AKWA-IBOM STATE

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

2013 – 2015

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

The Akwa Ibom 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 Akwa Ibom 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

Akwa Ibom State is one of the states in the south-south geo-political zone of Nigeria. It is located in the Niger Delta area of Nigeria and is among the oil and gas producing states in the country. The state has a landmass of 8,421 km2 and an estimated population of about 4.3 million an annual growth rate of 3.4% per annum. The male to female ratio is 103:100. There are three main dialects spoken in the state; Ibibio, Annang and Oron. About 75% of the inhabitants live in rural areas with majority of them engaging in subsistence farming and petty trading.

Since the first case of HIV was reported in Akwa Ibom state in 1989, the prevalence of the disease has consistently fluctuated between 12.7% when the first prevalence survey was conducted in 1999 to 8.0% in 2005 and 10.9% in 2010. These surveys also indicate a higher prevalence in the rural compared with the urban areas. The burden of the disease thus poses a great challenge to the development efforts in the state.

The Prevention of mother-to-child transmission of HIV (PMTCT) and paediatric care and support services were introduced in the state with support from the United Nations Children's Fund (UNICEF) in 2005 in seven health facilities. In 2007, the state government upgraded three of the seven sites to comprehensive HIV/AIDS treatment sites with the increase national and international support for HIV and AIDS control from implementing partners.

HIV/AIDS is not only draining the resources of the state but also depleting her workforce and increasing the number of orphans. The infection has also impacted negatively maternal and child health; increasing infant, child and maternal morbidity and mortality and reduction of life expectancy.

In response to this, the Akwa Ibom state government through the Ministry of Health, with support from FHI 360 and other partners, has embarked on scaling up PMTCT services. 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. Targets have been set in line with this goal and include that at least 90% of all HIV infected pregnant women will have access to PMTCT and that all HIV exposed infants will have access to early infant diagnosis and ARVs.

This operational plan for elimination of mother-to-child transmission of HIV, will guide the scale-up process. I therefore invite all stakeholders to utilize this document to guide their decisions in supporting PMTCT services in the state.

Thank you,

Dr Emem Abasi Bassey

Honourable Commissioner for Health
Akwa Ibom State

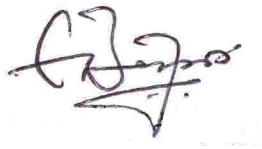
Acknowledgements

The State Ministry of Health wishes to acknowledge with gratitude, the immense contributions and support received from all individuals and groups involved in this eMTCT scale-up plan document. Our special thanks go to His Excellency, the Executive Governor of the state, Chief Godswill Akpabio, CON for the numerous projects he is executing in the health sector and providing an enabling environment for stakeholders to work in the sector. We wish to appreciate the efforts of staff working in all public and private health facilities in the state.

Let me also on behalf of the Ministry, appreciate Family Health International (FHI 360), the United States Agency for International development (USAID), the Local Government Service Commission, The Local Government Chairmen, PHC Directors and staff of the HIV and AIDS unit (SASCP) of the Ministry of Health. They all worked tirelessly to ensure the production of this document.

There are several others whose names I have not mentioned here but whose contributions to the production of this document are vital. I appreciate your immense contribution.

I thank you all,



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Acronyms

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 of HIV
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

In June 2011, the President accented to the "Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive". In 2012, under the leadership of National Agency for Control of HIV/AIDS (NACA), 12 states plus the Federal Capital Territory (FCT) which account for 70% of the PMTCT burden in Nigeria were identified for increased focus.

With second highest prevalence rate amongst pregnant women in the country and a HIV prevalence of 10.9%, the estimated number of HIV positive pregnant women in Akwa Ibom is estimated to be 24,605 (out of the estimated 241,296 women who were pregnant) in 2012. Only 7% of HIV positive pregnant women received ARVs for PMTCT in 2012. Review of available routine data, and a rapid health facility assessment (R-HFA) conducted in the state showed poor ANC attendance, low levels of hospital delivery and high traditional birth attendant (TBA) patronage. There were also facility coverage gaps observed during the assessment. Only 34 out of the 409 facilities that provide ANC services provided anti-retroviral drugs (ARVs) for PMTCT at the end of 2012. In addition, there is a severe human resource gap in Akwa Ibom state. Only 25 of the 335 facilities assessed (9 public and 16 private) met the national 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 findings from these efforts were used at a two-day planning workshop on April 16th and 17th 2013, to develop a costed eMTCT scale up plan which aligned with the goals and targets contained in the national eMTCT scale up plan. At the end of the meeting, a costed *"Akwa Ibom State Operational Plan for the Elimination of Mother-to-Child Transmission of HIV 2013-2015"* aligning with the President's Comprehensive Response Plan for HIV/AIDS in Nigeria (PCRP) with an estimated cost of NGN 13,651,441,163 (USD 88,073,814) was developed.

A modeling exercise was completed to estimate the potential impact of meeting three 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.

In summary, **10,374** infections among WRA, **25,910** pregnancies among HIV-positive women, **17,982** infections among HIV exposed infants (HEI), **6,718** infant deaths, **207** maternal deaths will be prevented by meeting the PMTCT targets. Combined, this will result in **1,074,760** DALYs saved in Akwa Ibom State by 2015 if the scale-up plan is implemented to scale.

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 (ARV) were receiving[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 prevention of mother-to-child transmission (PMTCT) of HIV 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) 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 critical bottlenecks still exist 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 level and integration into existing maternal, neonatal & child health and reproductive health programs.

By the end of 2011, maternal HTC coverage was about 14% and PMTCT prophylaxis 8% of 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

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 is among the top ten countries with poor maternal 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 its PMTCT programme. Led by the National Agency for the Control of HIV/AIDS (NACA), all stakeholders including the Federal Ministry of Health (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 LGA levels as well as the private sector with support of local and international partners. NACA launched the PMTCT Scale-up Technical Committee in December 2011. The purpose was to engage the states 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, i.e. 12+1, 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 states of the country benefiting by 2015.

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
Bayelsa	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

1.4 FUNDING OPPORTUNITIES

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 allocation of resources 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).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 Akwa Ibom State

2.1 STATE PROFILE

Akwa Ibom State is situated in the South-South zone and administratively divided into 31 LGAs. The total population from the 2006 census was 3,920,051, which at an annual growth rate of about 3.4% was projected at approximately 4,825,924 people in the year 2012.

It is estimated that there are about 1,061,703 women reproductive age (WRA) (15-49) in which, translates to, while the children under-five years and below one year of age were 902,935 and 180,587, respectively. The annual total number of pregnant women is put at 5% of the population which translates to about 225,734. It was reported that about 36.9% of the births in 2011 were hospital deliveries and 44% of the births in the same year had been attended to by skilled personnel.

There are 590 health facilities in the state, the majority of which are public sector facilities. There is one tertiary health facility; 47 secondary health care facilities; 363 primary health care facilities and 153 other health facilities. Critical cadres of service providers include 187 doctors, 1,491 nurses, 73 Pharmacists and 78 laboratory staff.

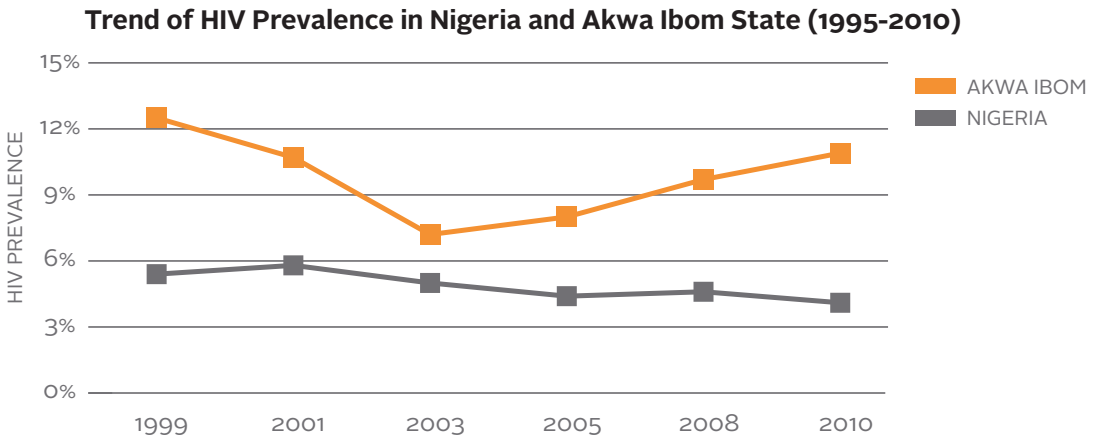
Four hundred and nine (409) health facilities in the state provide MCH services. The total estimated number of deliveries during this same period was 231,676. It is important to note that all the government owned primary and secondary health facilities in Akwa Ibom provided free MCH services. In the 2011 Multiple Cluster Indicator Survey, ANC attendance was reported as 67.3% while delivery by a skilled birth attendant was 39.7%. The same survey showed that 49.5% of women were delivered by traditional birth attendants (TBAs). The uptake of contraception was 13.4% while the unmet need for contraception was 29.9%[6]. Both figures are higher than the national rate.

2.2 HIV/AIDS IN AKWA IBOM STATE

Figure 1 illustrates the trend in HIV prevalence based on the sentinel survey conducted in ANC settings among pregnant women from 1999 to 2010, compared with the national average during the same period. The prevalence was first recorded while at the peak of 12.5% in 1999, which declined to 7.2% in the year 2003. Thereafter, it consistently increased to 10.9%, from 2005 to 2010. The HIV prevalence among pregnant women in the state has consistently been above the national average of the years, which is of particular importance to the magnitude of vertical transmission of HIV within the state.

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

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



Source: Federal Ministry of Health Technical Report, 2010 National HIV Sero-prevalence Sentinel Survey

2.3 PMTCT IN AKWA IBOM STATE

With a state prevalence of 10.9%, about 26,301 pregnant women are estimated to be HIV positive. Approximately 8,653 preventable HIV infections occurred among infants in Akwa Ibom in 2012. There are 122 health facilities providing HTC integrated with other MCH services for pregnant women and 34 facilities providing ARVs for PMTCT.

