABPHCB/ SMoI	
Radio jingle on PMTCT male involvement and safe disclosure aired 180 times/month on major radio stations in the state for men	Radio Jingles x 180 times.				ABMOH/SMoI, ABPHCB	
Road shows and drama campaigns conducted in 60 communities for community influencers and gatekeepers	60 communities				FMoH/SMoH, SMoWASD	
Referral/linkages						
Hold 1-day advocacy orientation meeting for key stakeholders (at the State and Local Government levels) on using the advocacy talking point guide						
Print and distribute 30,000 booklets of referral forms to TBAs for pregnant women.	3000 booklets of referral forms				ABMoH/ABPHCB, SMoI	SMOH

Prong 3: Prevention of unintended pregnancies in women living with HIV

Objective 3: Increase access to quality HIV counseling and testing to at least 90% of pregnant women by 2015

Objective 4: ARV prophylaxis for PMTCT received by at least 90% of all HIV positive pregnant women and breastfeeding infant-mother pairs

Key interventions and activities	Target	Timeline			Responsible party	Funding source
		2013	2014	2015		
Focus area: PMTCT Service supply system						
Service delivery						
Set up logistics for DBS sample collection, transport and result retrieval (including CD4 sample transfer)	342 facilities	Q2-Q4	Q1-Q4	Q1-Q4		
Training & capacity						
Conduct 6-day Integrated PMTCT training for HCWs in 42 SHCs at the rate of 3 per SHC.	126 healthcare workers x 6 days (42 SHCs at the rate of 3 per SHC).	Q2-Q4	Q1-Q4	Q1		
Conduct 5-day IMAI/IMPAC training for HCWs in 126 PHCs at 2 healthcare workers trained per PHC.	126 healthcare workers x 5days	Q3	Q2			
Conduct 5-day pharmaceutical care trainings for pharmacists in PMTCT sites (secondary health facilities and CP preceptors) including LMIS	2 pharmacy staff / PMTCT site x 5 days	Q3	Q2	Q1		
Conduct 2-day ART dispensing and documentation training for nurses/ pharmacy technicians in PHCs	1 dispensing officer trained/PHC for 2 days	Q3	Q2	Q1		
Conduct 5-day onsite pharmacy best practices training for HCW in SHC and PHCs	1 pharmacy staff / SHC and PHC for 5 days	Q3	Q2	Q1		
Conduct 5-day Laboratory training for laboratory scientists and technicians on quality assurance in 342 health facilities (1 per facility)	342 facilities (1/ facility)	Q3	Q2	Q1		
Conduct a 3-day training on Infection Prevention and Control (IPAC) for HCW in 342 sites (1 per site)	342 sites (1 per site)	Q3	Q2	Q1		
Linkages/referrals						
Conduct 2-day adherence counseling and referral trainings for HCWs, CBO, mentor mothers	1 adherence counsellor / facility, 1 CP preceptor, 1 CBO , 2 mentor mothers /LGA	Q3	Q2	Q1		
Link active EID sites to the National PCR Lab (no cost)		Q2-Q4	Q1-Q4	Q1-Q4		

Prong 3: Prevention of unintended pregnancies in women living with HIV

Objective 3: Increase access to quality HIV counseling and testing to at least 90% of pregnant women by 2015 *(continued)*

Objective 4: ARV prophylaxis for PMTCT received by at least 90% of all HIV positive pregnant women and breastfeeding infant-mother pairs *(continued)*

Key interventions and activities	Target	Timeline			Responsible party	Funding source
		2013	2014	2015		
Focus area: PMTCT Service supply system *(continued)*						
Mentoring & supervision						
Conduct monthly mentoring visits and joint supervisory to PMTCT sites	4 persons /site / month x 342 facilities	Q4	Q1-Q4	Q1-Q4		
Conduct quarterly service quality improvements in PMTCT sites	2 persons /site per quarter x 342 facilities	Q4	Q1-Q4	Q1-Q4		
Site activation						
Activate 342 sites for PMTCT/EID/RH service provision	4 persons/ site for 1 day each/site	Q4	Q3	Q2		
IEC materials						
Procure copies of the National PMTCT guidelines, SOPs, job aids and IEC materials for 342 facilities	342 facilities	Q3-Q4	Q1, Q2 & Q4	Q1-Q4		
Distribute copies of the National PMTCT guidelines, SOPs, job aids and IEC materials for 342 facilities (tie to site activation and mentoring visits)	342 facilities	Q3-Q4	Q1-Q4	Q1-Q4		
Procure IMPAC training materials for 126 PHCs	126 PHCs	Q3-Q4	Q1-Q4	Q1-Q4		
Distribute IMPAC training materials for 126 PHCs (tie to trainings/ site activation)	126 PHCs	Q3-Q4	Q1-Q4	Q1-Q4		
Focus area: Health care commodities						
Procurement (quantification, forecasting)						
Drugs						
Procurement of ARVs for triple prophylaxis (TDF + 3TC + EFV) 90%	34,918.2	Q4	Q1-Q4	Q1	SIT, SACA, SASCP	State Govt., Donor Partners
Procurement of ARVs for triple prophylaxis (AZT + 3TC + EFV) 5%	1,939.9	Q4	Q1-Q4	Q1	SIT, SACA, SASCP	State Govt., Donor Partners
Procurement of ARVs for triple prophylaxis (other regimen) 5%	1,939.9	Q4	Q1-Q4	Q1	SIT, SACA, SASCP	State Govt., Donor Partners
Procurement of OI medication (CTX)	38,798	Q4	Q1-Q4	Q1	SIT, SACA, SASCP	State Govt., Donor Partners

Prong 3: Prevention of unintended pregnancies in women living with HIV

Objective 3: Increase access to quality HIV counseling and testing to at least 90% of pregnant women by 2015 *(continued)*

Objective 4: ARV prophylaxis for PMTCT received by at least 90% of all HIV positive pregnant women and breastfeeding infant-mother pairs *(continued)*

Key interventions and activities	Target	Timeline			Responsible party	Funding source
		2013	2014	2015		
Focus area: Health care commodities *(continued)*						
Procurement (quantification, forecasting) *(continued)*						
Drugs *(continued)*						
Procurement of Haematenics	38,798	Q4	Q1-Q4	Q1	SIT, SACA, SASCP	State Govt., Donor Partners
Procurement of other commodities (antibiotics, antifungals, etc.)	3,880	Q4	Q1-Q4	Q1	SIT, SACA, SASCP	State Govt., Donor Partners
Procurement of NVP syrup for babies	36,858	Q4	Q1-Q4	Q1	SIT, SACA, SASCP	State Govt., Donor Partners
Procurement of CTX for babies	36,858	Q4	Q1-Q4	Q1	SIT, SACA, SASCP	State Govt., Donor Partners
Procurement of Safe Delivery Kit	38,798	Q4	Q1-Q4	Q1	SIT, SACA, SASCP	State Govt., Donor Partners
Procurement of ITNs, SP and Drugs for treatment of malaria	38798	Q4	Q1-Q4	Q1	SIT, SACA, SASCP	State Govt., Donor Partners
Equipment						
Procurement of air-conditioners & refrigerators for lab and pharmacy	72	Q4	Q1-Q4	Q1	SIT, SACA, SASCP	State Govt., Donor Partners
Procurement of lab equipment for PHCs (POC CD4 and accessories)	30	Q4	Q1-Q4	Q1	SIT, SACA, SASCP	State Govt., Donor Partners
Procurement of lab equipment, starter reagents and consumables for Secondary Health facilities (CD4, Chemistry and Haematology)	300	Q4	Q1-Q4	Q1	SIT, SACA, SASCP	State Govt., Donor Partners
Procure of laboratory machines (PCR)	1	Q4	Q1-Q4	Q1	SIT, SACA, SASCP	State Govt., Donor Partners
Procurement of lab equipment & maintenance	42	Q4	Q1-Q4	Q1	SIT, SACA, SASCP	State Govt., Donor Partners
Procurement and distribution of SMS printers	72	Q4	Q1-Q4	Q1	SIT, SACA, SASCP	State Govt., Donor Partners
Consumables						
Procurement of DBS kits	0	Q4	Q1-Q4	Q1	SIT, SACA, SASCP	State Govt., Donor Partners
Distribution of DBS kits (all distribution pooled)	342	Q4	Q1-Q4	Q1-Q4	SIT, SACA, SASCP	State Govt., Donor Partners
Procurement of RTKs (already costed in Prong 1)	318, 346	Q4	Q1-Q4	Q1	SIT, SACA, SASCP	State Govt., Donor Partners

