BAYELSA STATE

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

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Foreword

As the world marches towards an HIV/AIDS free generation, it is imperative that every government, nation, community and person is engaged towards achieving zero new infections, zero AIDS related deaths and zero stigma and discrimination of people living with HIV (PLHIV) and those affected by HIV/AIDS.

Bayelsa State is one of the 12+1 states that contribute 70% of Nigeria's burden of mother-to-child transmission of HIV (MTCT). With an HIV prevalence rate of 9.1%, approximately every one in 10 pregnant persons in Bayelsa State is HIV positive, yet coverage of prevention of mother-to-child transmission of HIV (PMTCT) services had been low. Only 38 of the 226 health facilities in the state provide PMTCT related services. Consequently, state performance relative to key PMTCT indicators shows only 1-6% achievements.

This plan was developed using inputs from assessments conducted in 2013. Supported by FHI 360 and with funding from USAID, we embarked on a state-wide rapid health facility assessment. The Saving One Million Lives team from the Federal Ministry of Health also supported us to conduct a PMTCT diagnostics - the PMTCT Deep Dive. These assessments helped us to identify key areas to focus our resources on towards eMTCT.

We are buoyed by the fact that if we achieve the targets set in this operational plan by 2015, we would have averted 3,813 pregnancies among HIV-positive women; averted 6,139 new HIV infections among HIV-exposed infants averted 2,310 infant deaths among HIV-exposed infants. All these will contribute to 372,888 DALYs saved. This is a good reason to invest and we believe that this return on investment is well worth our efforts.

The State Government has therefore embarked on a massive health infrastructural development coupled with employment of health personnel in all cadres of the Health Sector. Every local government headquarters in the state would soon boast of a state-of-the-art General Hospital/Referral Centre. Our partners have also continued to train our health workers and support the provision of services both in health facilities and in our communities.

I wish to appreciate the contributions of all stakeholders to the development of this "Operational Plan for the "Elimination of Mother-to-Child Transmission of HIV 2013-2015". I hereby enjoin all Partners to make concerted efforts to the successful implementation of this plan in a collaborative manner to achieve the goal of the scale up of eMTCT in the state.

I hereby reaffirm the support and commitment of Bayelsa State Government to this Plan and all the processes that will be involved thereafter.

Dr. Anapurere Michael Awoli

Honourable Commission for Health
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Acknowledgements

We wish to thank His Excellency, the Governor of Bayelsa State, Honourable Henry Seriake Dickson for the privilege given to the Ministry of Health, Development Partners, and other stakeholders to carry out this very important assignment aimed at providing the desired platform towards the elimination of mother-to-child transmission of HIV/AIDS in the state.

It is our collective prayer that this report meets the expectations of Government and serves as a blue print to institutionalizing the much-desired application or comprehensive HIV/AIDS services in our health care system.

We are particularly grateful to Dr. Anapurere Awoli (Honourable Commissioner for Health), Dr. Bribina Frank Samayin (Permanent Secretary, Ministry of Health), other Directors and Staff of the Ministry of Health, Director General of SACA, Directors of SACA and other stakeholders who sacrificed time and energy to develop this operational plan.

Our partners at the national level - NACA and FMOH are well appreciated for their inputs into this plan. Our development partners, particularly USAID, must also be mentioned for supporting this process and for working together with us towards our goal of ensuring an HIV-free generation.

Thank you and God bless you all.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Artemisin Combination Therapy
ARVs	Anti-Retroviral Drugs
BYSACA	Bayelsa State AIDS Control Agency
CBOs	Community Development Councils
CDC	Centre of 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
DBS	Dried Blood Spot (Sample)
DFID	UK Department for International Development
DPRS	Department of Planning Research and Statistics
DQA	Data Question Assurance
EID	Early Infant Diagnosis
eMTCT	Elimination of Mother-To-Child Transmission
FBOs	Faith Based Organizations
FCT	Federal Capital Territory
FMOH	Federal Ministry of Health
FP	Family Planning
FSP	Family Support Programme
FSW	Female Sex Worker
GF	Global Fund
GH	General Hospital
GHAIN	Global HIV/AIDS Initiative in Nigeria
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
NDUTH	Niger Delta University Teaching Hospital
NGOs	Non-Governmental Organizations
NPHCDA	National Primary Health Care Development Agency
NPP	National Prevention Plan
NSF	National Strategic Framework
OPD	Outpatient Department
PCR	Polymerase Chain Reaction
PEPFAR	President's Emergency Fund For AIDS Relief
PHC	Primary health care
PHC/DC	Department of 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

The sub-optimal coverage of Prevention of Mother to Child Transmission (PMTCT) of HIV services is evident in the fact that Nigeria has the highest burden of mother-to-child transmission of HIV (MTCT) in the world and is among the top ten countries with poor maternal and child health indices. In the light of the above, in June 2011, the President of the Federal Republic of Nigeria accented to the "Global plan to eliminate pediatric HIV and keep their mothers alive by 2015". 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.

HIV prevalence among pregnant women in the Bayelsa State was 9.1% based on the 2010 Antenatal Care (ANC) Sentinel Surveillance, which is the third highest in the country. Review of available data, the deep dive and a rapid health facility assessment conducted in the state showed very poor ANC attendance; poor hospital delivery, high traditional birth attendant (TBA) patronage and 101 out of the 167 facilities that provide ANC services did not provide antiretroviral drugs (ARVs) for PMTCT at the end of 2012. Of these, only 12 met the national human resource (HR) standard for PMTCT service provision while about 61 (60%) facilities had at least four clinical staff that could perform patient care duties (either nurses or community health workers).

Moreover, out of the estimated 9,297 HIV infected pregnant mothers, only 2% received ARVs for PMTCT. Kolokuma/Opokuma and Brass LGAs had the poorest PMTCT facility coverage and the highest rank in terms of both burden and coverage gap among the eights LGAs.

The findings from these efforts were used at a three-day planning workshop on July 30th and August 1st 2013, to develop a costed elimination of mother-to-child transmission (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 *"Bayelsa State Operational Plan for the Elimination of Mother-to-Child Transmission of HIV 2013-2015"* with an estimated cost of NGN 11,807,952,433 (USD 76,180,338) was developed.

A modeling exercise was completed to estimate the potential impact of reaching three of the eMTCT targets:

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

If the Bayelsa state eMTCT operational plan is implemented to scale, **3,302** infections among WRA, **9,187** pregnancies among HIV-positive women, **6,139** infections among HIV exposed infants (HEI), **2,310** infant deaths, **73** maternal deaths will be prevented by meeting the PMTCT targets. Combined, this will result in **372,620** DALYs saved in Bayelsa State by 2015.

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], 2, 215,130 AIDS related deaths[3] annually and 2,229,883 total AIDS orphans. By December 2012 only 491,021 out of an estimated 1.66 million people who require anti-retroviral drugs (ARVs) were receiving them[4].