The uptake of services and availability of interventions for PMTCT in the state in 2012 is summarized in Table 2 below.

Table 2: Uptake of PMTCT Services in Akwa Ibom State in 2012

	Indicator	Number
1	Total number of pregnant women in the state	242,721
2	Total number of antenatal new cases (booking)	208,319
3	Total number of deliveries	173,918
4	Number of pregnant women who were offered HCT for PMTCT and received their test results	166,273
5	Number of HIV positive women who received complete course of ARVs for PMTCT	164,362
6	Number of HIV positive mothers who received cotrimoxazole prophylaxis	147,161
7	Number of HIV exposed babies who received ARV prophylaxis	143,339
8	Number of HIV exposed babies who received cotrimoxazole prophylaxis	139,517
9	Number of HIV positive pregnant women who received infant feeding counselling	135,694
10	Number of HIV exposed babies who received PCR testing within 2 months of birth	114,671
11	Number of HIV positive pregnant women whose CD4 was estimated in order to stage the HIV disease	145,178
12	1Number of mothers who exclusively breast fed their babies at 3 months	97,470
13	Number of mothers who exclusively breast fed their babies at 6 months	64,980

7 Source: Federal MOH Technical Report 2010

SECTION

3 Process

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

In February 2013, with support from the UNAIDS and HIV/AIDS Division FMOH, Akwa Ibom State developed the first draft of its eMTCT operational plan. This draft plan was however, quite generic and was not finalized.

In order to specifically identify the health system challenges to be addressed to meet Akwa Ibom State's eMTCT targets, FHI 360 with support from USAID, provided technical assistance to Akwa Ibom State to conduct a state-wide rapid health facility assessment (RHFA). The assessment was done in all 31 LGAs in facilities identified as providing ANC services but not PMTCT services. The assessment covered seven domains: health human resource complement, client flow, scope of services provided, community support systems, facility health linkages, current infrastructure and future prospects for expansion. The results of this assessment (presented in Chapter 4) as well as review of other relevant documents informed the priority areas chosen and scale-up targets required to meet the eMTCT goal.

The findings from these efforts were presented and discussed during a planning workshop convened by the Akwa Ibom SMOH, on April 16th and 17th 2013, with 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 was then reviewed in line with findings from the RHFA. 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 identified informed the development of a comprehensive package with appropriate interventions to address the specific needs of 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 also presented in Chapter 6.

With the completion of all of these processes, the Akwa Ibom SMOH and SACA disseminated the *"Akwa Ibom State's eMTCT Scale-up Plan 2013-2015"* to His Excellency, Chief Godswill Akpabio, on April 18th 2013. The Governor was represented by the Hon. Commissioner for Health. The dissemination meeting was attended by all major stakeholders in the HIV/AIDS response in Akwa Ibom state and beyond, including FHI 360 (lead PEPFAR implementing partner for Akwa Ibom State).

SECTION

4 Rapid Health Facility Assessment

4.1 METHODOLOGY

A combination of quantitative and qualitative methods was used in the rapid assessment to determine the status of the health system to deliver PMTCT services in Akwa Ibom State.

The assessment covered all listed public and private health facilities in Akwa Ibom State which met defined criteria (see Box 1). A list of 590 facilities was obtained from the Department of Planning, Research and Statistics (DPRS), State Ministry of Health. In total, 409 had ANC services, 34 were currently providing ARVs for PMTCT while 12 had plans for PMTCT in 2013. Thus 335 facilities with antenatal services but no IP support for PMTCT or plans for PMTCT in 2013 were assessed.

4.2 FINDINGS

Box 1: Site selection

Site Inclusion Criterion

1. Providing ANC but no IP support for PMTCT services

Site Exclusion Criteria

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

Table 3: Characteristics of facilities providing ANC with no PMTCT ARV support

OWNERSHIP	FACILITY TYPE		TOTAL
	PRIMARY LEVEL	SECONDARY LEVEL	
Private			
Faith-based	1	1	2
Private for profit	12	39	51
Sub-total (private)			53
Public			
LGA	213	0	213
State government	63	6	69
Sub-total			282
Overall total	**289**	**46**	**335**

4.2.1 Facility Ownership and Healthcare Level

Approximately 84% of facilities assessed were public sector facilities. Table 3 on the previous page summarizes characteristics of the facilities assessed.

4.2.2 Human resources and service utilization

The human resource for health complements and service utilization data for the 12 months preceding the assessment were reviewed from each facility. The data showed fewer staff and wider coverage gaps in primary compared to secondary health centres. On the average, the secondary facilities had a higher number of health workers across all categories compared with the primary facilities; only 8% of the primary facilities were covered by doctors, whereas almost all (97.6%) facilities assessed had a nurse/midwife. Pharmacy technicians/pharmacists, laboratory technicians and records officers were the fewest per facility of all the health worker categories. The average number of 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.

4.2.3 Other domain summaries

Regarding the scope of services available, facility infrastructure, and environmental enablement for MCH and community support/participation disaggregated by facility level, almost all the clinical and laboratory services were available in most of the facilities assessed with the exception of TB services which was only available in about 16% (15.7%) of the facilities - a greater proportion of which were secondary level facilities (30.4%). Also, regarding identified structures, across all facility levels, space for laboratory (55.6%) were the least available. Primary level facilities (77.1%) were the most affected regarding non-availability of structures for laboratory services.

Furthermore, with respect to enabling environment, primary level facilities seem better off as they have more MDG support (16.1% vs. 2.2%), free ANC services (50.3% vs. 15.2%) and regular monthly outreach (93.2% vs. 30.4%). Also, it appeared none of the secondary facilities have MSS midwives whereas the primary facilities have a large number. Furthermore, primary level facilities were found to have better community systems compared with secondary facilities.

4.2.4 Summary of qualitative findings

In the key informant interviews (KII) conducted with health workers in the state, respondents were of the opinion that many women prefer the services of TBAs, private clinics and churches for deliveries even though these women usually attend ANC at health facilities. Some reasons offered for this practice include a firm traditional belief in the abilities of the TBA and superstitious beliefs.

The respondents provided several reasons for why some health facilities were well patronized; these reasons included the good relationship that health workers have with the community including the village development committee (VDC), follow-up of clients and the neatness of the facility surroundings. Health workers felt better staffing, provision of equipment and infrastructure, improved capacity building for staff as well as provision of better structures and social amenities would improve service quality in the state.

4.2.5 Scenarios for Scale-up

Only 25 of the 335 facilities assessed (nine public and 16 private) met the national prescribed HR criteria for scale-up (one doctor, one nurse/midwife, two community workers, one pharmacy staff, one laboratory staff, one medical records officer). The locally agreed criterion for scale-up was a facility with at least four staff that can provide clinical care and 218 facilities (173 public and 45 private) met this criteria. There is also a need for prioritization of LGAs for scale-up to ensure equity in distribution of services. For example, LGAs like Mkpat Enin, with no PMTCT services and a high MTCT burden could be prioritized for scale-up (see Table 4).

Table 4: LGA Ranking by MTCT Burden and PMTCT Service Coverage Gap in Akwa Ibom 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 positive pregnant women)	Total number of sites with MCH services	Proportion without PMTCT services	Rank 2 (service gap)	
MKPAT ENIN	10.9%	1153	28	8	100.00%	22	50
OBOT AKARA	10.9%	958	24	26	100.00%	22	46
NSIT UBIUM	10.9%	826	20	6	100.00%	22	42
UKANAFUN	9.7%	726	19	13	100.00%	22	41
IBIONO IBOM	10.9%	1226	30	11	90.91%	17	47
ITU	13.3%	1014	25	16	93.75%	19	44
NSIT ATAI	16.1%	705	18	11	100.00%	22	40
ORUK ANAM	10.9%	1117	26	12	91.67%	10	36
IKOT ABASI	10.9%	862	22	17	94.12%	12	34
EKET	13.3%	1371	31	21	90.48%	4	35
ORON	15.9%	827	21	11	90.91%	21	42
IKA	9.7%	421	7	9	100.00%	22	29
UYO	6.3%	1150	27	36	86.11%	1	28
ETIM EKPO	10.9%	689	17	11	90.91%	6	23
NSIT IBOM	6.5%	419	6	9	100.00%	22	28
ESSIEN UDIM	10.0%	1153	29	17	76.47%	2	31
ONNA	6.3%	463	10	15	93.33%	12	22
EASTERN OBOLLO	10.9%	390	5	6	100.00%	22	27
ESIT EKET	9.7%	367	3	9	100.00%	22	25
ABAK	10.9%	904	23	17	82.35%	3	26
OKOBO	10.9%	668	15	10	90.00%	19	34
UDUNG UKO	10.9%	345	2	8	100.00%	22	24
URUE OFFONG/ ORUKO	10.9%	460	9	11	90.91%	8	17
MBO	9.4%	573	14	9	88.89%	8	22
IBESIKPO ASUTAN	6.3%	515	12	10	90.00%	18	30
ETINAN	6.7%	675	16	20	85.00%	5	21
URUAN	6.9%	482	11	10	90.00%	12	23
IKOT EKPENE	3.2%	270	1	14	92.86%	12	13
IBEANO	12.5%	558	13	16	87.50%	7	20
INI	6.3%	372	4	11	90.91%	11	15
IKONO	5.8%	456	8	9	88.89%	12	20
Total		**22,115**		**409**	**92.00%**		

4.2.6 Recommendations

A comprehensive plan which addresses the 92% PMTCT service coverage gap to improve access to PMTCT services in Akwa Ibom is urgently needed. The plan must address the health system constraints to PMTCT service provision; human resource and infrastructure gaps. It should engage TBAs and religious organizations meaningfully as they are an intrinsic part of the health delivery system. In order to address the poor service utilization of facility based ANC and delivery services, a holistic demand creation strategy is vital. Equally important is community involvement and ownership by mobilizing ward and village development committees, faith and community-based organizations as major players. Finally, the private sector should be part of the eMTCT response in the state.

SECTION

5 Akwa Ibom eMTCT Operational Plan

5.1 RATIONALE

Mother-to-child transmission of HIV, though preventable, is currently responsible for virtually all new infections among children, thus 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 has been aligned 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 eMTCT.