Prong 3: Prevention of unintended pregnancies in women living with HIV

Objective 3: Increase access to quality HIV counseling and testing to at least 90% of pregnant women by 2015 *(continued)*

Objective 4: ARV prophylaxis for PMTCT received by at least 90% of all HIV positive pregnant women and breastfeeding infant-mother pairs *(continued)*

Key interventions and activities	Target	Timeline			Responsible party	Funding source
		2013	2014	2015		
Focus area: Health care commodities *(continued)*						
Distribution						
Drugs						
Distribution of ARV and OIs	342	Q4	Q1-Q4	Q1	SIT, SACA, SASCP	State Govt., Donor Partners
Logistics						
Sample transfer for logging (DBS)	342	Q4	Q1-Q4	Q1-Q4	SIT, SACA, SASCP	State Govt., Donor Partners
Sample transfer for Chemistry and Haematology	0	Q4	Q1-Q4	Q1-Q4	SIT, SACA, SASCP	State Govt., Donor Partners
Focus area: PMTCT demand creation systems						
Monitoring & supervision						
17 support group meetings held monthly in 1 LGA each	17 Support group meetings x 17 LGAs				ABMOH/LSACA	SMOH
17 ASHWAN support groups supported for ongoing mentorship to Women LHIV	17 support groups				ABSACA,SMOH,	ABSACA
Training on IPC						
Provide IPC & Couple counseling training to 2 HCW each in 5 PHCs of 17 LGA (170 PHCs)	170 HCWs				ABSACA,SMOH, SMoYD	
Training of peer educators on the importance of male involvement in PMTCT program	120 male peer educators					

Prong 4: Family centered care and support

Objective 5: Early HIV diagnosis services accessed by at least 90% of all HIV exposed infants

Objective 6: Life-long ART received by at least 90% of the pregnant infected women requiring treatment for their own health

Key interventions and activities	Target	Timeline			Responsible party	Funding source
		2013	2014	2015		
Focus area: PMTCT Service Supply Systems						
Linkages/referral						
Support referral and linkages of HIV positive pregnant women on lifelong ART and infected infants to comprehensive treatment sites (cost to be linked with client tracking)						
Mentoring & supervision						
Identify and support community-based mentor mothers to provide support for PMTCT service provision (including referrals, health talks, adherence counseling, client tracking, home based care)	85 mentor mothers (5/ LGA)	Q3-Q4	Q1-Q4	Q1-Q4		
Support HCWs/CBOs/support groups to conduct monthly client tracking	2 facility/CBO staff	Q3-Q4	Q1-Q4	Q1-Q4		
Focus area: Health care commodities						
Procurement (quantification, forecasting)						
Consumables						
Nutritional Support (Plumpy Nuts)	0	Q4	Q1-Q4	Q1-Q4	SIT, SACA, SASCP	State Govt., Donor Partners
Procurement of Internet modems and airtime	42	Q4	Q1-Q3		SIT, SACA, SASCP	State Govt., Donor Partners
Procurement of Basic Care Kit	38,798		Q1-Q4	Q1-Q2	SIT, SACA, SASCP	State Govt., Donor Partners
Supervision						
Supportive supervision for LMIS reporting	42					
Conduct Logistic TWG meetings (Bi-monthly)	15	Q4	Q3	Q2	SIT, SACA, SASCP	State Govt., Donor Partners

Prong 4: Family centered care and support

Objective 7: Ensure effective management: coordination, resourcing, monitoring and evaluation, of the e-PMTCT elimination plan *(continued)*

Key interventions and activities	Target	Timeline			Responsible party	Funding source
		2013	2014	2015		
Focus area: Monitoring and evaluation						
Data Quality Assurance						
Supply all Health facilities (public and private) with current M&E/ HMIS tools		Q3-Q4	Q1-Q4	Q1-Q4	SMoH/DPRS	PMTCT Scale-up Plan funds
Train all health facility health records staff on the current M&E/ HMIS tools, data management and data use	1,500 record officers	Q4	Q1-Q4		SMoH/DPRS, SACA & FHI 360	PMTCT Scale-up Plan funds, NMCP, UNFPA and WHO
LGA M&E/HMIS Officer to conduct performance analysis of the health facility reporting rates at both LGAs/State M&E meetings	36 months performance analysis	Q4	Q1-Q4	Q1-Q4	LGA HMIS Officers	N/A
Train existing Health Record Officers on health record management and M&E data management	1,500 Health Facility record officers	Q4	Q1-Q4		SMoH/DPRS, SACA & FHI 360	PMTCT Scale-up Plan funds, UNFPA and WHO
1-day stakeholders meeting at state-level to design and agree on Integrated Health Data Management approach by all State Health Program Officers and partners		Q3-Q4			SMoH/DPRS and SACA and Partners	PMTCT scale-up plan
1-day step-down stakeholders orientation at zonal-level to understand Integrated Health Data Management approach by all LGA Health Program Officers and partners		Q4			SMoH/DPRS and SACA and Partners	PMTCT scale-up plan
State DPRS & SACA to organize DHIS and Data Management training for 12 LGAs yet to be trained	12 LGA HMIS Officers	Q4			SMoH/DPRS and SACA and Partners	UNFPA & FHI 360
Establish State and LGA health data management teams to facilitate Integrated M&E/HMIS Supportive Supervision (ISS) and Data Quality Assurance (DQA)		Q4	Q1		SMoH/DPRS and SACA and Partners	PMTCT scale-up plan
Procurement of 3 Project Vehicles for Monitoring & Evaluation/HMIS activities	3 Toyota Hilux	Q4	Q1		SMoH/DPRS	PMTCT scale-up plan
Strategic information						
LGA M&E/HMIS Officer to conduct performance analysis of the health facility reporting rates at both LGAs/State M&E meetings	36 months performance analysis	Q4	Q1-Q4	Q1-Q4	LGA HMIS Officers	N/A

Prong 4: Family centered care and support

Objective 7: Ensure effective management: coordination, resourcing, monitoring and evaluation, of the e-PMTCT elimination plan *(continued)*