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

The national response analysis indicates that the weakest link in the national HIV/AIDS response is in the area of prevention. Access to prevention services is poor. According to the national prevention plan (NPP), the overall proportion of coverage and uptake of HIV preventive services such as HIV testing and counseling (HTC) and PMTCT 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 there still exist critical bottlenecks that impede the availability as well as access to the services. Limitations within the health system (inadequate governance, poor infrastructure, wide human resource gap, poor commodity supplies, weak health information systems and inadequate financing at all levels) hinder decentralization of PMTCT services to the primary health care levels and integration into existing maternal, neonatal & child health and reproductive health programs.

By the end of 2011, maternal HIV counseling and testing coverage was about 14% and PMTCT prophylaxis was at 8% for an estimated 229,000 HIV-positive pregnant women in the country. The sub-optimal coverage of PMTCT services is evident among others, 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 for the elimination of mother to child transmission of HIV (eMTCT), the Nigerian response has increased its focus on the PMTCT programme. Led by the National Agency for the Control of HIV/AIDS (NACA), all stakeholders including the 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.

It is in the light of the above that the President accented to the "Global plan to eliminate pediatric HIV and keep their mothers alive by 2015" in June 2011. This goal can only be achieved with the active involvement of all stakeholders including government at federal, state and local governmental area (LGA) levels as well as the private sector with support of local and international partners. NACA constituted the PMTCT Scale-up Technical Committee in December 2011. The purpose was to engage 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, United Nations Joint Programme on HIV/AIDS (UNAIDS), WHO, CDC and USAID.

In 2012, 12 states plus the FCT which account for 70% of the PMTCT burden in Nigeria were identified for increased focus. Significant effort has been channeled towards supporting these states to mobilize additional resources, improve coordination and increase the availability as well as access to PMTCT services. Health statistics such as number of women of child-bearing age, birth rate, HIV prevalence are expected to also guide prioritization of activities between LGAs and communities within the various states. Implementation is being carried out in a phased approach that will ensure better coordination of the response with all the states of the country benefiting by 2015.

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] could not have come at a better time. Federal, state and local governments have been challenged by the international community to significantly increase the resources allocated towards the HIV response in general and the PMTCT response in particular. The goal of the PCRP is to accelerate the implementation of key interventions over a two year period to bridge existing service access gaps, address key financial, health systems and coordination challenges and promote greater responsibility for the HIV response at Federal, State and local levels. In addition, multilateral and bilateral organizations such as the United Nations, World Bank, United States Government, Canadian Government and the Global Fund have increased their commitment and resource envelop 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 public-private partnerships (PPP) and investment in maternal and child health (MCH) services including PMTCT through corporate social responsibility (CSR).

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

SECTION

2 Bayelsa State

2.1 STATE PROFILE

Bayelsa State is situated in the South –South Zone and administratively divided into eight LGAs. The total population from the 2006 census was 1,704,515 people, which at an annual growth rate of about 2.92 % was projected at approximately 2,043,227 people at the end of 2012.

The state has one of the largest wetlands in the world. The massive oil exploration in the state as well as wide-spread under-development makes many communities inaccessible which has a negative impact on health status.

There were about 449,510 women of reproductive age (15-49 years) in the state in 2012, while the children under five years and below one year of age were 394,425 and 78,885, respectively. The annual total number of pregnant women (5% of the total population) translated to about 102,161. About 47.9 % of women received antenatal care from a skilled attendant while 37% were delivered by a skilled birth attendant. It is worthy of note that 56.5 % of women were delivered by a traditional birth attendant (TBA).

There are 226 health facilities in the Bayelsa State, most of which are under the public sector. The majority of the health facilities (169) are primary health care facilities with two tertiary and 37 secondary health care facilities.

2.2 HIV/AIDS IN BAYELSA STATE

Figure 1 illustrates the trend in HIV prevalence among pregnant women in Bayelsa State based on ANC sentinel surveillance from 1999 to 2010, compared to the national average during the same period. The prevalence was 4.3% in 1999 and rose to 7.2% in 2001, which was followed by a decline to 3.8% in 2005. However, after that period HIV prevalence among pregnant women has been on the rise reaching a peak of 9.1% at the last surveillance in 2010; making it the third highest in the country after the states of Benue (12.7%) and Akwa Ibom (10.9%)[6].

2.3 PMTCT IN BAYELSA STATE

Of the 226 health facilities in Bayelsa, 167 provide ANC services and only 38 provided ARVs for PMTCT at the end of 2012. There were 24 MSS sites; 10 of which provide PMTCT services. There are no free MCH services provided in Bayelsa.

Out of the estimated 102,161 pregnant women in 2012, the prevalence of 9.1% would translate to approximately 8,973 HIV infected pregnant mothers; approximately one-third of whom would transmit the virus to their babies in the absence of PMTCT interventions, resulting in 2,991 preventable pediatric HIV infections Bayelsa during 2012 alone.

Effective, comprehensive interventions for PMTCT can reduce the risk of transmission from 25-45% to less than 5%. PMTCT interventions were introduced and scaled up in the state and currently a number of health facilities provide the recommended package of services. The uptake of services and availability of interventions for PMTCT in the state has been summarized in Table 2.

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

Figure 1: Trend of State HIV Prevalence among Pregnant Women Compared to the National *(Source: Federal MOH Technical Report 2010)*

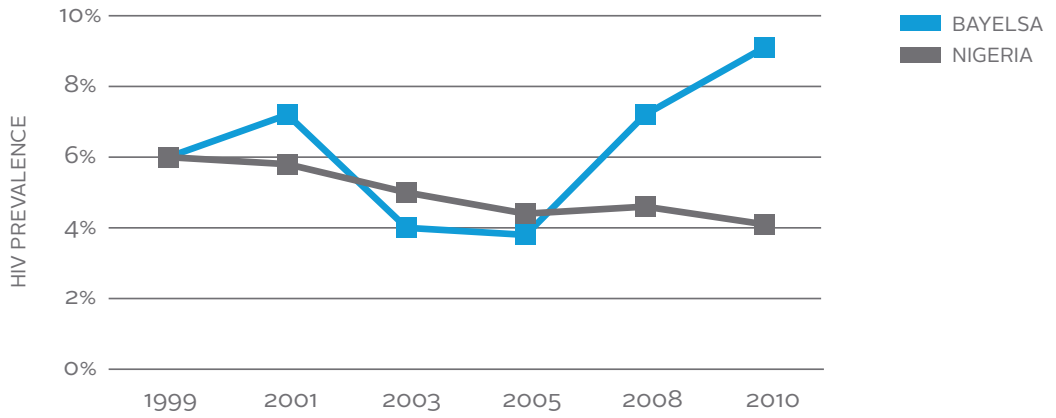

Table 2: Uptake of PMTCT Services in Bayelsa State

	INDICATOR	NUMBER
1	Total number of pregnant women in the State	102,161
2	Total number of antenatal new cases reported (booking)	28,284
3	Total number of deliveries reported (in facilities booked and unbooked)	2,353
4	Number of pregnant women who were offered HCT for PMTCT and received their test results	6,601
5	Number of HIV positive women who received complete course of ARVs for PMTCT	173
6	Number of HIV positive mothers who received cotrimoxazole prophylaxis	N/A
7	Number of HIV exposed babies who received ARV prophylaxis	69
8	Number of HIV exposed babies who received cotrimoxazole prophylaxis	49
9	Number of HIV positive pregnant women who received infant feeding counseling	941
10	Number of HIV exposed babies who received PCR testing within 2 months of birth	47
11	1Number of HIV positive pregnant women whose CD4 was estimated in order to stage the HIV disease	55
12	Number of mothers who exclusively breast fed their babies at 3 months	66
13	Number of mothers who exclusively breast fed their babies at 6 months	N/A

SECTION

3 Process

This eMTCT operational plan was developed under the leadership of the Bayelsa 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 of the Federal Ministry of Health (FMOH), Bayelsa developed the first draft of its eMTCT operational plan. However, this draft plan was quite generic and was not finalised.