5.2.2 Objectives

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

1. Reduce HIV incidence among 15-49 years old women by at least 50%
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 all pregnant women.
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 e-PMTCT elimination plan

5.3 SCALE UP TARGETS

To facilitate the elimination of MTCT in Akwa Ibom, the state has set targets for the process of scaling up PMTCT services. The parameters for measuring scale up include: ANC coverage, HTC coverage in ANC, the proportion of HIV positive women that are reached with services, ARV prophylaxis, early infant diagnosis (EID) coverage and access to lifelong ART for women of reproductive age on need of ART for their own health. The baseline figures for these parameters and the targets for this plan are presented in the table on the next page.

Table 5: State Level Targets for the Operational Plan

INDICATOR	BASELINE	2013	2014	2015	DATA SOURCE
Estimated Number of Women of Reproductive Age	1,061,703	1,098,422	1,136,410	1,175,713	NPC 2006 Projections
Estimated Number of Pregnant Women of Reproductive Age	241,296	249,641	258,275	267,207	NPC 2006 Projections
Projected ANC Attendance	69,459	99,857	167,879	240,488	MICS4 2011 Based Projections
Estimated Number of HIV-positive Pregnant Women	26,301	27,211	28,152	29,126	Prevalence Based Estimates
50% reduction in HIV incidence among 15-49 year old women.	0.96%	0.80%	0.64%	0.48%	National HIV Sero-prevalence Sentinel Survey
90% reduction in Unmet need for family planning among women living with HIV	20%	14%	8%	2%	MICS4 2011 Based Projections
90% of all pregnant women have access to quality HIV counselling and testing services	26,739 (11%)	99,857 (40%)	167,879 (65%)	240,487 (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	1,830 (7%)	10,884 (40%)	18,580 (66%)	26,213 (90%)	State Routine Health data on DHIS
90% of all HIV-exposed infants have access to Early HIV diagnosis services	331 (1%)	8,707 (32%)	17,173 (61%)	26,213 (90%)	State Routine Health data on DHIS
90% of HIV-infected women pregnant requiring treatment for their own health will have access to lifelong ART	430 (3%)	4,354 (32%)	8,586 (61%)	13,107 (90%)	State Routine Health data on DHIS
66% of ANC sites offer PMTCT services	34 (8%)	124 (30%)	271 (66%)	271 (66%)	eMTCT scale-up plan development workshop

5.4 IMPLEMENTATION APPROACHES

The primary approach will be integration of PMTCT into the existing maternal, neonatal, child/adolescent health, reproductive health and other related services. Successful implementation of the Operational Plan will be dependent upon the following major strategic outcomes:

- PMTCT programme coordination, management and resource mobilization strengthened;
- Physical infrastructure and equipment for provision of quality PMTCT services rehabilitated;
- The human resource capacity for delivery of quality PMTCT services strengthened;
- PMTCT guidelines, manuals and related standards produced and widely disseminated;
- Medicines, related commodities and supplies as well as the procurement supplies management system strengthened;
- Advocacy for PMTCT with gate keepers and influential people within the community strengthened;

- Social mobilization at community level for PMTCT strengthened;
- Community education on PMTCT including promoting the utilization of the available MNCH/RH services enhanced; and
- PMTCT programme monitoring and evaluation as well as operational research strengthened.

The PCRP launched in July 2013 identifies key operational challenges to attaining universal access to HIV/AIDS services in Nigeria such as limited human capacity & service delivery, weak supply chain management systems, poor M&E + data management systems, poor ownership & leadership of the HIV response at various levels, and limited State government contributions to the fight against AIDS. The participants at the planning workshop were thus arranged in groups according to five focus areas:

1. PMTCT Service Supply Systems
2. PMTCT Health Care Commodities supply
3. PMTCT Demand Creation
4. Monitoring and Evaluation
5. Coordination, program management and resource mobilization

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 IEC materials and providing support to PMTCT sites through routine mentoring and technical supportive supervision.

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. The type of training will depend on the health facility level and cadre of staff providing PMTCT services. Quality integrated trainings are critical to the success of PMTCT service scale up.

Health care workers in secondary health facilities will be trained on the Integrated PMTCT curriculum, pharmacy best practice and laboratory service provision. Primary level health workers will learn the Integrated Management of Pregnancy and Childbirth (IMPAC) modules, adherence preparation and support as well as HTC, sample logging for CD4 and EID. Health facilities will be activated for PMTCT service provision after completion of trainings. The activation exercise involves setting up of points of services in the facility as well as a multi-disciplinary team who will provide hands-on mentoring and cordination of the service provision at the site. Post activation, health workers at supported facilities will receive regular supervision, mentoring and feedback from program data.

5.4.2 PMTCT Health Care Commodities supply

The supply chain management system for PMTCT commodities will be strengthened. Illustrative activities would include procurement of HIV 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 Akwa Ibom 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 would be educated 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 would work to 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 on the front burner, journalists would be trained on the benefits of ANC/PMTCT and encouraged 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 of HIV in Akwa Ibom 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 out rightly 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 sState 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)

There will be a presentation to stakeholder selected sites and processess for activation based on assessment report at the state, LGA and facility level to discuss and reach a consensus with the state government.The budget will be presented and counterpart funding will be sourced to ensure ownership and sustainability of the activated sites. The state PMTCT task team will be created to work with SIDHAS team and other implementing partners and ensure ongoing monitoring and supervisison. There is a need to disseminate the baseline assessment report, build consensus for the finalization of Akwa Ibom PMTCT and ART scale up plan. In addition, the Akwa Ibom PMTCT task team comprising of government, hospital heads and Implementing Partners will be launched.

SECTION

6 Benefits & Impact of Expanded Access to PMTCT Services in Akwa Ibom State

To estimate the potential impact of meeting PMTCT targets in Akwa Ibom state, a modeling 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 on the next page).

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

IN SUMMARY:

10,374
infections among WRA

25,910
pregnancies among HIV-positive women

17,982
infections among HIV exposed infants (HEI)

6,718
infant deaths

207
maternal deaths will be prevented by meeting the PMTCT targets.

Combined, this will result in

1,074,760
DALYs saved in Akwa-Ibom State by 2015 if the scale-up plan is implemented to scale.

Table 6: Potential Impact of Meeting PMTCT Targets in Akwa-Ibom State by 2015

TARGETS	2012	2013	2014	2015	TOTAL
1. Decrease HIV incidence among WRA	*0.96%*	*0.80%*	*0.64%*	*0.48%*	
2. Reduce unmet need for FP among HIV+ women	*29.0%*	*20.3%*	*11.6%*	*2.9%*	
3. Increase prophylaxis for HIV+ pregnant women	*14.0%*	*40.0%*	*66.0%*	*90.0%*	
OUTCOMES					
Status Quo Maintained: New HIV infections among WRA	10,042	10,198	10,357	10,518	41,116
Targets Achieved: New HIV infections among WRA	10,042	8,499	6,916	5,285	30,741
HIV infections averted among WRA	-	1,700	3,441	5,234	**10,374**
Status Quo Maintained: Pregnancies among HIV+ WRA	29,084	29,608	30,136	30,667	119,494
Targets Achieved: Pregnancies among HIV+ WRA	29,084	21,096	21,391	22,013	93,584
Pregnancies averted among HIV+ WRA	-	8,512	8,744	8,654	**25,910**
Status Quo Maintained: HIV infections among HEI	8,958	9,119	9,282	9,445	36,804
Targets Achieved: New HIV infections among HEI	8,958	4,852	3,251	1,761	18,822
HIV infections averted among HEI	-	4,267	6,030	7,684	**17,982**
Status Quo Maintained: Infant mortalities	4,139	4,214	4,289	4,365	17,007
Targets Achieved: Infant mortalities	4,139	2,504	2,033	1,612	10,289
Infant mortalities averted among HEI	-	1,710	2,256	2,752	**6,718**
Maternal mortalities averted among HIV+ women	-	68	70	69	**207**
DALYS saved	-	252,510	362,540	459,710	**1,074,760**

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

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.

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 mix observed in each state and assumed one year of use for new adopters. The CYPs for a minimum of year of use of each method were based on region-specific standards . 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.

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

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

13Measure 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: Quality HIV counseling and testing accessed by at least 90% of all women of reproductive age and their partners

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
STAFFING					
Recruit and deploy HCWs (nurses/midwives/CHEWs, lab and pharmacy staff) for HTC service provision at SHCs (no cost)	82 HCWs to be deployed (2 per facility)	Q3-Q4	Q1-Q4		SMOH
Recruit and deploy HCWs (nurses/midwives/CHEWs, lab and pharmacy staff) for HTC service provision at PHCs (no cost)	270 HCWs to be deployed (2 per facility)	Q3-Q4	Q1-Q4		SMOH
Training & capacity					
Conduct 10-day training for HCWs on HTC	440 HCWs to be trained on HTC	Q3	Q1 & Q3		SMOH/GF/PEPFAR
Conduct monthly mentoring and supportive supervisory visits to PMTCT sites	6 persons per month	Q3-Q4	Q1-Q4	Q1-Q4	SMOH
Conduct 1-day orientation/meeting for TBAs as community resource persons on HTC and referrals	TBAs in 31 LGAs (50 per LGA)	Q3-Q4	Q1-Q3		SMOH/GF
Sensitization					
Sensitize HCWs on PITC and multi-point HIV testing at health facilities (No cost - on-site sensitization)	All HCWs in the facility	Q3-Q4	Q1-Q4		SMOH
FOCUS AREA: HEALTH CARE COMMODITIES					
Procurement					
Drugs					
Procure drugs for STI treatment		Q3-Q4	Q1-Q4	Q1-Q4	SMOH
Procurement of ARVs for post exposure prophylaxis (TDF, 3TC, AZT, EFV, LPV/r)		Q3-Q4	Q1-Q4	Q1-Q4	SMOH
Consumables					
Procurement of RTKs (Determine) target 1,056,621	1,056,621		Q1-Q4		SMOH/SACA
Procurement of RTKs (Unigold)	115,172		Q1-Q4		SMOH/SACA
Procurement of RTKs (Stat pack)	57, 586		Q1-Q4		SMOH/SACA
Procurement of consumables (methylated spirit, cotton wool, gloves, lancet, work bench pad, jik, syringes, penile models, buffer, sharp boxes, bin liners) and ANC equipment	220	Q2	Q1-Q4		SMOH/SACA