Key interventions and activities	Target	Timeline			Responsible party	Funding source
		2013	2014	2015		
Focus area: Monitoring and evaluation *(continued)*						
Central database						
FHI 360 to discuss the need for harmonization of DHIS 2.0 instances with NACA and FMoH/DPRS		Q3-Q4			FHI 360 Country Office M&E Team	N/A
Routine monitoring						
Monthly LGAs M&E Coordination meetings established to review performance and advice on use of health data		Q4	Q1-Q4	Q1-Q4	SMoH/DPRS and SACA and Partners	PMTCT scale-up plan
Quarterly State M&E Coordination meetings established to review performance and advice on use of health data		Q4	Q1-Q4	Q1-Q4	SMoH/DPRS and SACA and Partners	PMTCT scale-up plan
Monthly routine sites supportive supervision by LGA data management team members	2,040 supervision visits (10 sites/ month/ LGA members)	Q4	Q1-Q4	Q1-Q4	State HMIS Officer and State Health Data Management Team	PMTCT scale-up plan
Quarterly state supportive supervision by state data management team members	5 LGAs visits/ month/ 2 LGA members	Q4	Q1-Q4	Q1-Q4	LGA HMIS Officers and LGA Health Data Management Team	PMTCT scale-up plan
Hold an annual state-level Health Data Producers and User (HDPU) meeting		Q4	Q3	Q2	SMoH/DPRS	PMTCT scale-up plan
Hold bi-annual state-level Health Data Consultative Committee (HDCC) meeting		Q4	Q2 & Q4	Q2 & Q4	SMoH/DPRS	PMTCT scale-up plan
Production of Quarterly Health Program Coverage analysis reports	4 quarterly health data bulletin / year	Q4	Q1-Q4	Q1-Q4	SMoH/DPRS	N/A
Capacity building						
Train existing Health Record Officers on health record management and M&E data management	1,500 health facility record officers	Q4	Q1-Q4		SMoH/DPRS, SACA & FHI 360	PMTCT Scale-up Plan funds, UNFPA and WHO
Advocacy						
Advocate to LGAs and State Government to commence incremental funding of printing and supply of M&E/HMIS tools from Year 3	4 advocacy visits.	Q4	Q1		SMoH/DPRS and SACA and Partners	PMTCT scale-up plan
Advocate to LGAs and State Government to release funds appropriated in the budget for M&E/ HMIS activities	4 advocacy visits.	Q4	Q1		SMoH/DPRS and SACA and Partners	PMTCT scale-up plan

Prong 4: Family centered care and support

Objective 7: Ensure effective management: coordination, resourcing, monitoring and evaluation, of the e-PMTCT elimination plan *(continued)*

Key interventions and activities	Target	Timeline			Responsible party	Funding source
		2013	2014	2015		
Focus area: Monitoring and evaluation *(continued)*						
Site activation						
All sites, LGAs and State M&E teams re-orientated on forecasting, procurement and supply chain management (PSCM) of M&E/ HMIS tools		Q4	Q1-Q4	Q1-Q4	SMoH/DPRS and SACA and Partners	N/A
Focus area: Program management						
Coordination and resource mobilization						
Adapt the national strategy for private sector engagement for the state	Hire one consultant for 10 working days	Q1			SACA	SACA/WB
Annual progress review meetings with all stakeholders including private and public health facilities			Q3	Q3		
Print and circulate annual progress report	2500 copies					
Conduct semi - annual progress review meetings with service providers.	6 review meetings		Q1 & Q3	Q1 & Q3	SIT	PEPFAR, GF, WB, UNICEF & WHO
Conduct quarterly supportive supervision and CQI visits to HFs		Q4	Q1-Q4	Q1-Q4	SIT	PEPFAR /PPFN
Support quarterly meeting of the PMTCT Task Team		Q3 & Q4	Q1-Q4	Q1-Q4		
Conduct semi- annual meeting of the State Management Team (Commissioners (SMoH & SMoW& SD) Permanent Secretaries, CE (HMB) and Directors) to review progress			Q1 & Q3	Q1 & Q3	SIT	PEPFAR
Hold Monthly JSIT meetings to review progress with SIDHAS staff and GSIT Members		Q3-Q4	Q1-Q4	Q1-Q4	SPM/SIT	PEPFAR
Hold semi- annual public-private sector forum to engender private sector participation and support			Q2 & Q4	Q2	SACA	SACA/WB
Develop and share annual budget with Abia State Planning Commission to feed into the SMoH and SACA annual budget		Q4	Q1 & Q4	Q1 & Q4		

Prong 4: Family centered care and support

Objective 7: Ensure effective management: coordination, resourcing, monitoring and evaluation, of the e-PMTCT elimination plan *(continued)*

Key interventions and activities	Target	Timeline			Responsible party	Funding source
		2013	2014	2015		
Focus area: Program management *(continued)*						
Situation analysis						
Develop and disseminate PMTCT scale up operational plan 2013 – 2015 to Key stakeholders and Health Service Providers		Q3			SIT & Implementing Partners	PEPFAR
Print and distribute costed state scale up operational plan	2500 copies of the state costed plan	Q4			FHI 360	PEPFAR
Conduct resource mapping and gap analysis			Q1		SASCP/SACA	SACA
HR & staffing						
Recruitment of relevant personnel based on identified HR gaps from activity 1.1.			Q1 & Q2		HMB, Civil Service Commission & LG Service Commission	State Government
Capacity building						
Conduct rapid facility assessment to define human resources, infrastructure and service gaps, personnel in tertiary, secondary and primary health facilities	1, 341 health facilities	Q2 & Q4				
Conduct a one-day orientation and deployment of newly recruited health care workers			Q1 & Q2			
Infrastructure						
Conduct physical infrastructural assessment of selected PMTCT sites to identify infrastructure gaps and upgrade needs (linked to prong 1 upgrades)		Q2 & Q3				
Develop bills of quantities for the facility upgrades		Q4	Q1			
Carry out renovation of identified HFs		Q4	Q1-Q4	Q1	FHI360	PEPFAR
Procurement and supplies of relevant furniture items and office equipment to all PMTCT HFs		Q4	Q1-Q4	Q1	SIT & Facility management	PEPFAR
Procurement of 2 vehicles, a truck and Hilux, for distribution health commodities from state medical store to all PMTCT HFs		Q4	Q1 & Q2		SMoH	State Government

Prong 4: Family centered care and support

Objective 7: Ensure effective management: coordination, resourcing, monitoring and evaluation, of the e-PMTCT elimination plan *(continued)*

Key interventions and activities	Target	Timeline			Responsible party	Funding source
		2013	2014	2015		
Focus area: Program management *(continued)*						
Community mobilization						
Advocacy						
Conduct advocacy to the Executive Governor to secure a waiver to recruit relevant health personnel		Q4	Q1-Q4	Q1-Q4		
Conduct advocacy to the First Lady to mobilize support for improved HR for Health at state and LGA levels		Q3-Q4	Q1-Q4	Q1-Q4	SMoH & SMoWA&SD with IPs	SACA/WB & PEPFAR
Advocacy and sensitization meeting with tertiary health institutions in the state to develop partnership through an MoU to address HR gaps by posting residents to HFs	Heads of tertiary health institutions	Q3-Q4	Q1-Q4	Q1-Q4	SMoH & HMB	State Government
Develop advocacy package (State Governor, private sector etc.)			Q1 & Q4		SIT	PEPFAR
Carry out advocacy to the State Governor to facilitate the allocation and timely release of funds for the implementation of PMTCT activities		Q3-Q4	Q1-Q4	Q1-Q4	SIT& SACA/HMB with IPs	
Sensitization						
Conduct 1-day sensitization meeting with NMA, NANNM, PSN, AGPMPN, PSN, ACPN and AMLSN consisting of five participants from each of the organizations and 10 GSIT members	55 participants (45 associations+ 10 GSIT members)		Q1		SMoH & SACA with IPs	SACA/WB & PEPFAR
Conduct 1-day sensitization meeting with NMA, NANNM, PSN, AGPMPN, PSN, ACPN and AMLSN	35 representatives (3 x 7 organizations)	Q4				
Conduct 1-day sensitization workshop for private sector and other business enterprises to secure their commitment and funding support for the roll out of the PMTCT scale up plan in Abia State	.		Q1	Q1	SMoH & HMB	PEPFAR

SECTION

8 Monitoring and Evaluation Plan

The existing Information Management System will be utilised for routine collection of programme data using the appropriate registers and reporting forms provided at by all the implementing health facilities. Reporting will follow established channels of reporting already existing. Data reporting from the communities/ facilities go through the LGA to the state level where data will be compiled and shared for use in planning and policy formulation and decision making processes. The core indicators are summarised in table 7 below:

Table 6: Targets of the Core Indicators for Abia State

Indicator	2012 (baseline)	2013	2014	2015
Number of health facilities that provide ANC plus PMTCT services (790 ANC facilities at R-HFA)	46	82	287	355
Number females age 15 – 49yrs newly tested HIV positive	4,397	3,739	3,055	2,343
Number of pregnant women counselled tested and given HIV results	21,552	82,190	126,658	156,150
Number of HIV infected women aged 15 – 49 years who accessed comprehensive family planning services	N/A	1,449	1,497	1,488
Number of pregnant women reached with antiretroviral drugs for PMTCT according to the national guidelines	1,659	6,316	9,733	11,999
Number of HIV positive pregnant women in need of treatment initiated on ART for their own health (50% of total)	983	3,158	4,866	6,666
Number of HIV exposed infants offered first PCR test from 6 – 8 weeks of age	86	6,316	9,733	11,999

8.1 ABIA STATE PMTCT M&E FRAMEWORK

GOAL	Improved maternal health and child survival by 2015 through the accelerated provision of comprehensive services for elimination of mother-to-child transmission of HIV			
PMTCT PRONG	HIV infection prevented among women of child-bearing age	Un-intended pregnancy prevented among women living with HIV	Mother-to-child transmission of HIV prevented	Family-centred HIV care, treatment and support provided
STATE OBJECTIVES	Reduced HIV incidence among 15-49 year old women by at least 50% by 2015	The unmet need for family planning among women living with HIV reduced by 90%	• Quality HIV counselling and testing accessed by at least 90% of all pregnant women • ARV prophylaxis for PMTCT received by at least 90% of all HIV positive pregnant women and breastfeeding infant-mother pairs	Family-centred HIV care, treatment and support provided
STATE INDICATORS	Percentage of females' age 15 – 24 yrs tested HIV positive	Number of clients accessing RH/FP counseling or services by HIV service referral point (PMTCT)	• No & proportion of health facilities that provide PMTCT services • No. & proportion of pregnant women counselled, tested and given HIV results • No. & proportion of pregnant women reached with antiretroviral drugs for PMTCT according to the national guidelines • No. & proportion of HIV exposed infants offered antiretroviral drugs for PMTCT according to the national guidelines • No. & proportion of HIV positive pregnant women offered quality infant feeding counselling	• No. & proportion of HIV positive pregnant women in need of treatment initiated on ART for their own health (40% of total) • No. & proportion of HIV exposed infants offered first PCR test from 6 – 8 weeks of age

SECTION

9 Summary Budget

The summary budget for the Abia State eMTCT plan is presented below. The detailed budget can be found in the appendix.

Table 7: Budget Summary Table

THEMATIC AREAS	Year 1 (NAIRA)	Year 2 (NAIRA)	Year 3 (NAIRA)	Total (NAIRA)	Total (DOLLAR)
PMTCT supply service systems	187,557,100	436,766,300	233,317,800	857,641,200	5,533,169
Health care commodities	2,231,571,758	5,005,093,826	1,411,263,610	8,647,929,194	55,793,092
PMTCT demand creation systems	66,925,280	138,454,840	44,536,480	249,916,600	1,612,365
Monitoring and evaluation	164,835,100	140,056,250	49,075,500	353,966,850	2,283,657
Program management	522,678,700	750,878,400	39,806,800	1,313,363,900	8,473,315
Total	**3,173,567,938**	**6,471,249,617**	**1,778,000,190**	**11,422,817,745**	**73,686,824**

SECTION

10 Appendix- Detailed Budget

Objective 1: Reduce HIV incidence among 15-49 year old women by at least 50% by 2015

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget Less One-off activities (Naira)
THEMATIC AREA: PMTCT SERVICE SUPPLY SYSTEMS			
Training & capacity	Conduct 10-day HTC training for health care workers in 342 health facilities (non-residential)	10,988,500	30,953,500
	Conduct 10-day training for CBOs and Community Pharmacists to provide HTC services within the communities (non-residential)	6,160,000	-
	Conduct 10-day training for Community Volunteers to provide HTC services within the communities (non-residential)	7,250,500	7,250,500
Sensitization	Conduct a bimonthly 1-day sensitization workshop for TBAs on HIV prevention activities including referrals and linkages for care	2,320,500	4,641,000
Mentoring & supervision	Conduct quarterly 1-day sensitization and advocacy meetings at the state, LGA and ward level to engage community resource persons for PMTCT service delivery	10,560,000	7,040,000
	Conduct weekly community outreaches to increase awareness for PMTCT services (integrate into immunization clinics)	62,856,000	136,188,000
IEC materials	Procure copies of the National HTC guidelines, SOPs, job aids and IEC materials for 342 facilities	476,100	1,414,500
	Distribute copies of the National HTC guidelines, SOPs, job aids and IEC materials for 342 facilities (tie to site activation/mentoring visits)		
PMTCT service supply systems sub-total		**100,611,600**	**187,487,500**
THEMATIC AREA: HEALTH CARE COMMODITIES			
Procurement (quantification, forecasting)	Procure and distribute HIV test kits and consumables in line with national algorithm	110,906,592	332,719,776
	Confirmatory tests	41,589,990	124,769,970
	Tie Breaker	4,158,990	12,476,970
	Procure male condoms for HIV prevention	193,199,283	579,597,850
	Procure female condoms for HIV prevention	449,188,326	1,347,564,978
	Procure gloves, goggles, sharps boxes, etc. and commodities for Elisa screening for blood transfusion	20,520,000	61,560,000
	Procure ARVs for post exposure prophylaxis (TDF, 3TC, AZT, EFV, LPV/r) - Already costed	147,843,659	443,530,976

Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)	Responsible Authority	Funding Source
10,988,500	52,930,500	341,487		
-	6,160,000	39,742		
-	14,501,000	93,555		
-	6,961,500	44,913		
-	17,600,000	113,548		
136,188,000	335,232,000	2,162,787		
476,100	2,366,700	15,269		
	-	-		
147,652,600	**435,751,700**	**2,811,301**		
110,906,592	554,532,960	3,577,632	SIT, SACA, SASCP	State Govt., Donor Partners
41,589,990	207,949,950	1,341,613	SIT, SACA, SASCP	State Govt., Donor Partners
4,158,990	20,794,950	134,161	SIT, SACA, SASCP	State Govt., Donor Partners
193,199,283	965,996,416	6,232,235	SIT, SACA, SASCP	State Govt., Donor Partners
449,188,326	2,245,941,630	14,489,946	SIT, SACA, SASCP	State Govt., Donor Partners
20,520,000	102,600,000	661,935	SIT, SACA, SASCP	State Govt., Donors
147,843,659	739,218,294	4,769,150	SIT, SACA, SASCP	State Govt., Donor Partners

SECTION
10 APPENDIX-DETAILED BUDGET

Objective 1: Reduce HIV incidence among 15-49 year old women by at least 50% by 2015 *(continued)*

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget Less One-off activities (Naira)
THEMATIC AREA: HEALTH CARE COMMODITIES *(CONTINUED)*			
Procurement (quantification, forecasting) *(continued)*	***Equipment***		
	Procure ANC equipment (autoclave and sterilization, etc.)	35,749,260	107,247,780
Distribution	***Drugs***		
	Distribute drugs (TDF, 3TC, AZT, EFV, LPV/r) - Already costed	1,792,000	3,584,000
	Consumables		
	Distribution of commodities	735,000	2,205,000
Linkages/ referrals	Link clients to emergency contraceptives and psychosocial support	-	-
IEC materials	Print STI syndromic management IEC materials	20,000,000	-
Health care commodities sub-total		**1,025,683,100**	**3,015,257,300**
Objective 1 sub-total		**1,126,294,700**	**3,202,744,800**