In order to specifically identify the health system challenges to be addressed to meet Bayelsa State's eMTCT targets, FHI 360 with support from USAID, provided technical assistance to Bayelsa State to conduct a state-wide rapid health facility assessment (RHFA). The assessment was carried out in facilities in all eight LGAs that were 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. Building on the RHFA, a diagnostic (deep dive) was also conducted by a team of consultants hired by the Saving One Million Lives (SOML) team.

The findings from these efforts were presented and discussed during a three-day planning workshop convened by the Bayelsa SMOH, on July 30th to August 1st 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 and deep dive. 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 these processes, the Bayelsa SMOH and SACA disseminated the *"Bayelsa State's eMTCT Scale-up Plan 2013-2015"* to His Excellency, Honorable Henry Seriake Dickson on November 20th 2013. The dissemination meeting was attended by all major stakeholders in the HIV/AIDS response in Bayelsa state and beyond, including FHI 360 (the lead PEPFAR implementing partner for Bayelsa State).

SECTION

4 State-wide 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 Bayelsa State. The assessment covered all listed public and private health facilities in Bayelsa State which met defined criteria (see Box 1). A list of 226 facilities was obtained from the Department of Planning, Research and Statistics (DPRS), State Ministry of Health. In total, 167 had ANC services, 38 were currently providing ARVs for PMTCT while 12 had plans for PMTCT in 2013. Thus 101 facilities were assessed; these had antenatal services but no support from an IP to provide PMTCT nor a plan for PMTCT in 2013.

Box 1: Site selection

Site Inclusion Criterion

- Providing ANC but no IP support for PMTCT services

Site Exclusion Criteria

- Specialist hospitals such as neuropsychiatry, dental and maxillofacial hospitals.
- 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			
Private for profit	1	16	17
Sub-total (private)	1	16	17
Public			
LGA	72	0	72
State government	0	12	12
Sub-total	72	12	84
Overall total	**73**	**28**	**101**

4.2 FINDINGS

4.2.1 Facility Ownership and Healthcare Level

The majority of the facilities assessed were public owned and at the primary health centre level. Only 17 out of the 101 facilities assessed were private for profit organizations. Table 3 below contains detailed characteristics of the facilities included in the assessment.

4.2.2 Human resources and service utilisation

The human resource for health complements and service utilisation data for the 12 months preceding the assessment were reviewed in each facility. The data shows fewer staff and large coverage gaps at primary centers compared to secondary health facilities. About 70% of primary level facilities had no doctors; almost 50% had no nurses or medical records officer, over 60% lacked pharmacy and laboratory staff.

Similarly service utilisation was lower in primary compared to secondary facilities. The data suggests that less than a third of ANC bookings result in a facility delivery. Almost a quarter of primary level facilities reported no deliveries in the preceding year. Generally, private facilities show better work force ratios and service utilisation figures compared to the public facilities assessed.

4.2.3 Other domain summaries

At the time of the assessment only 35.6% of primary level health facilities and 60.7% of secondary level health facilities had HTC services. While many buildings were not well maintained, the assessments documented availability of dedicated spaces for outpatient and antenatal consultations, phlebotomy and laboratory services, delivery, FP, counseling and TB services among others. About 25% of public facilities did not have labor and delivery services (with 24 hour shifts) while 15% of primary level health facilities reported not having delivery rooms.

The publicly-owned primary level health facilities generally appeared to have stronger links with community services. Almost half the surveyed primary level health facilities had MDG support for MCH and 61.6% provided free components of ANC.

4.2.4 Summary of qualitative findings

A significant number of the key informants (healthcare providers) revealed that the most favored birth providers in the state were traditional birth attendants. Other important providers included churches and maternity homes. Some of the reasons suggested for this development included a firm traditional belief in the abilities of the TBA, perceived higher cost of services at the health facilities, difficulties reaching health facilities due to distance and unavailability of staff especially at night.

Respondents believe that some facilities are well patronized due to strong relationships with the community including the Village Development Committee as well as security in the neighborhood. Furthermore, health workers suggested that better staffing of facilities, improved capacity building for staff as well as provision of better structures and social services will go a long way to improve health service quality in the state.

4.2.5 Scenarios for eligibility of PMTCT services

Only 12 (11.8%) of the 101 facilities assessed met the National HR standard for PMTCT service provision (one doctor, one nurse/midwife, two community workers, one pharmacy staff, one laboratory staff, one medical records officer). The criterion most frequently metwas having four clinical staff that could perform patient care duties (either nurses or community health workers); about 61 (60%) facilities qualified in this regard.

Table 4 below shows HIV MTCT burdens and PMTCT service coverage gap for the eight LGAs in Bayelsa State. LGAs are ranked 1 to 8; with larger MTCT burden and poorer PMTCT service coverage ranked higher and will be receive higher priority for scale up.

Although Sagbama LGA has the highest prevalence (12.7%) in Bayelsa, Ogbia LGA has the highest burden with an estimated number of HIV+ pregnant women in 2012 of 1730 and is thus ranked 8. Ekeremor has 419 estimated HIV+ pregnant women and is ranked 1. In the final analysis, Kolokuma/Opokuma and Brass LGAs have the poorest PMTCT facility coverage and the highest rank sum for both burden and coverage gap among the eight LGAs.

Table 4: LGA HIV burden and PMTCT Service Coverage Gap

LGAS	MTCT BURDEN			PMTCT SERVICE COVERAGE GAP			RANK SUM FOR PRIORITI-ZATION [RANK 1 + RANK 2]
	HIV prevalence	Estimated number of HIV+ pregnant women	Rank 1 (number of HIV+ pregnant women)	Number of sites with ANC services	Proportion without PMTCT services	Rank 2 (service gap)	
BRASS	7.6%	1223	7	11	91%	7	14
KOLOKUMA/ OPOKUMA	9.1%	1014	6	12	92%	8	14
OGBIA	9.1%	1730	8	13	59%	2	10
NEMBE	9.1%	975	4	17	85%	6	10
SAGBAMA	12.7%	990	5	23	74%	4	9
YENOGOA	8.7%	958	3	54	72%	5	8
EKEREMOR	9.1%	419	1	16	63%	3	4
SOUTHERN IJAW	3.5%	736	2	21	43%	1	3
Total	**9.1%**	**8045**		**167**	**70%**		

4.2.6 Summary from the diagnostic deep dive

The deep dive supported by the Saving One Million Lives (SOML) initiative highlighted supply related concerns such as: limited number of facilities in the state providing HCT, ARVs for PMTCT and early infant diagnosis (EID), human resource and infrastructure limitations at facility level, stock-out of essential commodities, transport and logistics challenges due to difficult riverine terrain and security concerns in some communities and LGAs. Demand related challenges include: high level of stigma associated with HIV, low HIV knowledge and existence of myths, fear of surgery, high cost of care in facilities, negative provider attitude and preference for home or TBA delivery.