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

Objective 1: Quality HIV counseling and testing accessed by at least 90% of all women of reproductive age and their partners *(continued)*

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: HEALTH CARE COMMODITIES *(continued)*					
Procurement *(contiuned)*					
Consumables (contiuned)					
Procurement of male condoms	148,349,546	Q2	Q1-Q4		SACA
Procurement of female condoms	1,483,495	Q2-Q4	Q1-Q4		SACA
Procurement of gloves, goggles, sharps boxes etc. (Already costed down)			Q1-Q4		SACA
Equipment					
Procurement of autoclaves and sterilization equipment (Already costed down)			Q1-Q2		SMOH
Printing of STI syndromic management IEC			Q1-Q3		SMOH/SACA/ ministry of Information
Distribution					
Drugs					
Distribution of the drugs		Q3-Q4	Q1-Q4	Q1-Q4	SMOH
Consumables					
Distribution of RTKs and consumables		Q2-Q4	Q1-Q4		SACA
Distribution of condoms (already costed)			Q1-Q4		SACA
Linkages					
Linkage to emergency contraceptives and psychosocial support		Q3-Q4	Q1-Q4	Q1-Q4	SACA
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					
Engage with CBOs/FBOs and community volunteers to conduct community outreaches (IPC, community dialogues, community drama/theater) to increase demand for PMTCT services					
CBOs/FBOs and community volunteers to facilitate the set up and orientation of 50 Mothers Clubs per LGA (31 LGAs) - Each club is made up of 10 women influencers in the community					

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

Objective 1: Quality HIV counseling and testing accessed by at least 90% of all women of reproductive age and their partners *(continued)*

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: PMTCT DEMAND CREATION SYSTEMS *(continued)*					
Community mobilization					
Advocacy					
Hold a 2-day advocacy talking point development meeting (during the SBCC training)	Communication specialist from IPs, Government (health Educators), CBOs, FBOs	Q3-Q4	Q1-Q4		SACA/ Ministry of information
Hold a 1-day advocacy orientation meeting for key stakeholders (at the State and Local Government levels) on using the advocacy talking point guide	Stakeholders at the state and local government levels	Q3	Q1& Q3		SMOH/SACA/ LACAs
Monthly communication support to 310 trained TBAs to educate, mobilize and follow up PMTCT clients	TBAs, Faith based delivery personnel	Q3-Q4	Q1-Q4		SMOH/SACA
IEC materials					
Adopt/adapt, print and disseminate IEC materials (310,000 leaflets - 10,000/LGA, 31,000 posters - 1,000/LGA, pamphlets, fliers etc.)	Pregnant women and their partners, TBAs/FBOs, Healthcare workers, Religious leaders	Q2-Q4	Q1-Q4		SMOH/SACA/ Ministry of Information.
Others					
Provide and replenish care kit (gloves consumable, methylated spirits, cotton wool etc) for 310 trained TBAs	TBAs, Faith based delivery personnel	Q2-Q4	Q1		SMOH/SACA
Monitoring & supervision					
Conduct quarterly advocacy/sensitization meeting for 40 religious leaders (pastors, imams)		Q3-Q4	Q1-Q4	Q1-Q4	SMOH/SACA/ GF
Conduct quarterly advocacy/sensitization meeting for 30 Journalists		Q3-Q4	Q1-Q3		SMOH/SACA/ ministry of Information/ GF
Conduct quarterly advocacy/sensitization meeting for 35 community leaders		Q3-Q4	Q1-Q4		SMOH/SACA/ Ministry of Information/ LACAs
Conduct quarterly sensitization and advocacy meetings at the State and LGA level for 40 policy makers					SMOH/SACA/ Ministry of information/ LACAs
CBOs/FBOs and community volunteers to facilitate monthly meetings with 62 Ward Development Committees (2 per LGA) on PMTCT issues and services					SMOH/SACA/ Ministry of Information/ LACAs
Conduct monthly community sensitization on PMTCT for members of the mothers Club in each LGA (10 per community).					SMOH/SACA/ Ministry of Information/ LACAs
Conduct monthly general men specific awareness on the benefits of ANC and PMTCT using existing structures and forums in the communities					SMOH/SACA/ Ministry of Information LACAs/ WDCs

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
		2013	2014	2015	
FOCUS AREA: PMTCT SYSTEM SUPPLY SERVICES					
Training & capacity					
Conduct 5-day training RH coordinators on SRH/ HIV integration	35 persons to be trained (1 per LGA and 4 state staff)	Q4			SMOH/GF
IEC materials					
Print and disseminate the SRH/HIV guidelines, service providers' curriculum and manual to all facilities	1,000 each of Guidelines, SOPs and Job aids for 220 HFs	Q2			SMOH/FMOH/GF
FOCUS AREA: HEALTH CARE COMMODITIES					
Procurement					
Consumables					
Procure of FP consumables (needles & syringes, cotton wool, gloves, methylated spirit, Jik)	40, 888	Q3-Q4	Q1-Q4	Q1-Q4	SMOH/ SPHCDA
Procure FP commodities (Condoms, COC, POP, Injectables - Depo, Noristerat, Implants - Jadelle, Implanon, IUCD) (FREE)	40, 888	Q3-Q4	Q1-Q4	Q1-Q4	Through UNFPA/ FMOH
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)		Q3-Q4	Q1-Q2		SMOH/ SPHCDA
Distribution					
Consumables					
Distribution of commodities through cluster review and resupply meeting	72	Q3-Q4	Q1-Q4	Q1-Q4	Through UNFPA/ FMOH
Stock management (CLMS)					
Capacity building on CLMS (Contraceptive Logistic Management System) for nurses and CHEWS		Q3-Q4	Q1-Q2		Through UNFPA/ FMOH

Prong 3: Prevention of mother to child transmission of 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
		2013	2014	2015	
FOCUS AREA: PMTCT SERVICE SUPPLY SYSTEM					
Staffing					
Recruit and deploy HCWs (doctors/nurses/midwives/ CHEWs, lab and pharmacy staff) for PMTCT service provision at SHCs	35 persons to be trained (1 per LGA and 4 state staff)	Q4			SMOH/GF
Recruit and deploy HCWs (doctors/nurses/midwives/ CHEWs, lab and pharmacy staff) for PMTCT service provision at PHCs	270 HCWs to be deployed (2 per facility)	Q3-Q4	Q1-Q4	Q1-Q4	SMOH
Training & capacity					
Conduct TOT in Integrated PMTCT for 20 healthcare workers	20	Q3			SMOH/PEPFAR
Conduct TOT in Integrated PMTCT for 20 healthcare workers	20	Q3			SMOH/PEPFAR
Conduct 6-day Integrated PMTCT training for HCWs in SHCs for 85 persons to be trained (2 persons per facility and 3 from the state)	85	Q3-Q4	Q1-Q4	Q1	SMOH/PEPFAR/GF
Conduct 6-day IMPAC training for HCWs in PHCs for 362 persons	362	Q3-Q4	Q1-Q2		SMOH/PEPFAR/GF
Conduct 2-day onsite training on adherence counselling for HCWs for 440 people	440	Q3-Q4	Q1-Q4	Q1	SMOH/PEPFAR/GF
Conduct 5-day pharmaceutical care trainings for HCWs in PMTCT sites (secondary health facilities and CP preceptors) including LMIS	66 persons to be trained (1 pharmacist per facility and 25 CPs)	Q3-Q4	Q1		SMOH
Conduct 3-day ART dispensing and documentation training for HCW in PHCs	362 persons to be trained (2 persons per facility and 4 from the LGA)	Q3-Q4	Q1-Q4	Q1	SMOH
Conduct 5-day onsite pharmacy best practices training for HCW for SHC and PHCs	All HCWs in the facility	Q3-Q4	Q1-Q4	Q1	SMOH
Conduct 5-day laboratory training for HCWs in SHCs	82 persons to be trained (2 persons per facility)	Q3-Q4			SMOH
Linkages/referrals					
Engage CBOs for identification and referral of pregnant women from community to facility for PMTCT services and client tracking	31 CBOs to be engaged (1 CBO per LGA)	Q3-Q4			SMOH

Prong 3: Prevention of mother to child transmission of 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
		2013	2014	2015	
FOCUS AREA: PMTCT SERVICE SUPPLY SYSTEM *(continued)*					
Mentoring & supervision					
Conduct monthly mentoring visits and joint supervisory to PMTCT sites		Q2-Q4	Q1-Q4	Q1-Q4	SMOH/GF
Conduct quarterly service quality improvements in PMTCT sites		Q3-Q4	Q1-Q4	Q1-Q4	SMOH
Site activation					
Activate 220 sites for PMTCT/EID service provision (3 days per SHCs and 2 days per PHC)	220 sites	Q3-Q4	Q1-Q2		SMOH/PEPFAR/GF
Community services					
Engage community volunteers and pharmacists to conduct community outreaches for HTC in PMTCT – 10 volunteers per LGA	310 community volunteers	Q3-Q4	Q1-Q4	Q1-Q4	SMOH/PEPFAR
Train the community volunteers and pharmacists on HTC and referrals in PMTCT (10 volunteers per LGA)	310 community volunteers	Q3-Q4	Q1-Q2		SMOH/PEPFAR
Support PHC staff to conduct twice monthly HTC outreaches at TBAs/Churches (2 per PHC)	358 PHC staff	Q3-Q4	Q1-Q4	Q1-Q4	SMOH/PEPFAR
FOCUS AREA: HEALTH CARE COMMODITIES					
Procurement (quantification, forecasting)					
Drugs					
Procure ARVs for triple prophylaxis (TDF+3Tc+EFV) 90%	12, 702	Q3-Q4	Q1-Q4	Q1-Q4	SMOH
Procure ARVs for triple prophylaxis (AZT+3TC+EFV)5%		Q3-Q4	Q1-Q4	Q1-Q4	SMOH
Procure ARVs for triple prophylaxis (Other regiments 5%)		Q3-Q4	Q1-Q4	Q1-Q4	SMOH
Procure OI medications (CTX)	26, 886	Q3-Q4	Q1-Q4	Q1-Q4	SMOH
Procure Haematinics		Q3-Q4	Q1-Q4	Q1-Q4	SMOH
Procure ITNs, SP and drugs for treatment of malaria	Linkage to NMCP	Q3-Q4	Q1-Q4	Q1-Q4	SMOH
Procurement of NVP syrup	Pooled Procurement	Q3-Q4	Q1-Q4	Q1-Q4	SMOH