Objective 2: The unmet need for family planning among women living with HIV reduced by 90%

THEMATIC AREA: PMTCT SERVICE SUPPLY SYSTEMS			
Training & capacity	Conduct 5-day training of HCW on SRH/ HIV integration (non- residential)	8,568,000	-
IEC materials	Procure copies of the National SRH guidelines, SOPs, job aids and IEC materials for 342 facilities	476,100	1,414,500
	Distribute copies of the National SRH guidelines, SOPs, job aids and IEC materials for 342 facilities (tie to site activation/mentoring visits)		
Service delivery	Provide family planning services to 5,000 HIV positive non-pregnant women/annum (no cost)		
PMTCT service supply systems sub-total		**9,044,100**	**1,414,500**

Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)	Responsible Authority	Funding Source
35,749,260	178,746,300	1,153,202	SIT, SACA, SASCP	State Govt., Donor Partners
1,792,000	7,168,000	46,245	SIT, SACA, SASCP	State Govt., Donor Partners
735,000	3,675,000	23,710	SIT, SACA, SASCP	State Govt., Donor Partners
-	-	-	SIT, SACA, SASCP	State Govt., Donor Partners
-	20,000,000	129,032	SIT, SACA, SASCP	State Govt., Donor Partners
1,005,683,100	**5,046,623,500**	**32,558,861**		
1,153,335,700	**5,482,375,200**	**35,370,163**		

-	8,568,000	55,277		
469,200	2,359,800	15,225		
	-	-		
	-	-		
469,200	**10,927,800**	**70,502**		

SECTION
10 APPENDIX-DETAILED BUDGET

Objective 2: The unmet need for family planning among women living with HIV reduced by 90% *(continued)*

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget Less One-off activities (Naira)
THEMATIC AREA: HEALTH CARE COMMODITIES			
Procurement (quantification, forecasting)	***Consumables***		
	Procurement of FP commodities (condoms, COC, POP, Injectables - Depo, Noristerat, Implants - Jadelle, Implanon, IUCD)	-	-
	Procurement of FP consumables (needles & syringes, cotton wool, gloves, methylated spirit, Jik)	3,373,400	10,120,200
	Procure emergency contraception	506,011	-
	Equipment		
	Procure Equipment for family planning (clinic couches, angle lamp, sterilization units, IUCD insertion kits, weighing scale, BP apparatus, stethoscope, Jadelle insertion kits, sharps boxes, furniture etc) -Already costed under Equipment procurement & Maintenance	-	-
Distribution	***Consumables***		
	Distribution of commodities through cluster review and resupply meeting	1,792,000	3,584,000
Stock management (CLMS)	Capacity building on CLMS (Contraceptive Logistic Management System) for nurses and CHEWS	3,516,000	-
	FP Models e.g penile, pelvis, gynecological models	1,026,000	-
Health care commodities sub-total		**10,213,411**	**13,704,200**
THEMATIC AREA: PMTCT DEMAND CREATION SYSTEMS			
Training on IPC	Conduct a 10-day training for 40 select communication officers in Social & behaviour change communication at State and Local government levels	13,055,000	-
	Conduct community outreaches to carry-out HCT and generate demand for PMTCT	351,750	1,055,250
	Conduct 3-day residential training for 105 Ward Development Committee members as agents to develop talking points create demand for PMTCT services (35 Wards per LGA)	4,154,000	
	Conduct a 3-day training for 3 community resource persons (CORPS) on PMTCT/HCT. 3 per LGA in 17 LGAs	6,976,000	20,928,000
	Support with training materials		
	Conduct training for 50 TBAs and FBOs/LGA in 17 LGAs on PMTCT,MNCH and providing referrals to new PHCs	4,458,080	13,374,240

Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)	Responsible Authority	Funding Source
-	-	-	SIT, SACA, SASCP	FMOH/UNFPA
3,373,400	16,867,000	108,819	SIT, SACA, SASCP	State Govt., Donor Partners
-	506,011	3,265	SIT, SACA, SASCP	State Govt., Donor Partners
-	-	-	SIT, SACA, SASCP	State Govt., Donor Partners
1,792,000	7,168,000	46,245	SIT, SACA, SASCP	State Govt., Donor Partners
-	3,516,000	22,684	SIT, SACA, SASCP	State Govt., Donor Partners
-	1,026,000	6,619	SIT, SACA, SASCP	State Govt., Donor Partners
1,005,683,100	**5,046,623,500**	**32,558,861**		
-	13,055,000	84,226		
351,750	1,758,750	11,347	ABSACA, SMOWASD, SMOH, LACA	
	4,154,000	26,800		
6,976,000	34,880,000	225,032	FMoH/SMoH, SMoWASD	
	-	-	ABMOH/ABPHCB/ LACA	
4,458,080	22,290,400	143,809	ABACA,SMOH, LACA	

SECTION
10 APPENDIX-DETAILED BUDGET

Objective 2: The unmet need for family planning among women living with HIV reduced by 90% *(continued)*

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget Less One-off activities (Naira)
THEMATIC AREA: PMTCT DEMAND CREATION SYSTEMS *(CONTINUED)*			
Community Mobilization	***Sensitization***		
	Conduct 1-day sensitization meeting with stakeholders on importance of PMTCT services	730,000	-
	Conduct community sensitization in wards	2,160,000	6,480,000
Referral/ linkages	Print and distribute 30,000 booklets of referral forms to TBAs	6,170,000	18,510,000
	Hold a 1-day advocacy orientation meeting for key stakeholders (at the State and Local Government levels) on using the Advocacy talking point guide	2,373,200	-
Media engagement	Radio and TV jingles generating demand for PMTCT service uptake developed		
	Radio and TV jingles aired 180 times per month on major radio stations		
	Radio jingle on PMTCT male involvement and safe disclosure developed		
	Radio jingle on PMTCT male involvement and safe disclosure aired 180 times/month on major radio stations in the state		
	Road shows and drama campaigns conducted in 60 communities	1,428,000	4,284,000
IEC materials	Print and provide the Ward Development Committees with appropriate tools to advocate for increased uptake and integration of PMTCT services within the community and the facilities. (This budget includes production of IEC, radio, TV, Job Aids etc.)	17,415,500	52,246,500
	Adapt and translate IEC materials		
	IEC materials produced		
PMTCT demand creation system		**59,271,530**	**116,877,990**
Objective 2 sub-total		**78,529,041**	**131,996,690**

Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)	Responsible Authority	Funding Source
-	730,000	4,710	ABMOH/ SMOWASD, ABPHCB/LACA	SMOH
2,160,000	10,800,000	69,677	ABMOH/ SMOWASD, ABPHCB/ LACA	
6,170,000	30,850,000	199,032		
-	2,373,200	15,311	ABMoH/ ABPHCB, SMoI	SMOH
	-	-	ABMOH/ABPHCB/ SMoI	SMOH
	-	-	ABMOH/ABPHCB/SMoI	SMOH
	-	-	ABMOH/ABPHCB/SMoI	
	-	-	ABMOH/ SMoI, ABPHCB	
1,428,000	7,140,000	46,065	FMoH/ SMoH, SMoWASD	
17,415,500	87,077,500	561,790	ABMOH/ABPHCB/ SMoI	SMOH
	-	-	ABMOH/ABPHCB	
	-	-	ABMOH/ABPHCB/ LACA	
38,959,330	**215,108,850**	**1,387,799**		
44,593,930	**255,119,661**	**1,645,933**		

SECTION

10 APPENDIX-DETAILED BUDGET

Objective 3: ARV prophylaxis for PMTCT received by at least 90% of all HIV positive pregnant women and breastfeeding infant-mother pairs