4.2.7 Recommendations

A comprehensive plan to close the 70% PMTCT service coverage gap and to improve access in Bayelsa state must address human resource and infrastructure gaps as well as poor service utilisation for ANC and delivery. Traditional birth attendants are major stakeholders in maternal health services in the state and as such should be engaged as part of a holistic demand creation strategy. Equally important is community involvement and ownership by mobilizing ward and village development committees, faith and community-based organizations as major players. Finally, private sector engagement will be critical to reaching clients who would rather access health care from a private health service provider.

SECTION

5 Bayelsa State eMTCT Operational Plan

5.1 RATIONALE

Mother-to-child transmission of HIV is currently responsible for virtually all of the estimated 3,122 new pediatric HIV infections which occurred in Bayelsa in 2012. The risk of MTCT can be reduced from an average of 25 – 45% to less than 5% through comprehensive interventions that cover the pre-pregnancy, pregnancy, labor and post-delivery period. Thus, universal access to quality PMTCT services 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 elimination of mother-to-child transmission of HIV.

5.2.2 Objectives

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

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

5.3 SCALE UP TARGETS

Table 5: State Level Targets for the Operational Plan

INDICATORS	BASELINE (2012)	YEAR 1 (2013)	YEAR 2 (2014)	YEAR 3 (2015)	DATA SOURCE
Estimated number of WRA (22% of total population)	449,510	462,636	476,145	490,048	NPC 2006 Projections
Estimated number of pregnant women (5% of total population)	102,161	105,144	108,215	111,375	NPC 2006 Projections
Projected ANC attendance (47.9% of estimated pregnant women)	48,935	63,087	75,750	100,237	MICS4 2011 Based Projections
Estimated number of HIV-positive pregnant women	9,297	9,568	9,848	10,135	Prevalence Based Estimates
50% reduction in HIV incidence among 15-49 year old women (Estimated incidence based on adjusted prevalence of 9.1%)	0.8%	0.7%	0.5%	0.4%	National HIV Sero-prevalence Sentinel Survey
90% reduction in unmet need for family planning among WRA (Based 42.3% unmet needs: MICS 2011)	42.30%	29.60%	16.90%	4.20%	MICS4 2011 Based Projections
90% of all pregnant women have access to quality HIV counselling and testing services (Bayelsa health system stats, 2013)	6,601 (7%)	18,926 (30%)	41,663 (55%)	90,213 (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	173 2%	957 (10%)	5,416 (55%)	9,122 (90%)	State Routine Health data on DHIS
90% of all HIV-exposed infants have access to early HIV diagnosis services	69 (0.70%)	957 (10%)	5,416 (55%)	9,122 (90%)	State Routine Health data on DHIS
90% of HIV-infected women pregnant requiring treatment for their own health have access to lifelong ART (Based on 50% of HIV positive pregnant women requiring ART)	389 (8%)	718 (15%)	2,708 (55%)	4,561 (90%)	State Routine Health data on DHIS
66% of ANC facilities offering PMTCT services	38 (30%)	62 (37%)	111 (66%)	111 (66%)	State Routine Health data on DHIS

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 program 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 gatekeepers and influential people within the community strengthened;
- Social mobilization at community level for PMTCT strengthened;
- Community education on PMTCT including promoting the utilisation of the available MNCH/RH services enhanced; and
- PMTCT program 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 monitoring & evaluation (M&E) and data management systems, poor ownership & leadership of the HIV response at various levels, and limited state government contributions to the fight against AIDS. The sequence of interventions developed at the planning workshop were thus arranged to address 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

Comprehensive PMTCT services have been found to be a strong determinant in the significant reduction in the number of new pediatric infections and improvement of treatment outcomes for HIV infected mothers. The PMTCT service supply systems include but are not limited to: (1) training of health care workers, (2) site activation for PMTCT service provision, (3) distribution of guidelines, standard operating procedures (SOPs), job aids and information, education, communication (IEC) materials; and (4) providing support to PMTCT sites through routine mentoring and technical supportive supervision.

Health care workers in secondary health facilities will be trained using the Integrated PMTCT curriculum and the Integrated Management of Pregnancy and Child Birth (IMPAC) curriculum will be used for training health care workers in secondary and primary level facilities respectively. Update trainings and step down trainings will further increase standards and the pool of health care providers. National guidelines and SOPs, job aids and IEC materials will be provided. Mentoring and supportive supervision will be an integral part of implementation. Health facilities will be activated for PMTCT service provision and supervised by a multi-disciplinary team who will provide hands-on mentoring, cordination and commodity supply for service provision.

5.4.2 PMTCT Health Care Commodities supply

To ensure a succesful and rapid scale up of PMTCT services, there is need for a strengthened supply chain management system for PMTCT commodities like test Kits, ARVs, laboratory commodities as well as consumables. Existing state supply chain management systems will be strengthened and integrated with donor-supported systems to ensure a prompt and efficient system for PMTCT in the state which will help in circumventing all the flaws identified with the current supply system.

5.4.3 PMTCT Demand Creation

Demand creation will be an important factor in program development and planning in Bayelsa. This is due to the low patronage of MNCH services in the state. Moreover, if the recipient communities do not accept or buy into the access program, it will be a waste of resources.

The state demand creation strategy is developed in line with the national strategic approach, which requires repositioning of PMTCT centers as places of *'Confidence Building and Empowerment'*. The PMTCT centers would be branded with appropriate and acceptable logos, the centers and services provided would be promoted through radio jingles, TV messages etc. as places where they (mothers and their babies) can get skilled care from qualified and friendly healthcare workers and also be able to discuss their future plans.

Health workers will be trained for improved interpersonal skills and partnerships fostered between HCWs, TBAs and faith houses through orientation, trainings and dialogues. Male and female PLHIV groups will be encouraged to work as partners and shall receive training as peer educators and mentors. They will conduct community dialogue and mobilization activities; addressing issues of HIV related stigma and to support and encourage pregnant women to seek ANC/PMTCT services in facilities where services are offered.

One barrier to accessing prophylaxis at birth is the common practice of delivering outside of a facility with traditional birth attendant or churches. Forging partnership between CBOs, facilities, community health workers (CHW) and TBAs will be an important strategy.