Prong 3: Prevention of mother to child transmission of 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
		2013	2014	2015	
FOCUS AREA: HEALTH CARE COMMODITIES *(continued)*					
Procurement (quantification, forecasting) *(continued)*					
Consumables					
Procure CT in pregnant women (Determine)	Pooled Procurement	Q3-Q4	Q1-Q4	Q1-Q4	SMOH
Procure RTKs for CT in pregnant women (Unigold)		Q3-Q4	Q1-Q4	Q1-Q4	SMOH
Procure RTKs for CT in pregnant women (Statpack)	Pooled Procurement	Q3-Q4	Q1-Q4	Q1-Q4	SACA
Procure other prevention commodities (antibiotics, antifungals etc.)	2,688	Q3-Q4	Q1-Q4	Q1-Q4	SMOH
Procurement of CTX for babies	Pooled Procurement	Q3-Q4	Q1-Q4	Q1-Q4	SMOH
Procurement of Basic Care Kits	2, 500	Q3-Q4	Q1-Q4	Q1-Q4	SMOH
Procurement of Mama Kits Packs		Q3-Q4	Q1-Q4	Q1-Q4	SMOH
Equipment					
Procure lab equipment to PHC (POC CD4 and accessories)		Q2			SMOH
Procure of lab equipment, starter reagents and consumables for secondary health facilities (CD4, Chemistry & Haematology)		Q2			SMOH
Procure furniture (shelves, pallets & cabinets) & air-conditioners for drugs		Q2			SMOH
Logistics					
Sample transfer for Hematology and Chemistry		Q2			SMOH
Equipment Maintenance		Q2			SMOH
FOCUS AREA: PMTCT DEMAND CREATION SYSTEMS					
Community Mobilization					
Conduct 3-day training for 10 TBAs/faith based delivery centres per LGA as community resource persons on PMTCT, adherence counselling and referrals and develop action points	310 TBAs, Faith based delivery personnel	Q2			SMOH/SACA/ Ministry of information/ LACAs
Linkages & referrals					
Print and distribute 30,000 booklets of referral forms to TBAs	30,000 booklets of referral forms	Q2			SMOH/SACA/ Ministry of Education/

Prong 4: Family centered care and support

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: PMTCT SERVICE SUPPLY SYSTEMS					
Training					
Identify and train mentor mothers on adherence counselling, referrals and client tracking in PMTCT		Q3-Q4	Q1-Q2		SMOH
Mentoring & supervision					
Support mother support groups (MSGs) to provide community based adherence support and tracking of HIV positive pregnant women and their infants		Q3-Q4	Q1-Q4	Q1-Q4	SMOH/GF
FOCUS AREA: PMTCT SERVICE SUPPLY SYSTEMS					
Procurement (quantification, forecasting)					
Consumables					
Procure Internet modems and airtime	Costed under M&E	Q2			SMOH/SACA/
Procure DBS kits	13, 500	Q3-Q4	Q1-Q4	Q1-Q4	SMOH
Equipment					
Procure and distribute SMS printers	105, 000	Q2			SMOH/SACA/
Distribution					
Consumables					
Distribute DBS kits	All distribution pooled	Q3-Q4	Q1-Q4	Q1-Q4	SMOH
Supervision					
Supportive supervision for LMIS reporting		Q3-Q4	Q1-Q4	Q1-Q4	SMOH/SACA
Others					
Sample transfer for logging	20, 000	Q2			SMOH/SACA/
FOCUS AREA: PMTCT DEMAND CREATION SYSTEMS					
Community mobilization					
Sensitization					
Conduct orientation of PLHIV support groups in each LGA on PMTCT including infant feeding counseling, treatment adherence counseling	Support groups of PLWHA	Q2-Q4	Q1-Q4		SMOH/SACA/ LACAs

Prong 4: Family centered care and support

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
		2013	2014	2015	
FOCUS AREA: PMTCT SERVICE SUPPLY SYSTEMS					
Linkages/referrals					
Support HCW to conduct client tracking		Q3-Q4	Q1-Q4	Q1-Q4	SMOH
Link active EID sites to the National PCR Lab (No cost)		Q3-Q4	Q1-Q2		SMOH
Support referral and linkages of HIV positive pregnant women on lifelong ART and infected infants to comprehensive treatment sites		Q3-Q4	Q1-Q4	Q1-Q4	SMOH/SACA/ Ministry of women Affairs/ LACAs
FOCUS AREA: HEALTH CARE COMMODITIES					
Procurement (quantification, forecasting)					
Drugs					
Procurement of ARVs for treatment - Pooled procurement		Q3-Q4	Q1-Q4	Q1-Q4	SMOH
Logistics					
Conduct quarterly Logistic TWG meetings		Q3-Q4	Q1-Q4	Q1-Q4	SMOH/SACA

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: MONITORING AND EVALUATION					
Data Quality Assurance					
Conduct quarterly PMTCT Data Quality Assessment and mentorship at the implementing sites	All HFs carrying out PMTCT services	Q2-Q4	Q1-Q4	Q1-Q4	SMOH/SACA/ GF
Conduct monthly data verification and validation	All HFs carrying out PMTCT services	Q3-Q4	Q1-Q4	Q1-Q4	SMOH/SACA/ DPRS/ GF
Strategic information					
Publish eMTCT status report and other health information products		Q4	Q2& Q4	Q2& Q4	SMOH/SACA/ Ministry of Information

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
		2013	2014	2015	
FOCUS AREA: MONITORING AND EVALUATION *(continued)*					
Central database					
Redeployment of 2 staff as database administrators	Database administrator	Q3			SMOH/SACA/ DPRS
Training of 2 database administrators	Database administrator	Q4			SMOH/SACA/DPRS
Study tour of 2 database administrators to FMOH & FHI 360 headquarters	Database administrator	Q4	Q2		SMOH/SACA
Coordination					
Hold monthly PMTCT program coordination and data review meetings	PMTCT Site Coordinators, Med Supts& Site M&E Officers State PMTCT Team	Q2-Q4	Q1-Q4	Q1-Q4	SMOH/SACA/LACAs
Conduct quarterly 1 day meeting of the PMTCT TWG		Q2-Q4	Q1-Q4	Q1-Q4	SMOH/SACA
Conduct quarterly cluster coordination meetings		Q2-Q4	Q1-Q4	Q1-Q4	
Conduct 1 day state sensitization for state disease control officers	Heads of various Disease Control units @ state level	Q3			SMOH/SACA/ SASCP
Conduct 1-day meeting to inaugurate LGA Data Management team	Heads of various Disease Control units @ LGA level	Q3			SMOH/SACA/ DPRS/ SASCP/ LACAs
LGA M&E meeting (data review)	Data Management Team	Q2-Q4	Q1-Q4	Q1-Q4	SMOH/SACA/ DPRS/ SASCP/ LACAs
Quarterly state level M&E meetings	31 LGA HMIS officers & State M&E team	Q2-Q4	Q1-Q4	Q1-Q4	SMOH/SACA/ DPRS/ SASCP/ LACAs
Supportive supervision					
Conduct bi-monthly supportive supervision to PMTCT sites	All HFs carrying out PMTCT services	Q2-Q4	Q1-Q4	Q1-Q4	SMOH/SACA/ DPRS/ SASCP
Capacity building					
Conduct 4-day training of 15 state M&E officers on PMTCT data management	5 State & 31 LGA M&E Officers	Q3			SMOH/SACA/ DPRS/ SASCP
Conduct 4-day training of 40 HCWs at PHCs and SHCs on PMTCT data management	HCWs from PHCs &SHCs	Q3-Q4	Q2-Q4	Q2-Q4	SMOH/SACA/ DPRS/ SASCP/
Conduct 3-day training of 31 LGA M&E officers on PMTCT data management					SMOH/SACA/ DPRS/ SASCP
Others					
Print and distribute M&E tools	All HFs carrying out PMTCT services	Q2&Q4	Q2&Q4	Q2&Q4	SMOH/SACA/ DPRS

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
		2013	2014	2015	
FOCUS AREA: PROGRAM MANAGEMENT					
Coordination and resource mobilization					
Conduct monthly cluster coordination meetings		Q3-Q4	Q1-Q4	Q1-Q4	GF/PEPFAR
Build the capacity of LACAs/Primary Health Care Department to effectively monitor and coordinate the implementation of PMTCT scale up plan		Q3-Q4	Q1-Q4	Q1-Q4	GF/PEPFAR
Conduct quarterly State Implementation Team meetings		Q3-Q4	Q1-Q4	Q1-Q4	PEPFAR
Conduct bi-annual Partners Forum		Q3	Q1&Q3	Q1&Q3	World Bank
Hold quarterly PMTCT technical working group meetings (TWG)		Q3-Q4	Q1-Q4	Q1-Q4	World Bank
Conduct resource mapping and gap analysis		Q3-Q4	Q1		World Bank
Develop advocacy package (State Governor, private sector, etc)			Q1&Q2		World Bank
Carry out advocacy to the State Governor to facilitate the allocation and timely release of funds for the implementation of PMTCT activities			Q2		World Bank
Carry out advocacy to multinationals to support PMTCT implementation plan			Q2		World Bank
Organize trainings for CSOs on resource mobilization			Q3		World Bank
Support TWG, SMoH, SASCP and SACA on budgeting, resource mobilization and program management			Q3		World Bank
Initiate PPP with private sector organizations (MTN, Mobile etc.)			Q3		World Bank
Develop, print and distribute costed state PMTCT operational plan		Q1-Q3			PEPFAR
Conduct bi-annual progress review meetings		Q3	Q1&Q3	Q1&Q3	World Bank
Infrastructure					
Procure & maintain 4-wheel drive vehicle for supervision and monitoring		Q2-Q4	Q1-Q4	Q1-Q4	GF
Conduct monthly mentorship to the implementing sites		Q2-Q4	Q1-Q4	Q1-Q3	PEPFAR
Assess infrastructure needs in supported sites		Q2-Q3			PEPFAR/AKS
Carry out infrastructural upgrades		Q4	Q1&Q2		PEPFAR/AKS
Provide incentives for health care workers based on number of clients served (communication allowance)		Q2-Q4	Q1-Q4	Q1-Q3	PEPFAR/AKS
Conduct facility assessment to define service coverage		Q1			PEPFAR