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget Less One-off activities (Naira)
THEMATIC AREA: PMTCT SERVICE SUPPLY SYSTEMS			
Service delivery	Set up logistics for DBS sample collection, transport and result retrieval (including CD4 sample transfer)	3,312,000	19,680,000
Training & capacity	Conduct 6-day Integrated PMTCT training for HCWs in 42 SHCs	7,863,000	8,508,000
	Conduct 5-day IMAI/IMPAC training for HCWs in 126 PHCs	11,169,000	17,420,500
	Conduct 5-day pharmaceutical care training for pharmacists in PMTCT sites (Secondary health facilities and CP preceptors) including LMIS	4,649,000	5,045,000
	Conduct 2-day ART dispensing and documentation training for nurses/pharmacy technicians in PHCs	2,266,000	3,712,000
	Conduct 5-day onsite pharmacy best practices training for HCW in SHC and PHCs	10,005,000	29,725,000
	Conduct 5-day laboratory training for laboratory scientists and technicians on quality assurance in 342 health facilities	7,683,000	22,940,000
	Conduct a 3-day training on Infection Prevention and Control (IPAC) for HCW in 342 sites	4,910,000	14,535,000
Linkages/ referrals	Conduct 2 day-adherence counselling and referral training for HCWs, CBO, mentor mothers	1,842,800	4,242,800
	Link active EID sites to the National PCR Lab (no cost)		
Mentoring & supervision	Conduct monthly mentoring visits and joint supervisory to PMTCT sites	7,452,000	44,280,000
	Conduct quarterly service quality improvements in PMTCT sites	1,242,000	7,380,000
Site activation	Activate 342 sites for PMTCT/EID/RH service provision	2,380,500	7,072,500
IEC materials	Procure copies of the National PMTCT guidelines, SOPs, Job aids and IEC materials for 342 facilities	1,269,600	3,772,000
	Distribute copies of the National PMTCT guidelines, SOPs, job aids and IEC materials for 342 facilities (tie to site activation and mentoring visits)	-	-
	Procure IMPAC training materials for 126 PHCs	661,500	1,039,500
	Distribute IMPAC training materials for 126 PHCs (tie to trainings/ site activation)	-	-
PMTCT service supply systems sub-total		**66,705,400**	**189,352,300**

Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)	Responsible Authority	Funding Source
6,528,000	29,520,000	190,452		
-	16,371,000	105,619		
-	28,589,500	184,448		
7,760,000	17,454,000	112,606		
2,988,000	8,966,000	57,845		
10,005,000	49,735,000	320,871		
7,683,000	38,306,000	247,135		
5,066,000	24,511,000	158,135		
1,380,800	7,466,400	48,170		
	-	-		
14,688,000	66,420,000	428,516		
2,448,000	11,070,000	71,419		
2,346,000	11,799,000	76,123		
1,251,200	6,292,800	40,599		
-	-	-		
918,000	2,619,000	16,897		
-	-	-		
63,062,000	**319,119,700**	**2,058,837**		

SECTION
10 APPENDIX-DETAILED BUDGET

Objective 3: ARV prophylaxis for PMTCT received by at least 90% of all HIV positive pregnant women and breastfeeding infant-mother pairs *(continued)*

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget Less One-off activities (Naira)
THEMATIC AREA: HEALTH CARE COMMODITIES			
Procurement (quantification, forecasting)	***Drugs***		
	Procurement of ARVs for triple prophylaxis (TDF + 3TC + EFV) 90%	88,705,687	266,117,062
	Procurement of ARVs for triple prophylaxis (AZT + 3TC + EFV) 5%	7,505,472	22,516,416
	Procurement of ARVs for triple prophylaxis (other regimen) 5%	15,420,672	46,262,016
	Procurement of OI medication (CTX)	1,075,440	3,226,320
	Procurement of Haematinics	1,613,160	4,839,480
	Procurement of other commodities (antibiotics, antifungals, etc.)	1,552,000	4,656,000
	Procurement of NVP syrup for babies	4,422,960	13,268,880
	Procurement of CTX for babies	1,842,900	5,528,700
	Procurement of Safe Delivery Kit	15,519,200	46,557,600
	Procurement of ITNs, SP and drugs for treatment of malaria	15,519,200	46,557,600
	Equipment		
	Procurement of air-conditioners & refrigerators for lab and pharmacy	15,120,000	15,120,000
	Procurement of lab equipment for PHCs (POC CD4 and accessories)	25,499,250	25,499,250
	Procurement of lab equipment, starter reagents and consumables for Secondary Health facilities (CD4, Chemistry and Haematology)	340,305,000	340,305,000
	Procure Laboratory machines (PCR)	20,000,000	-
	Procurement of Lab Equipment & maintenance	340,313,081	340,313,081
	Procurement and distribution of SMS printers	51,227,166	51,227,166

Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)	Responsible Authority	Funding Source
88,705,687	443,528,436	2,861,474	SIT, SACA, SASCP	State Govt., Donor Partners
7,505,472	37,527,360	242,112	SIT, SACA, SASCP	State Govt., Donor Partners
15,420,672	77,103,360	497,441	SIT, SACA, SASCP	State Govt., Donor Partners
1,075,440	5,377,200	34,692	SIT, SACA, SASCP	State Govt., Donor Partners
1,613,160	8,065,800	52,037	SIT, SACA, SASCP	State Govt., Donor Partners
1,552,000	7,760,000	50,065	SIT, SACA, SASCP	State Govt., Donor Partners
4,422,960	22,114,800	142,676	SIT, SACA, SASCP	State Govt., Donor Partners
1,842,900	9,214,500	59,448	SIT, SACA, SASCP	State Govt., Donor Partners
15,519,200	77,596,000	500,619	SIT, SACA, SASCP	State Govt., Donor Partners
15,519,200	77,596,000	500,619	SIT, SACA, SASCP	State Govt., Donor Partners
-	30,240,000	195,097	SIT, SACA, SASCP	State Govt., Donor Partners
-	50,998,500	329,023	SIT, SACA, SASCP	State Govt., Donor Partners
	680,610,000	4,391,032	SIT, SACA, SASCP	State Govt., Donor Partners
-	20,000,000	129,032	SIT, SACA, SASCP	State Govt., Donor Partners
-	680,626,162	4,391,137	SIT, SACA, SASCP	State Govt., Donor Partners
-	102,454,332	660,996	SIT, SACA, SASCP	State Govt., Donor Partners

SECTION
10 APPENDIX-DETAILED BUDGET

Objective 3: ARV prophylaxis for PMTCT received by at least 90% of all HIV positive pregnant women and breastfeeding infant-mother pairs *(continued)*

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget Less One-off activities (Naira)
THEMATIC AREA: HEALTH CARE COMMODITIES *(CONTINUED)*			
Procurement (quantification, forecasting) *(continued)*	***Consumables***		
	Procurement of DBS kits	373,140	-
	Distribution of DBS kits (All distribution pooled)	735,000	2,205,000
	Procurement of RTKs (already costed in Prong 1)		
Distribution	***Drugs***		
	Distribution of ARV and OIs	735,000	2,205,000
Logistics	Sample transfer for logging (DBS)	20,520,000	61,560,000
	Sample transfer for Chemistry and Haematology	16,200,000	48,600,000
Health care commodities sub-total		**984,204,328**	**1,346,564,570**
THEMATIC AREA: PMTCT DEMAND CREATION SYSTEMS			
Mentoring & supervision	17 support group meetings held monthly in 1 LGA each	3,264,000	9,792,000
	17 ASWHAN support groups supported for ongoing mentorship to Women LHIV	1,632,000	4,896,000
Training on IPC	Provide IPC & Couple counseling training to 2 HCW each in 5 PHCs of 17 LGA (170 PHCs)	681,150	2,043,450
	Training of peer educators on the importance of male involvement in PMTCT program.	1,668,600	3,893,400
	Provide support for 40 Male Peers in Community Activity on Male involvement in 17 LGA's per month	408,000	952,000
PMTCT demand creation systems sub-total		**7,653,750**	**21,576,850**
Objective 3 sub-total		**1,058,563,478**	**1,557,493,720**

Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)	Responsible Authority	Funding Source
-	373,140	2,407	SIT, SACA, SASCP	State Govt., Donor Partners
735,000	3,675,000	23,710	SIT, SACA, SASCP	State Govt., Donor Partners
	-	-	SIT, SACA, SASCP	State Govt., Donor Partners
735,000	3,675,000	23,710	SIT, SACA, SASCP	State Govt., Donor Partners
20,520,000	102,600,000	661,935	SIT, SACA, SASCP	State Govt., Donor Partners
16,200,000	81,000,000	522,581	SIT, SACA, SASCP	State Govt., Donor Partners
191,366,691	**2,522,135,590**	**16,271,843**		
3,264,000	16,320,000	105,290	ABMOH/LSACA	SMOH
1,632,000	8,160,000	52,645	ABSACA,SMOH,	ABSACA
681,150	3,405,750	21,973	ABSACA,SMOH, SMoYD	
-	5,562,000	35,884		
-	1,360,000	8,774		
5,577,150	**34,807,750**	**224,566**		
260,005,841	**2,876,063,040**	**18,546,471**		

SECTION

10 APPENDIX-DETAILED BUDGET

Objective 4: Early HIV diagnosis services accessed by at least 90% of all HIV exposed infants

Objective 5: Increase provision of early HIV diagnosis services to at least 90% of all HIV exposed infants

Objective 6: Increase provision of life-long ART to at least 90% of the pregnant, infected women requiring treatment for their own health

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget Less One-off activities (Naira)
THEMATIC AREA: PMTCT SERVICE SUPPLY SYSTEMS			
Mentoring & supervision	Identify and support community-based mentor mothers to provide support for PMTCT service provision (including referrals, health talks, adherence counselling, client tracking, home based care)	2,295,000	4,590,000
	Support HCWs/CBOs/Support groups to conduct monthly client tracking	8,901,000	53,922,000
Linkages/ Referrals	Support referral and linkages of HIV positive pregnant women on lifelong ART and infected infants to comprehensive treatment sites (cost to be linked with client tracking)		
PMTCT service supply systems sub-total		**11,196,000**	**58,512,000**
THEMATIC AREA: HEALTH CARE COMMODITIES			
Procurement (quantification, forecasting)	***Drugs***		
	Procure ARVs for treatment of HIV positive mothers	147,843,659	443,530,976
	Procure ARVs for treatment of HIV positive babies	25,373,520	76,120,560
	Procure OIs for HIV positive mothers	6,983,640	20,950,920
	Procure OIs for HIV positive babies	1,036,500	1,036,500
	Consumables		
	Nutritional Support (Plumpy Nuts)	11,639,400	34,918,200
	Procurement of internet modems and airtime	1,386,000	1,386,000
	Procurement of Basic Care Kit	11,639,400	34,918,200
Supervision	Supportive supervision for LMIS reporting	4,528,800	13,586,400
	Conduct logistic TWG meetings (bi-monthly)	1,040,000	3,120,000
Health care commodities sub-total		**211,470,919**	**629,567,756**
Objective 4,5 and 6 sub-total		**222,666,919**	**688,079,756**

Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)	Responsible Authority	Funding Source
4,590,000	11,475,000	74,032		
17,544,000	80,367,000	518,497		
	-	-		
22,134,000	**91,842,000**	**592,529**		
147,843,659	739,218,294	4,769,150	SIT, SACA, SASCP	State Govt., Donor Partners
25,373,520	126,867,600	818,501	SIT, SACA, SASCP	State Govt., Donor Partners
6,983,640	34,918,200	225,279	SIT, SACA, SASCP	State Govt., Donor Partners
-	2,073,000	13,374	SIT, SACA, SASCP	State Govt., Donor Partners
11,639,400	58,197,000	375,465	SIT, SACA, SASCP	State Govt., Donor Partners
-	2,772,000	17,884	SIT, SACA, SASCP	State Govt., Donor Partners
11,639,400	58,197,000	375,465	SIT, SACA, SASCP	State Govt., Donor Partners
4,528,800	22,644,000	146,090		
1,040,000	5,200,000	33,548	SIT, SACA, SASCP	State Govt., Donor Partners
209,048,419	**1,050,087,094**	**6,774,755**		
231,182,419	**1,141,929,094**	**7,367,284**		

SECTION

10 APPENDIX-DETAILED BUDGET

Objective 7: Coordination, Resourcing, Monitoring And Evaluation, the eMTCT Elimination Plan

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget Less One-off activities (Naira)
THEMATIC AREA: MONITORING & EVALUATION			
Data Quality Assurance	Supply all health facilities (public and private) with current M&E/ HMIS tools	12,903,000	9,677,250
	Train all health facility Health Records staff on the current M&E/HMIS tools, data management and data use	87,625,000	87,625,000
	LGA M&E/HMIS Officer to conduct performance analysis of the health facility reporting rates at both LGAs/state M&E meetings	-	-
	Train existing Health Record Officers on Health Record Management and M&E data management	-	-
	1-day stakeholders meeting at state-level to design and agree on Integrated Health Data Management approach by all State Health Program Officers and partners	80,000	-
	1-day step-down stakeholders orientation at zonal-level to understand Integrated Health Data Management approach by all LGA Health Program Officers and partners	450,000	-
	State DPRS & SACA to organize DHIS and Data Management training for 12 LGAs yet to be trained	2,232,100	-
	Establish State and LGA Health data management teams fo faciltate Integrated M&E/HMIS Supportive Supervision (ISS) and Data Quality Assurance (DQA)	-	-
	Procurement of 3 project vehicles for M&E/HMIS activities	22,500,000	-
Strategic Information	LGA M&E/HMIS Officer to conduct performance analysis of the Health facility reporting rates at both LGAs/state M&E meetings	-	-
Central Database	FHI 360 to discuss the need for harmonization of DHIS 2.0 instances with NACA and FMoH/DPRS	-	-
Routine Monitoring	Monthly LGAs M&E Coordination meetings established to review performance and advice on use of health data	715,000	1,716,000
	Quarterly State M&E Coordination meetings established to review performance and advice on use of health data	620,000	1,488,000
	Monthly routine sites supportive supervision by LGA data management team members	500,000	1,500,000
	Quarterly state supportive supervision by State data management team members	280,000	1,120,000
	Hold 1 annual state-level Health Data Producers and User (HDPU) meeting	300,000	300,000
	Hold bi-annual state-level Health Data Consultative Committee (HDCC) meeting	500,000	500,000
	Production of Quarterly Health Program Coverage analysis reports	-	-

Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)	Responsible Authority	Funding Source
6,451,500	29,031,750	187,302	SMoH/DPRS	PMTCT Scale-up Plan funds
-	175,250,000	1,130,645	SMoH/DPRS, SACA & FHI 360	PMTCT Scale-up Plan funds, NMCP, UNFPA and WHO
-	-	-	LGA HMIS Officers	N/A
-	-	-	SMoH/DPRS, SACA & FHI 360	PMTCT Scale-up Plan funds, UNFPA and WHO
-	80,000	516	SMoH/DPRS and SACA and Partners	PMTCT scale-up plan
-	450,000	2,903	SMoH/DPRS and SACA and Partners	PMTCT scale-up plan
-	2,232,100	14,401	SMoH/DPRS and SACA and Partners	UNFPA & FHI 360
-	-	-	SMoH/DPRS and SACA and Partners	PMTCT scale-up plan
-	22,500,000	145,161	SMoH/DPRS	PMTCT scale-up plan
-	-	-	LGA HMIS Officers	N/A
-	-	-	FHI 360 Country Office M&E Team	N/A
1,716,000	4,147,000	26,755	SMoH/DPRS and SACA and Partners	PMTCT scale-up plan
1,488,000	3,596,000	23,200	SMoH/DPRS and SACA and Partners	PMTCT scale-up plan
1,500,000	3,500,000	22,581	State HMIS Officer and State Health Data Management Team	PMTCT scale-up plan
1,120,000	2,520,000	16,258	LGA HMIS Officers and LGA Health Data Management Team	PMTCT scale-up plan
300,000	900,000	5,806	SMoH/DPRS	PMTCT scale-up plan
500,000	1,500,000	9,677	SMoH/DPRS	PMTCT scale-up plan
-	-	-	SMoH/DPRS	N/A