5.4.4 Monitoring and Evaluation

A strong and functional M&E system is a critical factor for tracking, measuring and estimating the progress made in any intervention including eMTCT. With a strong M&E system and standard data management processes, there is a high possibility that: (1) inefficiencies associated with data collection and reporting will be reduced, (2) PMTCT intervention process, outputs and outcomes will be better tracked thereby creating an effective way of tracking interventions and evaluating program impact and, (3) answers are provided to operational questions form the stakeholders about programs being implemented. Recognizing these, the M&E system proposed for this scale-up will be so designed to address all identified deficiencies with respect to M&E coordination across board (i.e.at all levels). This design shall include establishing and maintaining a central routine health database, procurement & supply chain management for M&E tools, establishing systems for mentoring and supportive supervision and data quality assurance (DQA) system, and building human resource capacity for M&E as well as information use and data sharing.

5.4.5 Coordination and resource mobilization

The state HIV/AIDS response will be led by the state management team (SMT) chaired by the Honorable Commissioner for Health, with representation from government, civil society organizations (CSOs), private sector and partners, and the secretariat at SACA. The SMT will provide much needed oversight, governance and coordination of all effort within the state. The joint state implementation team (J-SIT) will develop and implement annual work plans as well as provide monitoring and supportive supervision to PMTCT sites. Sites selection including all

the processess related to their activation shall be presented to stakeholders drawn from the state, local government and selected facilities. Annual budgets arrived at shall be presented to stakeholders and counterpart funding shall be sourced from government (state and LGA) and the private sector to ensure ownership and sustainability of the activated sites. An annual resource mapping and gap analysis will inform targeted advocacy and resource mobilization activities. The state PMTCT task team will be inagurated. The task team will be responsible for technical guidance and oversight of the state PMTCT program and will collaborate with the J-SIT in the provision of monitoring and supervision of all the activated sites.

A score card of performance per LGA will be produced and shared quarterly with all stakeholders. The best performing LGA will receive an award during the annual state HIV/AIDS summit.

SECTION

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

To estimate the potential impact of meeting PMTCT targets in Bayelsa 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 below. Briefly, 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.

TARGETS:

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

Table 6: Potential Impact of Meeting PMTCT Targets in Bayelsa State by 2015

TARGETS	2012	2013	2014	2015	TOTAL
1. Decrease HIV incidence among WRA	*0.80%*	*0.60%*	*0.50%*	*0.40%*	
2. Reduce unmet need for FP among HIV+ women	*42.30%*	*29.60%*	*16.90%*	*4.20%*	
3. Increase prophylaxis for HIV+ pregnant women	*2%*	*10%*	*55%*	*90%*	
OUTCOMES					
Status Quo Maintained: New HIV infections among WRA	3,155	3,221	3,289	3,358	13,023
Targets Achieved: New HIV infections among WRA	3,155	2,684	2,195	1,686	9,721
HIV infections averted among WRA	-	537	1,093	1,672	**3,302**
Status Quo Maintained: Pregnancies among HIV+ WRA	8,973	9,177	9,385	9,599	37,134
Targets Achieved: Pregnancies among HIV+ WRA	8,973	6,168	6,285	6,522	27,948
Pregnancies averted among HIV+ WRA	-	3,009	3,101	3,077	**9,187**
Status Quo Maintained: HIV infections among HEI	3,122	3,193	3,265	3,339	12,919
Targets Achieved: New HIV infections among HEI	3,122	1,974	1,163	522	6,780
HIV infections averted among HEI	-	1,219	2,103	2,818	**6,139**
Status Quo Maintained: Infant mortalities	1,386	1,417	1,449	1,482	5,734
Targets Achieved: Infant mortalities	1,386	900	660	478	3,424
Infant mortalties averted among HEI	-	517	789	1,005	**2,310**
Maternal mortalities averted among HIV+ women	-	24	25	24	**73**
DALYS saved	-	79,140	128,429	165,050	**372,620**

IN SUMMARY:

3,302
infections among WRA

9,187
pregnancies among HIV-positive women

6,139
infections among HIV exposed infants (HEI)

2,310
infant deaths

73
maternal deaths will be prevented by meeting the PMTCT targets.

Combined, this will result in

372,620
DALYs saved in Bayelsa State by 2015 if the scale-up plan is implemented to scale.

Impact Estimation Methodology and Assumptions

1. **Infections averted among women of reproductive age (15-49 years)** were calculated based on State specific estimates of HIV incidence, prevalence, and population growth as well as the size of population of women of reproductive age in 2012. Prevalence estimates are based on levels ANC sentinel surveillance for each State, which is the most reliable and accepted. True incidence is difficult to measure at the State level. There is a national estimate of incidence (1%)[7], 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[8] (state prevalence – national prevalence /100). Estimates of population growth[9] varied by State and are referenced accordingly as are estimates of the size of the population of women 15-49 by State.

2. **The number of pregnancies prevented among HIV + women** was estimated by subtracting the number of pregnancies expected if unmet need was reduced by 90% from the number of expected pregnancies among HIV + women if unmet need was not reduced. The number of expected pregnancies in each scenario was based on a couple-year of protection (CYP) conversion factor produced by MSI[10]. CYPs in each scenario were estimated based on the current contraceptive mix observed in each state and assumed 1 year of use for new adopters. The CYPs for a minimum

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

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

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

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

of year of use of each method were based on region-specific standards[12]. 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%[13].

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. 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%)[14].

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)[15]** 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 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