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
		2013	2014	2015	
FOCUS AREA: PROGRAM MANAGEMENT *(continued)*					
Supportive Supervision					
Conduct monthly mentorship to the implementing sites		Q2-Q4	Q1-Q4	Q1-Q4	PEPFAR
Provide operational resources for the state implementation team (SIT)/critical mass committee of LACA to carry out joint monitoring and supervisory activities on monthly basis (transportation)		Q1-Q4	Q1-Q4	Q1-Q3	AKSG

SECTION

8 Monitoring and Evaluation Plan

The existing Information Management System will be utilised for routine collection of programme data using the registers and reporting forms at implementing health facilities. The reporting will follow the established channels through the LGAs to the state level where data will be compiled and shared for use in planning and policy decision making processes. The core indicators are summarised in Table 7 below.

Table 7: Targets of the Core Indicators for Akwa Ibom State

Indicator	2012 (baseline)	2013	2014	2015
Number of health facilities that provide ANC plus PMTCT services	34	134	252	252
Number females age 15 – 49 yrs newly tested HIV positive	9,081	7,686	6,254	4,779
Number of pregnant women counselled tested and given HIV results	26,739	99,857	167,879	240,487
Number of HIV infected women aged 15 – 49 years who accessed comprehensive family planning services	N/A	10,130	10,407	10,299
Number of pregnant women reached with antiretroviral drugs for PMTCT according to the national guidelines	1,830	10,884	18,580	26,213
Number of HIV positive pregnant women in need of treatment initiated on ART for their own health (50% of total)	430	4,354	8,586	13,107
Number of HIV exposed infants offered first PCR test from 6 – 8 weeks of age	331	8,707	17,173	26,213

8.1 AKWA IBOM 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	• Early HIV diagnosis services accessed by at least 90% of all HIV exposed infants • Life-long ART received by at least 90% of the pregnant, infected women requiring treatment for their own health.
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 of the budget for the plan is highlighted in the table below. Please see *Appendix 1* for the detailed budget.

Table 8: Budget Summary Table

THEMATIC AREAS	Year 1	Year 2	Year 3	Total N	Total $
PMTCT supply service systems	1,061,338,320	1,061,338,320	530,669,160	2,653,345,800	17,118,360
Health care commodities	2,030,136,000	2,030,136,000	1,015,068,000	5,075,339,999	32,744,129
PMTCT demand creation systems	139,766,120	139,766,120	69,883,060	349,415,300	2,254,292
Monitoring and evaluation	893,433,760	893,433,760	446,716,880	2,233,584,400	14,410,222
Program management	1,335,902,265	1,335,902,265	667,951,133	3,339,755,664	21,546,811
Total	**5,460,576,465**	**5,460,576,465**	**2,730,288,233**	**13,651,441,163**	**88,073,814**

SECTION

10 Appendix- Detailed Budget

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

Objective 1: Quality HIV counselling and testing accessed by at least 90% of all pregnant women

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget Less One-off activities (Naira)	Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)
THEMATIC AREA: PMTCT SERVICE SUPPLY SYSTEMS						
Staffing	Recruit and deploy HCWs (nurses/midwives/CHEWs, lab and pharmacy staff) for HTC service provision at SHCs (no cost)	-	-			
	Recruit and deploy HCWs (nurses/midwives/CHEWs, lab and pharmacy staff) for HTC service provision at PHCs (no cost)		-			
Training & capacity	Conduct a bimonthly 1-day sensitization workshop for TBAs on HIV prevention activities including referrals and linkages for care	63,547,200	63,547,200	31,773,600	158,868,000	1,024,955
	Conduct monthly mentoring and supportive supervisory visits to PMTCT sites	89,280,000	89,280,000	44,640,000	223,200,000	1,440,000
	Conduct 1 day orientation/ meeting for TBAs as community resource persons on HTC and referrals	8,088,000	8,088,000	4,044,000	20,220,000	130,452
Sensitization	Sensitize HCWs on PITC and multi-point HIV testing at health facilities (No cost - on-site sensitization)	-	-	-		-
PMTCT service supply systems sub-total		**100,611,600**	**187,487,500**	**147,652,600**	**435,751,700**	**2,811,301**

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

Objective 1: Quality HIV counselling and testing accessed by at least 90% of all pregnant women *(continued)*

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget Less One-off activities (Naira)	Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)
THEMATIC AREA: HEALTH CARE COMMODITIES						
Procurement (quantification, forecasting)	***Drugs***					
	Procure drugs for STI treatment	1,800,000	1,800,000	900,000	4,500,000	29,032
	Procurement of ARVs for post exposure prophylaxis (TDF, 3TC, AZT, EFV, LPV/r)	-	-	-	-	-
	Consumables					
	Procurement of RTKs (Determine) (target 1,056,621)	101,435,616	101,435,616	50,717,808	253,589,040	1,636,058
	Procurement of RTKs (Unigold)	38,038,320	38,038,320	19,019,160	95,095,800	613,521
	Procurement of RTKs (Stat pack)	2,073,060	2,073,060	1,036,530	5,182,650	33,436
	Procurement of consumables (methylated spirit, cotton wool, gloves, lancet, work bench pad, jik, syringes, penile models, buffer, sharp boxes, bin liners) and ANC equipment	17,600,000	17,600,000	8,800,000	44,000,000	283,871
	Procurement of male condoms	237,359,274	237,359,274	118,679,637	593,398,184	3,828,375
	Procurement of female condoms	110,372,028	110,372,028	55,186,014	275,930,070	1,780,194
	Procurement of gloves, goggles, sharps boxes etc (already costed down)	-	-	-		-
	Equipment					
	Procurement of autoclaves and sterilization equipment (already costed down)	-	-	-		-
	Printing of STI syndromic mgt IEC	-	-	-		-

SECTION
10 APPENDIX-DETAILED BUDGET

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

Objective 1: Quality HIV counselling and testing accessed by at least 90% of all pregnant women *(continued)*

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget Less One-off activities (Naira)	Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)
THEMATIC AREA: HEALTH CARE COMMODITIES *(continued)*						
Distribution	***Drugs***					
	Distribution of the drugs	-	-	-		-
	Consumables					
	Distribution of RTKs and consumables	20,916,000	20,916,000	10,458,000	52,290,000	337,355
	Distribution of condoms (already costed)	-	-	-		-
Linkages	Linkage to emergency contraceptives and psychosocial support	-	-	-		
Health Care Commodities sub-total		**529,594,298**	**529,594,298**	**264,797,149**	**1,323,985,744**	**8,541,844**
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	6,480,000	6,480,000	3,240,000	16,200,000	104,516
	Engage with CBOs/FBOs and community volunteers to conduct community outreaches (IPC, community dialogues, community drama/theater) to increase demand for PMTCT services	62,000,000	62,000,000	31,000,000	155,000,000	1,000,000
	CBOs/FBOs and community volunteers to facilitate the set up and orientation of 50 Mothers Clubs per LGA (31 LGAs) - Each club is made up of 10 women influencers in the community	-	-	-		-

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

Objective 1: Quality HIV counselling and testing accessed by at least 90% of all pregnant women *(continued)*

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget Less One-off activities (Naira)	Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)
THEMATIC AREA: PMTCT DEMAND CREATION SYSTEMS *(continued)*						
Community Mobilization	***Advocacy***					
	Hold 2-day Advocacy talking Point Development Meeting (during the SBCC training)	6,480,000	6,480,000	3,240,000	16,200,000	104,516
	Hold 1-day Advocacy orientation meeting for key stakeholders (at the State and Local Government levels) on using the Advocacy talking point guide	190,400	190,400	95,200	476,000	3,071
	Monthly communication support to 310 trained TBAs to educate, mobilize and follow up PMTCT clients	4,464,000	4,464,000	2,232,000	11,160,000	72,000
Media engagement	Produce and air interactive radio and TV program in Pidgin and Ibibio	8,944,000	8,944,000	4,472,000	22,360,000	144,258
	Adapt and air 6 radio spots/ jingles in 3 languages (English, pidgin & Ibibio) on ANC	5,320,000	5,320,000	2,660,000	13,300,000	85,806
Mentoring & supervision	Conduct quarterly advocacy/ sensitization meeting for 40 religious leaders (pastors, imams)	848,000	848,000	424,000	2,120,000	13,677
	Conduct quarterly advocacy/ sensitization meeting for 30 Journalists	643,680	643,680	321,840	1,609,200	10,382
	Conduct quarterly advocacy/ sensitization meeting for 35 community leaders	780,800	780,800	390,400	1,952,000	12,594
	Conduct quarterly sensitization and advocacy meetings at the state and LGA level	794,240	794,240	397,120	1,985,600	12,810

SECTION
10 APPENDIX-DETAILED BUDGET

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

Objective 1: Quality HIV counselling and testing accessed by at least 90% of all pregnant women *(continued)*