SECTION

10 APPENDIX-DETAILED BUDGET

Objective 7: Coordination, Resourcing, Monitoring And Evaluation, the eMTCT Elimination Plan

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget Less One-off activities (Naira)
THEMATIC AREA: MONITORING & EVALUATION			
Capacity Building	Train existing Health Record Officers on Health Record Management and M&E data management	-	-
	Explore engagement of NYSC and SURE-P Graduate Internship Program to augment Health Records Officers	36,000,000	36,000,000
Advocacy	Advocate to LGAs and State Government to commence incremental funding of printing and supply of M&E/HMIS tools from Year 3	-	-
	Advocate to LGAs and Abia Government to release funds appropriated in the budget for M&E/ HMIS activities	65,000	65,000
	Advocate to Local Government Civil Service Commission and Abia Government to employ adequate number of qualified Health Records Officers (HROs)	65,000	65,000
Site activation	All sites, LGAs and state M&E teams re-orientated on Forecasting, Procurement and Supply Chain Management (PSCM) of M&E/ HMIS tools	-	-
Monitoring and evaluation sub-total		**164,835,100**	**140,056,250**
THEMATIC AREA: PROGRAMME MANAGEMENT			
Situation analysis	Develop and disseminate PMTCT scale up operational plan 2013 - 2015	6,330,600	-
	Print and distribute costed state scale up operational plan	-	-
	Conduct resource mapping and gap analysis	672,000	-
Coordination & Resource mobilization	Adapt the national strategy for private sector engagement for the state	672,000	-
	Annual progress review meetings with all stakeholders including private and public health facilities	-	10,429,500
	Print and circulate annual progress report	-	5,000,000
	Conduct semi - annual progress review meetings	-	
	Conduct quarterly supportive supervision and CQI visits to HFs	10,400,000	20,800,000
	Support quarterly meeting of the PMTCT Task Team	2,176,800	4,353,600
	Conduct semi- annual meeting of the State Management Team (Commissioners (SMoH & SMoW& SD) Permanent Secretaries, CE (HMB) and Directors) to review progress	3,815,100	7,630,200
	Hold monthly JSIT meetings to review progress	225,000	450,000
	Hold semi- annual public-private sector forum to engender private sector participation and support	1,005,000	1,005,000
	Develop and share annual budget to feed into the SMoH and SACA annual budget	-	-

Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)	Responsible Authority	Funding Source
-	-	-	SMoH/DPRS, SACA & FHI 360	PMTCT Scale-up Plan funds, UNFPA and WHO
36,000,000	108,000,000	696,774		
-	-	-	SMoH/DPRS and SACA and Partners	PMTCT scale-up plan
-	130,000	839	SMoH/DPRS and SACA and Partners	PMTCT scale-up plan
	130,000	839		
-	-	-	SMoH/DPRS and SACA and Partners	N/A
49,075,500	**353,966,850**	**2,283,657**		
-	6,330,600	40,843	SIT & Implementing Partners	PEPFAR
-	-	-	FHI 360	PEPFAR
-	672,000	4,335	SASCP/SACA	SACA
-	672,000	4,335	SACA	SACA/WB
10,429,500	20,859,000	134,574		
5,000,000	10,000,000	64,516		
-	-	-	SIT	PEPFAR, GF, WB, UNICEF & WHO
10,400,000	41,600,000	268,387	SIT	PEPFAR /PPFN
4,353,600	10,884,000	70,219		
7,630,200	19,075,500	123,068	SIT	PEPFAR
450,000	1,125,000	7,258	SPM/SIT	PEPFAR
1,005,000	3,015,000	19,452	SACA	SACA/WB
-	-	-		

SECTION

10 APPENDIX-DETAILED BUDGET

Objective 7: Coordination, Resourcing, Monitoring And Evaluation, the eMTCT Elimination Plan

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget Less One-off activities (Naira)
THEMATIC AREA: PROGRAMME MANAGEMENT *(CONTINUED)*			
Infrastructure	Conduct physical infrastructural assessment of selected PMTCT sites to identify infrastructure gaps and upgrade needs (linked to activity 1.1.)	-	-
	Develop bills of quantities for the facility upgrades	1,344,000	-
	Carry out renovation of identified HFs	410,400,000	615,600,000
	Procurement and supplies of relevant furniture items and office equipment	56,714,400	85,071,600
	Procurement of two vehicles, a truck and Hilux, for distribution health commodities from state medical store to HFs	-	-
HR & Staffing	Recruitment of relevant personnel based on identified HR gaps from activity 1.1.	-	-
Community Mobilization	***Advocacy***		
	Conduct advocacy to the Executive Governor to secure a waiver to recruit relevant health personnel	-	-
	Conduct advocacy to the First Lady to mobilize support for improved HR for Health at State and LG levels	-	-
	Advocacy and sensitization meeting with tertiary health institutions in the state to develop partnership through an MoU to address HR gaps by posting residents to HFs	-	-
	Develop advocacy package (State Governor, private sector etc.)	36,000	36,000
	Carry out advocacy to the State Governor to facilitate the allocation and timely release of funds for the implementation of PMTCT activities	-	-
	Sensitization		
	Conduct one-day sensitization meeting with NMA, NANNM, PSN, AGPMPN, PSN, ACPN and AMLSN	-	-
	Conduct 1-day sensitization meeting with NMA, NANNM, PSN, AGPMPN, PSN, ACPN and AMLSN	502,500	-
	Conduct one day sensitization workshop for private sector and other business enterprises to secure their commitment and funding support for the roll out of the PMTCT scale up plan in Abia state	502,500	502,500
Capacity Building	Conduct rapid facility assessment to define human resources, infrastructure and service gaps	27,882,800	-
	Conduct a 1-day orientation and deployment of recruited personnel	-	-
Programme management sub-total		**522,678,700**	**750,878,400**
Objective 7 sub-total		**687,513,800**	**890,934,650**
Grand total		**3,173,567,938**	**6,471,249,617**

Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)	Responsible Authority	Funding Source
-	-	-		
-	1,344,000	8,671		
-	1,026,000,000	6,619,355	FHI 360	PEPFAR
-	141,786,000	914,748	SIT & Facility Management	PEPFAR
-	-	-	SMoH	State Govt
-	-	-	HMB, Civil Service Commission & LG Service Commission	State Government
-	-	-		
-	-	-	SMoH & SMoWA&SD with IPs	SACA/WB & PEPFAR
-	-	-	SMoH & HMB	State Government
36,000	108,000	697	SIT	PEPFAR
-	-	-	SIT& SACA/HMB with IPs	
-	-	-	SMoH & SACA with IPs	SACA/WB & PEPFAR
-	502,500	3,242		
502,500	1,507,500	9,726	SMoH & HMB	PEPFAR
-	27,882,800	179,889	SIT	PEPFAR
-	-	-	HMB, SMoH and LGSC	State Government
49,075,500	**353,966,850**	**2,283,657**		

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