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

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

14 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

15 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	
FOCUS AREA: PMTCT SERVICE SUPPLY SYSTEMS					
Training & capacity					
Conduct 10-day training for HCWs on HTC	3 persons per facility (1 PHC coordinator and 2 LGA focal persons)	Q4	Q1	Q2	SAPC, SACA
Conduct 3-day training for PHCs on logistics management	1 person per facility x 85 facilities + 1 focal person per each LGA (totaling 93 participants)	Q4	Q1		SAPC, SACA
Conduct 5-day training for secondary facilities on logistics management	2 persons per facility x 16 facilities plus 3 persons from the SMOH (totaling 35 participants)		Q1		SAPC, SACA
Print and distribute HTC guidelines, SOPs, job aids and flow charts	2 copies of each x 101 facilities	Q4			SAPC, SACA
Community services					
Conduct 1-day dissemination/sensitization meeting at the state level to gatekeepers and key stakeholders	100 participants	Q4			SIT, PMTCT Task Team
Conduct 1-day advocacy/sensitization meeting at the LGA/ Ward level to gatekeepers and key stakeholders in the community	50 participants per LGA x 3 meetings in each LGA (totaling 24 meetings)	Q4	Q3	Q3	SAPC, SACA
Conduct 1-day sensitization meeting for TBAs in the community	20 participants per LGA	Q4			SAPC, SACA
Mentoring & supervision					
Conduct quarterly quality improvement visits to PMTCT sites	8 persons (PHC Coordinator, state officials -CMD, DPH, SACA, DMS, DPRS, SASCP, DPS and IPs)	Q4	Q1-4	Q1-4	SIT, SAPC, 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					
Procurement (quantification, forecasting)					
Consumables					
Procure Determine HIV kits	2,415,739 (1,421,023 Women of reproductive age-group; 710, 511 partners and 284,205 buffer for trainings, quality controls & repeat testing)	Q4	Q1-4	Q1-4	HMB,SAPC, SACA
Procure Unigold HIV kits	219,832 (9.1% positivity rate + trainings, quality controls & repeat testing)	Q4	Q1-4	Q1-4	HMB,SAPC, SACA
Procure Stat Pak HIV test kits	6,600 (3% discordancy in addition to trainings, quality control & repeat testing	Q4	Q1-4	Q1-4	HMB,SAPC, SACA
Procure laboratory consumables	101 facilities	Q4	Q1-4	Q1-4	HMB,SAPC, SACA
Procure IPAC commodities	101 facilities	Q4	Q1-4	Q1-4	HMB,SAPC, SACA
Procure medical consumables	101 facilities	Q4	Q1-4	Q1-4	HMB,SAPC, SACA
Procure male condoms for HIV prevention	102, 313, 584 male condoms (50% per year)	Q4	Q1-4	Q1-4	HMB,SAPC, SACA
Procure female condoms for HIV prevention	107,608 (10% of WRA)	Q4	Q1-4	Q1-4	HMB,SAPC, SACA
Procure DBS bundle kit	33,289 (16,645 no of exposed infants for EID services at 2 tests per exposed infant)	Q4	Q1-4	Q1-4	HMB,SAPC, SACA
Procure PCR reagent	1 facility (all reagents shall be procured)	Q4	Q1-4	Q1-4	HMB,SAPC, SACA
Procure PCR consumables	1 facility (all PCR consumables shall be procured)	Q4	Q1-4	Q1-4	HMB,SAPC, SACA
Equipment					
Procure PCR machines and accessories (X 1)	1 facility		Q1-2		HMB, SAPC, 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)*					
Distribution					
Consumables					
Cost and distribute all healthcare commodities		Q4	Q1-4	Q1-4	HMB,SAPC, SACA
Stock management (CLMS)					
Conduct 5-day logistics management training on health commodities for laboratory scientists/technicians & pharmacists/pharmacy technicians (refer to services supply group)		Q4			HMB,SAPC, SACA
Assess & upgrade of laboratories/ lab store, pharmacy /pharmacy stores for PMTCT and ART services (linked with program management)		Q4			HMB,SMOH, SACA
Staffing					
Initiate deployment of HCWs (lab scientist/technician, pharmacists/technicians) for service provision at SHCs and PHCs (linked with program management)		Q4	Q1-4	Q1-4	HMB, LGA Service Commission
Training & capacity					
Conduct pharmaceutical care training for pharmacist/ pharmacy technicians (linked with program management)		Q4	Q1-4		SMOH
Conduct 6-day lab activation training for lab scientists/ technician for ART sites (linked with service supply)	2 persons per facility X 12 facilities X 6 days	Q4	Q1-4		SMOH
Conduct onsite 3-day sample handling training for HCW in PMTCT sites (10 persons - nurses, doctors, laboratory staff- per facility X 3); linked to service supply		Q4	Q1-4		SMOH
Conduct PCR training for laboratory scientists (2 peers facility X 10 days); refer to service supply		Q4	Q1-4		SMOH
Others					
Provide funds for the transportation of blood samples for laboratory analysis (CD4, chemistry and haematology)	6,832 sample transfers for 28 months from 61 PMTCT sites at transfer rate of 4 times per month	Q4	Q1-4		SMOH
Provide funds for transportation of DBS samples to and from EID laboratories	6832 DBS sample transfers for 28 months from 61 sites at a transfer rate of 4 times per month	Q4	Q1-4		SMOH
Provide funds for sputum sample transfer from facilities to TBL referral laboratories.	40 movement per month from DOTs site to TB referral hospital	Q4	Q1-4		SMOH
Provide funds for sputum sample transfer from TBL referral labs to Benin & Calabar	40 movement per month from TBL referral to Benin	Q4	Q1-4		SMOH

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					
Training on IPC					
Conduct a 5-day workshop for stakeholders to develop an SBCC PMTCT strategy for Bayelsa State	20 stakeholders		Q1		SACA, SAPC
Train staff of key line ministries, agencies and CSOs on social and behavior change communication (SBCC)	2 staff per line ministry x 5 line ministries (education, information, health, gender, LG)+ 2 CSO representatives + 2 SACA and PLHIV networks (totaling 20 participants)		Q2		SACA, SAPC
Conduct a 5-day workshop to adapt and pretest materials (print and electronic messages/ materials) for all four PMTCT prongs	15 persons (including technical experts) X 5 days		Q1		SACA, SAPC
Review and finalize BCC messages by technical experts (already costed in the preceding column)	Technical experts		Q1-3		SACA, SAPC
Conduct a 2-day training for support group (SG) members on interpersonal communication (IPC), public speaking and giving testimonies	2 participants per SG X 16 SGs in 1 batch (totaling 32 SGs)		Q3		SACA, SAPC
Train TBAs and CBOs/SGs on integrated ANC/HTC/ PMTCT/IYCF for 3 days at LGA level	72 CBOs/ SG at 3 participants each + 240 TBAs (totaling 312 participants) x 3 days at the LGA level		Q2-Q4		SACA, SAPC
Train 240 TBAs to recognize danger signs, IPAC and how to refer pregnant women to health facilities for ANC/HTC/PMTCT services as appropriate	240 TBAs x 2 days abridged IPAC (at the LGA level)		Q2		SACA, SAPC
Train community members as peer educators to educate men and women of reproductive age on HIV prevention including ANC/HTC/ PMTCT/IYCF	20 PEs per LGA x 8 LGAs x 3 days	Q3-Q4	Q1-Q2		CBOs
Community mobilization					
Sensitization					
Conduct 1-day sensitization and advocacy meetings at the State level which shall include advocacy packs.	100 key state level actors X 100 advocacy packs	Q4			DG SACA, DPH, SAPC
Conduct 1-day sensitization and advocacy to gatekeepers and influential people at LGA level	100 community/traditional leaders and influencers per LGA x 8 LGAs	Q4			LACA, LGA SMO
Conduct a 1-day sensitization meeting for religious leaders (pastors, imams)	100 persons across 8 LGAs, to be facilitated by clergy living with HIV	Q4			LACA, LGA SMO