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget Less One-off activities (Naira)	Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)
THEMATIC AREA: PMTCT DEMAND CREATION SYSTEMS *(continued)*						
Mentoring & supervision *(continued)*	CBOs/FBOs and community volunteers to facilitate monthly meetings with 62 Ward Development Committees (2 per LGA) on PMTCT issues and services	5,136,000	5,136,000	2,568,000	12,840,000	82,839
	Conduct monthly community sensitisation on PMTCT for members of the Mothers Club in each LGA (10 per community)	-	-	-		-
	Conduct monthly general men specific awareness on the benefits of ANC and PMTCT using existing structures and forums in the communities	-	-	-		-
IEC materials	Adopt/adapt, print and disseminate IEC materials (310,000 leaflets - 10,000/LGA, 31,000 posters - 1,000/LGA, pamphlets, fliers etc)	7,564,000	7,564,000	3,782,000	18,910,000	122,000
Others	Provide and replenish care kit (gloves consumable, methylated spirits, cotton, wool etc) for 310 trained TBAs	5,208,000	5,208,000	2,604,000	13,020,000	84,000
PMTCT demand creation systems		**114,853,120**	**114,853,120**	**57,426,560**	**287,132,800**	**1,852,470**
Objective 1 sub-total		**805,362,618**	**805,362,618**	**402,681,309**	**2,013,406,544**	**12,989,720**

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%

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget Less One-off activities (Naira)	Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)
THEMATIC AREA: PMTCT SERVICE SUPPLY SYSTEMS						
Training & capacity	Conduct 5-day training RH coordinators on SRH/ HIV integration	4,524,800	4,524,800	2,262,400	11,312,000	72,981
IEC materials	Print and disseminate the SRH/HIV guidelines, service providers' curriculum and manual to all facilities	1,400,000	1,400,000	700,000	3,500,000	22,581
PMTCT service supply systems sub-total		**5,924,800**	**5,924,800**	**2,962,400**	**14,812,000**	**95,561**
THEMATIC AREA: HEALTH CARE COMMODITIES						
Procurement (quantification, forecasting)	***Consumables***					
	Procure of FP consumables (needles & syringes, cotton wool, gloves, methylated spirit, Jik)	8,177,600	8,177,600	4,088,800	20,444,000	131,897
	Procure FP commodities (Condoms, COC, POP, Injectables - Depo, Noristerat, Implants - Jadelle, Implanon, IUCD) (FREE)	6,000,000	6,000,000	3,000,000	15,000,000	96,774
	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)	6,482,154	6,482,154	3,241,077	16,205,385	104,551
Distribution	***Consumables***					
	Distribution of commodities through cluster review and resupply meeting	1,860,000	1,860,000	930,000	4,650,000	30,000
Stock management (CLMS)	Capacity building on CLMS (Contraceptive Logistic Management System) for nurses and CHEWS	13,744,000	13,744,000	6,872,000	34,360,000	221,677
Health Care Commodities sub-total		**36,263,754**	**36,263,754**	**18,131,877**	**90,659,385**	**584,899**
Objective 2 sub-total		**42,188,554**	**42,188,554**	**21,094,277**	**105,471,385**	**680,461**

SECTION
10 APPENDIX-DETAILED BUDGET

Prong 3: Prevention of mother-to-child transmission of HIV

Objective 3: Increase access to quality HIV counselling 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

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget Less One-off activities (Naira)	Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)
THEMATIC AREA: PMTCT SERVICE SUPPLY SYSTEMS						
Training & capacity	Conduct TOT in Integrated PMTCT	8,344,000	8,344,000	4,172,000	20,860,000	134,581
	Conduct TOT in Integrated Management of Pregnancy and Childbirth (IMPAC)	3,244,800	3,244,800	1,622,400	8,112,000	52,335
	Conduct 6-day Integrated PMTCT training for HCWs in SHCs	12,233,920	12,233,920	6,116,960	30,584,800	197,321
	Conduct 6-day IMPAC training for HCWs in PHCs	4,398,400	4,398,400	2,199,200	10,996,000	70,942
	Conduct 2-day onsite training on adherence counselling for HCWs	3,520,000	3,520,000	1,760,000	8,800,000	56,774
	Conduct 5-day pharmaceutical care trainings for HCWs in PMTCT sites (secondary health facilities and CP preceptors) including LMIS	48,935,680	48,935,680	24,467,840	122,339,200	789,285
	Conduct 3-day ART dispensing and documentation training for HCW in PHCs	1,975,200	1,975,200	987,600	4,938,000	31,858
	Conduct 5-day onsite pharmacy best practices training for HCW for SHC and PHCs	12,233,920	12,233,920	6,116,960	30,584,800	197,321
	Conduct 5-day laboratory training for HCWs in SHCs	4,398,400	4,398,400	2,199,200	10,996,000	70,942
Linkages/re-ferrals	Engage CBOs for identification and referral of pregnant women from community to facility for PMTCT services and client tracking	7,440,000	7,440,000	3,720,000	18,600,000	120,000

Prong 3: Prevention of mother-to-child transmission of HIV

Objective 3: Increase access to quality HIV counselling 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)*

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget Less One-off activities (Naira)	Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)
THEMATIC AREA: PMTCT SERVICE SUPPLY SYSTEMS *(continued)*						
Mentoring & supervision	Conduct monthly mentoring visits and joint supervisory to PMTCT sites	2,976,000	2,976,000	1,488,000	7,440,000	48,000
	Conduct quarterly service quality improvements in PMTCT sites	45,880,000	45,880,000	22,940,000	114,700,000	740,000
Site activation	Activate 220 sites for PMTCT/ EID service provision	4,775,000	4,775,000	2,387,500	11,937,500	77,016
IEC materials	Print and disseminate national guidelines, job aids and SOPs for PMTCT/EID and HTC	1,400,000	1,400,000	700,000	3,500,000	22,581
	Print and distribute IMPAC training materials for PHCs (training manuals and modules)	1,528,000	1,528,000	764,000	3,820,000	24,645
Community services	Engage community volunteers and pharmacists to conduct community outreaches for HTC in PMTCT	691,920,000	691,920,000	345,960,000	1,729,800,000	11,160,000
	Train the community volunteers and pharmacists on HTC and referrals in PMTCT	573,000	573,000	286,500	1,432,500	9,242
	Support PHC staff to conduct twice monthly HTC outreaches at TBAs/churches	21,480,000	21,480,000	10,740,000	53,700,000	346,452
PMTCT service supply systems sub-total		**877,256,320**	**877,256,320**	**438,628,160**	**2,193,140,800**	**14,149,295**

SECTION
10 APPENDIX-DETAILED BUDGET

Prong 3: Prevention of mother-to-child transmission of HIV

Objective 3: Increase access to quality HIV counselling 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)*

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget Less One-off activities (Naira)	Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)
THEMATIC AREA: HEALTH CARE COMMODITIES						
Procurement (quantification, forecasting)	***Drugs***					
	Procure ARVs for triple prophylaxis (TDF+3Tc+EFV) 90%	122,945,198	122,945,198	61,472,599	307,362,996	1,982,987
	Procure ARVs for triple prophylaxis (AZT+3TC+EFV)5%	10,399,334	10,399,334	5,199,667	25,998,336	167,731
	Procure ARVs for triple prophylaxis (other reagents 5%)	21,349,171	21,349,171	10,674,586	53,372,928	344,341
	Procure OI medications (CTX)	6,452,640	6,452,640	3,226,320	16,131,600	104,075
	Procure Haematinics	3,226,320	3,226,320	1,613,160	8,065,800	52,037
	Procure ITNs, SP and drugs for treatment of malaria	16,131,600	16,131,600	8,065,800	40,329,000	260,187
	Procurement of NVP syrup	6,452,640	6,452,640	3,226,320	16,131,600	104,075
	Consumables					
	Procure CT in pregnant women (Determine)	16,557,120	16,557,120	8,278,560	41,392,800	267,050
	Procure RTKs for CT in pregnant women (Unigold)	3,383,820	3,383,820	1,691,910	8,459,550	54,578
	Procure RTKs for CT in pregnant women (Statpack)	1,692,000	1,692,000	846,000	4,230,000	27,290
	Procure other prevention commodities (antibiotics, antifungals etc.)	4,000,000	4,000,000	2,000,000	10,000,000	64,516
	Procurement of CTX for babies	2,688,600	2,688,600	1,344,300	6,721,500	43,365
	Procurement of Basic Care Kits	16,131,600	16,131,600	8,065,800	40,329,000	260,187
	Procurement of Mama Kits Packs	21,508,800	21,508,800	10,754,400	53,772,000	346,916

Prong 3: Prevention of mother-to-child transmission of HIV

Objective 3: Increase access to quality HIV counselling 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)*

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget Less One-off activities (Naira)	Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)
THEMATIC AREA: HEALTH CARE COMMODITIES *(continued)*						
Procurement (quantification, forecasting) *(continued)*	***Equipment***					
	Procure lab equipment to PHC (POC CD4 and accessories)	13,599,600	13,599,600	6,799,800	33,999,000	219,348
	Procure of lab equipment, starter reagents and consumables for secondary health facilities (CD4, Chemistry & Haematology)	97,232,309	97,232,309	48,616,154	243,080,772	1,568,263
	Procure furniture (shelves, pallets & cabinets) & air-conditioners for drugs	844,932,000	844,932,000	422,466,000	2,112,330,000	13,627,935
Distribution	***Drugs***					
	Distribute ARVs and OIs	-	-	-	-	-
Others	Sample transfer for Haematology and Chemistry	21,480,000	21,480,000	10,740,000	53,700,000	346,452
	Equipment maintenance	22,965,600	22,965,600	11,482,800	57,414,000	370,413
Health Care Commodities sub-total		**1,253,128,353**	**1,253,128,353**	**626,564,176**	**3,132,820,882**	**20,211,748**
THEMATIC AREA: PMTCT DEMAND CREATION SYSTEMS						
Community Mobilization	Conduct 3-day training for 10 TBAs/faith-based delivery centres per LGA as community resource persons on PMTCT, adherence counselling and referrals and develop action points	12,310,000	12,310,000	6,155,000	30,775,000	198,548
Linkages and referrals	Print and distribute 30,000 booklets of referral forms to TBAs	6,124,000	6,124,000	3,062,000	15,310,000	98,774
PMTCT demand creation systems sub-total		**18,434,000**	**18,434,000**	**9,217,000**	**46,085,000**	**297,323**
Objective 3 & 4 sub-total		**2,148,818,673**	**2,148,818,673**	**1,074,409,336**	**5,372,046,682**	**34,658,366**