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 *(continued)*					
Advocacy					
Conduct high level advocacy visit to the First Lady/ Governor of Bayelsa	Delegates: HCH, DG SACA, SSA on PHC, DPH, DPHC, SAPC, Chairman House Committee on Health	Q3			DG SACA, DPH, SAPC
Conduct focused advocacy to gatekeepers and influential people at community level (which will be included in the CBO grant awards)		Q4	Q1-Q2		CBOs, Support Groups
Conduct 1-day training on advocacy and community mobilization on PMTCT for 24 CSOs (CBOs and support groups)	3 CSOs per LGA at a rate of 3 participants per CSO x 8 LGAs (totaling 72 persons)	Q4			SACA, SAPC
Media engagement					
Produce and broadcast radio messages	2 messages X 4 Prongs X 4 languages and aired twice daily X 7 days a month		Q1		SACA, SAPC
Broadcast messages via community radio	7 days per month X 101 communities		Q1-Q4	Q1-Q4	DG SACA, DPH, SAPC
Produce and broadcast TV messages	1 message X 4 prongs X 1 language; aired four times daily x 7 days per month		Q1-Q4	Q1-Q4	DG SACA, DPH, SAPC
Broadcast mobile phone bulk messages	1 message x 4 prongs X 1 language; monthly		Q1		DG SACA, DPH, SAPC
Broadcast messages via social media	2 messages x 4 prongs X 1 language		Q1-Q4	Q1-Q4	DG SACA, DPH, SAPC
Establish/strengthen community radio systems to disseminate PMTCT messages (with speakers; amplifiers, megaphone engines/DVD players, wirings)	32 community radios		Q1-Q4		SACA, SAPC
Conduct training for journalists including community radio broadcasters to mainstream ANC/HTC/PMTCT/RH/FP messages into their programs	60 journalists (state/LGA/ community Info officers); 303 community radio workers x 2 days at LGA level in 10 batches (totaling 363 participants)		Q2-Q4		
IEC materials					
Produce SBCC materials posters, pamphlets, fliers, pens, t-shirts, etc.)	Posters X 80,000; flyers X 80,000; T shirts X 5000; pens X10000; notebooks X 10,000 (60% produced Y2; 40% produced Year 3)		Q1	Q1	SACA, SAPC
Distribute SBCC materials (not costed, linked to the preceding row)			Q1-Q4	Q1-Q4	CBOs, support groups, health facilities

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)*					
Mentoring & Supervision					
Conduct quarterly community outreaches in communities, FBOs, TBA homes and during festival activities	30 participants per dialogue per community x 5 communities per LGA x 8 LGAs per quarter x 4 quarters		Q1-Q4	Q1-Q4	CBOs, support Groups
Support trained peer educators to conduct peer sessions, mentor peers and refer for ANC/HTC/ FP/ RH/ PMTCT services	20 PEs per LGA x 8 LGAs x N2000 per month		Q1-Q4	Q1-Q4	CBOs
Others					
Launch Bayelsa State eMTCT Implementation Plan at state level	100 persons across 8 LGAS	Q3			DG SACA, DPH, SAPC
Community services					
Demonstrate use of and distribute condoms through CBOs, community health workers and TBAs	Penile models : 240 TBAs, 24 CSOs gets 2 models each; 101 HFs (totaling 437)		Q1-Q4	Q1-Q4	SACA, SAPC
Provide grants to CBOs and support groups to implement integrated community PMTCT programmes	N1,000,000 per organization per annum X 24 orgs X 2 years		Q1	Q1	SACA
Conduct community dialogues with all stakeholders including TBA, community leaders, men and women	30 participants per dialogue per community x 5 communities per LGA x 8 LGAs per quarter x 4 quarters		Q1-4	Q1-Q4	CBOs
Create calendar of festivals in various communities/LGAs			Q1,Q3	Q1,Q3	CBOs
Conduct a 5-day training for community health workers on integrated ANC/HTC/PMTCT service delivery	2 participants per PHC x 68 PHCs x 3 days (in 4 batches)	Q4	Q1		SASCP, Pact
Establish male care forums at community level to champion male involvement in ANC/HTC/ PMTCT service	20 participants x 5 communities per LGA x 8 LGAs		Q1-Q4	Q1-Q4	CBOs

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

Objective 2: Reduce the unmet need for family planning among women living with HIV 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 of HCW & 8 LGA FP focal persons on SRH/ HIV integration in all activated sites.	1 person per facility x 101 facilities + 1 focal person per LGA + 2 persons from SMOH (111 participants)+ 2 facilitators per batch (in 3 batches)	Q4	Q1-Q2		SMOH
Conduct 2-day training on CLMS for 8 LGA FP focal persons and 54 persons from newly activated sites + 2 SMOH + 2 facilitators	1 person per LGA + 1 person from newly activated SDPs + 2 persons from SMOH (64 participants) + 2 facilitators per batch from FMOH	Q4	Q1		SMOH
Site activation					
Activate family planning SDPs in all the facilities (not costed)	101 facilities				SMOH
Service delivery					
Print and distribute SRH/HIV guidelines, service providers' curriculum and manual to all facilities	2 copies of each x 101 facilities	Q4			SMOH
FOCUS AREA: HEALTH CARE COMMODITIES					
Distribution					
Consumables					
Provide financial support to transport family planning commodities from state stores to SDPs (costed in distribution plans)	Cost for distribution to 54 sites (provision for 47 sites already in place)	Q4	Q1-Q4	Q1-Q4	SMOH RH unit
Stock management (CLMS)					
Conduct training of LGA focal persons on Contraceptive Logistics Management information tools (CLMIS) (cost for 64 persons); refer to services supply	Cost for 64 persons X 3 days	Q4	Q1-Q2		SMOH RH unit
FOCUS AREA: PMTCT DEMAND CREATION SYSTEMS					
Community services					
Train frontline health workers on family planning methods to integrate into community outreaches	2 persons selected from 101 facilities targeted for scale up across the 8 LGAs (totaling 202 participants)	Q4	Q1-Q2		SAPC/SMOH RH unit