SECTION
10 APPENDIX-DETAILED BUDGET

Prong 4: Family centered care and support

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

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget Less One-off activities (Naira)	Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)
THEMATIC AREA: PMTCT SERVICE SUPPLY SYSTEMS						
Training	Identify and train mentor mothers on adherence counselling, referrals and client tracking in PMTCT	1,804,000	1,804,000	902,000	4,510,000	29,097
Others	Support mother support groups (MSGs) to provide community based adherence support and tracking of HIV positive pregnant women and their infants	7,440,000	7,440,000	3,720,000	18,600,000	120,000
PMTCT service supply systems sub-total		**9,244,000**	**9,244,000**	**4,622,000**	**23,110,000**	**149,097**
THEMATIC AREA: HEALTH CARE COMMODITIES						
Procurement (quantification, forecasting)	Procure Internet modems and airtime	1,860,000	1,860,000	930,000	4,650,000	30,000
	Procure DBS kits	135,437,400	135,437,400	67,718,700	338,593,500	2,184,474
	Procure and distribute SMS printers	1,050,000	1,050,000	525,000	2,625,000	16,935
Distribution	*Consumables*					
	Distribute DBS kits	-	-	-		-
Supervision	Supportive supervision for LMIS reporting	7,878,000	7,878,000	3,939,000	19,695,000	127,065
Others	Sample transfer for logging	52,800,000	52,800,000	26,400,000	132,000,000	851,613
Health Care Commodities sub-total		**199,025,400**	**199,025,400**	**99,512,700**	**497,563,500**	**3,210,087**
THEMATIC AREA: PMTCT DEMAND CREATION SYSTEMS						
Community Mobilization	***Sensitization***					
	Conduct orientation of PLHIV support groups in each LGA on PMTCT including infant feeding counselling, treatment adherence counselling	6,479,000	6,479,000	3,239,500	16,197,500	104,500
PMTCT demand creations systems sub-total		**6,479,000**	**6,479,000**	**3,239,500**	**16,197,500**	**104,500**
Objective 5 sub-total		**214,748,400**	**214,748,400**	**107,374,200**	**536,871,000**	**3,463,684**

Prong 4: Family centered care and support

Objective 6: Life-long ART received by 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)	Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)
THEMATIC AREA: PMTCT SERVICE SUPPLY SYSTEMS						
Linkages/ referrals	Support HCW to conduct client tracking	7,440,000	7,440,000	3,720,000	18,600,000	120,000
	Link active EID sites to the National PCR Lab	-	-	-	-	-
	Support referral and l inkages of HIV positive pregnant women on life-long ART and infected infants to comprehensive treatment sites	558,000	558,000	279,000	1,395,000	9,000
PMTCT service supply systems sub-total		**7,998,000**	**7,998,000**	**3,999,000**	**19,995,000**	**129,000**
THEMATIC AREA: HEALTH CARE COMMODITIES						
Procurement (quantification, forecasting)	***Drugs***					
	Procurement of ARVs for treatment	6,828,595	6,828,595	3,414,298	17,071,488	110,139
Logistics	Conduct Logistic TWG meetings	5,295,600	5,295,600	2,647,800	13,239,000	85,413
Health Care Commodities sub-total		**12,124,195**	**12,124,195**	**6,062,098**	**30,310,488**	**195,552**
Objective 6 sub-total		**20,122,195**	**20,122,195**	**10,061,098**	**50,305,488**	**324,552**

SECTION
10 APPENDIX-DETAILED BUDGET

Cross cutting areas: Family centered care and support

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

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget Less One-off activities (Naira)	Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)
THEMATIC AREA: MONITORING & EVALUATION						
Data Quality Assurance	Conduct quarterly PMTCT Data Quality Assessment and mentorship at the implementing sites	928,400	928,400	464,200	2,321,000	14,974
	Conduct monthly data verification and validation	2,785,200	2,785,200	1,392,600	6,963,000	44,923
Strategic Information	Publish eMTCT status report and other Health Information Products	-	-	-	-	-
Coordination	Hold monthly PMTCT program coordination and data review meetings	-	-	-		-
	Conduct quarterly 1-day meeting of the PMTCT TWG	-	-	-		-
	Conduct quarterly cluster coordination meetings	-	-	-		-
	Conduct 1-day sensitization for state disease control officers	21,200	21,200	10,600	53,000	342
	Conduct 1-day meeting to inaugurate LGA data management team	643,900	643,900	321,950	1,609,750	10,385
	LGA M&E meeting (data review)	24,654,300	24,654,300	12,327,150	61,635,750	397,650
	Quarterly State Level M&E meetings	844,800	844,800	422,400	2,112,000	13,626
Central Database	Redeployment of 2 staff as database administrators	3,600,000	3,600,000	1,800,000	9,000,000	58,065
	Training of 2 database Administrators	361,600	361,600	180,800	904,000	5,832
	Study tour of 2 database Administrators to FMOH & FHI 360 headquarters	153,200	153,200	76,600	383,000	2,471

Cross cutting areas: Family centered care and support

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

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget Less One-off activities (Naira)	Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)
THEMATIC AREA: MONITORING & EVALUATION *(continued)*						
Supportive supervision	Conduct bi-monthly supportive supervision to PMTCT sites	1,519,200	1,519,200	759,600	3,798,000	24,503
Capacity Building	Conduct 4-day training of 15 State M&E officers on PMTCT data management	996,200	996,200	498,100	2,490,500	16,068
	Conduct 4-day training of 40 HCWs at PHCs and SHCs on PMTCT data management	14,481,600	14,481,600	7,240,800	36,204,000	233,574
	Conduct 3-day training of 31 LGA M&E officers on PMTCT data management	1,604,160	1,604,160	802,080	4,010,400	25,874
Other	Print and distribute M&E tools	840,840,000	840,840,000	420,420,000	2,102,100,000	13,561,935
Monitoring and supervision sub-total		**893,433,760**	**893,433,760**	**446,716,880**	**2,233,584,400**	**14,410,222**
THEMATIC AREA: PROGRAM MANAGEMENT						
Coordination & Resource mobilisation	Conduct monthly cluster coordination meetings	14,520,000	14,520,000	7,260,000	36,300,000	234,194
	Build the capacity of LACAs/Primary Health Care Department to effectively monitor and coordinate the implementation of PMTCT scale up plan	2,981,200	2,981,200	1,490,600	7,453,000	48,084
	Conduct quarterly State Implementation Team meetings	4,859,000	4,859,000	2,429,500	12,147,500	78,371
	Conduct bi-annual Partners Forum	952,000	952,000	476,000	2,380,000	15,355

SECTION
10 APPENDIX-DETAILED BUDGET

Cross cutting areas: Family centered care and support

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

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget Less One-off activities (Naira)	Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)
THEMATIC AREA: PROGRAM MANAGEMENT *(continued)*						
Coordination & Resource mobilisation *(continued)*	Hold quarterly PMTCT technical working group meetings (TWG)	3,426,000	3,426,000	1,713,000	8,565,000	55,258
	Conduct resource mapping and gap analysis	485,900	485,900	242,950	1,214,750	7,837
	Develop advocacy package (State Governor, private sector, etc.)	2,064,960	2,064,960	1,032,480	5,162,400	33,306
	Carry out advocacy to the State Governor to facilitate the allocation and timely release of funds for the implementation of PMTCT activities	72,000	72,000	36,000	180,000	1,161
	Carry out advocacy to multinationals to support PMTCT implementation plan	72,000	72,000	36,000	180,000	1,161
	Organize trainings for CSOs on resource mobilization	5,295,600	5,295,600	2,647,800	13,239,000	85,413
	Support TWG, SMoH, SASCP and SACA on budgeting, resource mobilization and program management	5,295,600	5,295,600	2,647,800	13,239,000	85,413
	Initiate PPP with private sector organizations (MTN, Mobile etc.)	234,000	234,000	117,000	585,000	3,774
	Develop, print and distribute costed state PMTCT operational plan	4,993,000	4,993,000	2,496,500	12,482,500	80,532
	Conduct bi-annual progress review meetings	6,227,000	6,227,000	3,113,500	15,567,500	100,435

Cross cutting areas: Family centered care and support

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

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget Less One-off activities (Naira)	Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)
THEMATIC AREA: PROGRAM MANAGEMENT *(continued)*						
Infrastructure	Procure & maintain 4-wheel drive vehicle for supervision and monitoring	8,400,000	8,400,000	4,200,000	21,000,000	135,484
	Conduct monthly mentorship to the implementing sites	16,740,000	16,740,000	8,370,000	41,850,000	270,000
	Assess infrastructure needs in supported sites	792,000	792,000	396,000	1,980,000	12,774
	Carry out infrastructural upgrades	440,000,000	440,000,000	220,000,000	1,100,000,000	7,096,774
	Provide incentives for health care workers based on number of clients served (communication allowance)	21,120,000	21,120,000	10,560,000	52,800,000	340,645
	Conduct facility assessment to define service coverage	5,313,305	5,313,305	2,656,652	13,283,262	85,698
HR & Staffing	Recruit and deploy more health workers based on identified needs	792,000,000	792,000,000	396,000,000	1,980,000,000	12,774,194
Monitoring and supervision	Conduct monthly mentorship to implementing sites	-	-	-		-
	Transportation for the state implementation team (SIT)/critical mass committee of LACA for joint supervisory activities monthly	58,701	58,701	29,350	146,752	947
Program management sub-total		**1,335,902,265**	**1,335,902,265**	**667,951,133**	**3,339,755,664**	**21,546,811**
Objective 7 sub-total		**2,229,336,025**	**2,229,336,025**	**1,114,668,013**	**5,573,340,064**	**35,957,033**
Grand total		**5,460,576,465**	**5,460,576,465**	**2,730,288,233**	**13,651,441,163**	**88,073,814**

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Strengthening Integrated Delivery of HIV/AIDS Services

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NIGERIANS AND AMERICANS IN PARTNERSHIP TO FIGHT HIV/AIDS

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