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: Provide ARV prophylaxis for PMTCT to 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					
Training & capacity					
Conduct 6-day IMPAC training for HCWs in PHCs	2 persons per facility x 45 facilities + 1 person per LGA + 2 from SMOH (100 participants) + 2 facilitators per batch + 5 EPT facilitators per batch in 3 batches (totaling 121 persons)	Q4	Q1		SAPC, SMOH
Conduct 6-day Integrated PMTCT/EID training for HCWs in secondary facilities	5 persons per facility x 16 facilities + 3 from SMOH (83 participants) + 2 facilitators per batch in 2 batches (totaling 87 participants)	Q4	Q1		SAPC, SMOH
Conduct 6-day HCC training for HCWs in secondary facilities	5 persons per facility x 16 facilities + 3 from SMOH (83 participants) 2 facilitators per batch in 2 batches (totaling 87 persons)		Q2-Q3		SAPC, SMOH
Conduct 5-day pharmaceutical care training for LGA pharmacists (2 per LGA) & community pharmacists preceptors	2 pharmacists per LGA + 16 secondary facility pharmacists + 2 SMOH (34participants)	Q4	Q1		SAPC, SMOH
Conduct 2-day ARV dispensing and documentation for pharmacy technicians, nurses CHO and CHEWs	2 participants x 45 facilities (90 participants)in 3 batches, 2 facilitators per batch	Q4	Q1-Q2		SAPC, SMOH
Conduct 5-day onsite pharmacy best-practice training for HCWs	7 participants per site x 61 facilities	Q4	Q1-Q4		SAPC, SMOH
Conduct 6-day laboratory training for 2 HCW in secondary facilities	2 participants per site x 16 facilities + 2 SMOH (totaling 34 participants)	Q4			SAPC, SMOH
Conduct 2-day laboratory training for HCWs in PHCs	1 participant x 45 facilities + 1per LGA (totaling 53 participants)	Q4	Q1		SAPC, SMOH
Linkages/referrals					
Conduct 2-day onsite training on adherence counseling and client tracking/referrals	3 persons per facility x 61 facilities (totaling 183 participants)	Q4	Q1-Q2		SAPC, SMOH
Conduct 2-day training for TBAs on universal precautions and modified obstetric practices (including referrals and client tracking)	20 TBAs per LGA x 8 LGAs + 3 SMOH (163 participants)	Q4	Q1-Q2		SAPC, 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: Provide ARV prophylaxis for PMTCT to 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 and supportive supervision of PMTCT facilities	HCT, PMTCT, M&E, pharmacy, lab focal persons from SMOH per HMB (8 persons)	Q4	Q1-Q4	Q1-Q4	SAPC, SMOH
Support monthly meetings for TBAs at the LGA	20 TBAs per LGA x 8 LGAs	Q4	Q1-Q4	Q1-Q4	SAPC, SMOH
Support quarterly meetings for TBAs at the state	3 TBAs per LGA x 8 LGAs from 101 selected public-owned health facilities	Q4	Q1-Q4	Q1-Q4	SAPC, SMOH
Conduct 2-day training for mentor mothers, CBOs community volunteers and community pharmacists on adherence counseling, referrals, client tracking	12 persons per LGA (including 4 mentor mothers, 2 CVs, 2 CBOs, 2 CPs, 1 LGA, 1 facility)	Q4	Q1-Q4	Q1-Q4	SAPC, SMOH
Conduct bimonthly community outreaches to TBAs, churches, fishing camps, youth groups, markets in collaboration with the WDCs	2 CHEWS/ CVs per facility (twice a month)	Q4	Q1-Q4	Q1-Q4	SAPC, SMOH
Site activation					
Activate 61 sites for PMTCT service provision (2 days per site)	61 sites	Q4	Q1-Q2		SAPC, SMOH
Service delivery					
Print and distribute PMTCT and EID National guidelines, SOPs, job aids and service flow charts	2 copies of each x 61 facilities	Q4			SAPC, SMOH
Print and distribute IMPAC training materials for PHCs	2 copies of each x 45 facilities	Q4			SAPC, SMOH
FOCUS AREA: HEALTH CARE COMMODITIES					
Procurement (quantification, forecasting)					
Drugs					
Procure ARVs for infected pregnant women (cost by regimen & product AZT/3TC, NVP, TDF/3TC, EFV, LPV/R)	29,390 HIV positive pregnant women for 30 days a month X 28 months)	Q4	Q1-Q4	Q1-Q4	SAPC, SMOH
Procure ARVs for treatment of HIV positive individuals for 12 HCC sites (cost by regimen & product AZT/3TC, NVP, TDF/3TC, EFV, LPV/R)	1,114,404 (44% of the general population of estimated no of adults of reproductive age)	Q4	Q1-Q4	Q1-Q4	SAPC, SMOH
Procure ARVs for treatment of HIV positive children for 12 HCC sites (cost by regimen & product AZT/3TC, NVP, TDF/3TC, EFV, LPV/R)	111,440 (10% of the HIV positive adults)	Q4	Q1-Q4	Q1-Q4	SAPC, 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)*					
Drugs (continued)					
Procure ARVs for HIV exposed infants (cost by regimen & product NVP syrup)	15, 413 estimated no of HIV exposed infants (for 30 days a month X 28 months)	Q4	Q1-Q4	Q1-Q4	SAPC, SMOH
Procure cotrimoxazole for infected women and other OIs	101, 410 HIV positive women (9.1% of WRA - cost for 30 days X 28 months)	Q4	Q1-Q4	Q1-Q4	SAPC, SMOH
Procure cotrimoxazole for HIV exposed infants	15, 413 estimated no of HIV exposed infants (cost for 30 days X 28 months)	Q4	Q1-Q4	Q1-Q4	SAPC, SMOH
Consumables					
Procure CD4 , haematology and chemistry reagents (cost per equipment)	Cost for 40,061 tests for each equipment (estimated no of HIV positive pregnant women + 50% HIV positive men + 20% buffer stock)	Q4	Q1-Q4	Q1-Q4	SAPC, SMOH
Procure Hepatitis B, C and VDRL kits	2, 415, 739(1, 421, 023 WRA-group + 710, 511 partners + 284, 205 buffer for trainings, quality controls & repeat testing)	Q4	Q1-Q4	Q1-Q4	SAPC, SMOH
Procure pregnancy test kits	101, 410 HIV positive women (9.1% of WRA - cost for 30 days a month X 28 months)	Q4	Q1-Q4	Q1-Q4	SAPC, SMOH
Equipment					
Procure CD4 count machines, haematology and chemistry equipment (costed separately)	12 HCC sites	Q4	Q1-Q4	Q1-Q4	SAPC, SMOH
Procure CD4 POC	Cost for 24 CD4 POC (3 per LGA)	Q4	Q1-Q4	Q1-Q4	SAPC, SMOH
Distribution					
Consumables					
Print the national guidelines for PMTCT and HCT (refer to Service supply)		Q4	Q1-Q4		SAPC, SMOH
Disseminate job-aides to all health facilities (cost in distribution plan)		Q4	Q1-Q4		SAPC, 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)*					
Others					
Conduct monthly technical supportive supervisory visits to PMTCT sites (cost for 5 per X 5 days)	1 visit per month X 5 persons for 28 months	Q4	Q1-Q4	Q1-Q4	SAPC, SMOH
Conduct bimonthly LMIS data verification and validation exercise (cost for 5 persons X 5 days)	Cost for 1 visit bimonthly X 5 persons for 14 months	Q4	Q1-Q4	Q1-Q4	SAPC, SMOH
FOCUS AREA: PMTCT DEMAND CREATION SYSTEMS					
Linkages & referrals					
Train referral focal persons and establish referral network of health facilities, CBOs and TBAs	1 day referral orientation for 240 TBAs & 2 participants X (48 CBOs and 101 HFs) at LGA level				SACA, SAPC
Provide incentive package (gloves, blades, Dettol, detergent and cotton wool) to TBAs who complete referral of pregnant women to health facilities for ANC/PMTCT (especially the best TBA per month per LGA)			Q1-Q4	Q1-Q4	CBOs, Health facilities
Update, print and disseminate referral directory of service delivery points for ANC/HTC/PMTCT/RH/FP services	500 referral directory of TBAs, CBOs and HFs		Q2		SACA, SAPC
Training on IPC					
Conduct a 1-day training for clergy (pastors and imams) to include HIV/HTC/PMTCT messages in their sermons	100 clergy across 8 LGAs (in 3 batches)		Q3		SACA, SAPC
Others					
Conduct monthly TBA network coordination meeting	30 TBAs per LGA x 8 LGAs x 12 months at LGA level		Q1-Q4	Q1-Q4	CBOs
Brand PMTCT service centers as user-friendly centers	101 sign posts		Q3		SAPC
Establish male care forums at community level to champion male involvement in ANC/HTC/PMTCT service (linked to program management)					CBOs

Prong 4: Family centered care and support

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

Objective 6: Increase provision of lifelong 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					
Site activation					
Link activated sites to the National PCR lab (not costed)	61 PMTCT sites linked to the PCR laboratory	Q4	Q1-Q4	Q1-Q4	SAPC, SMOH
Mentoring & supervision					
Support facility based client tracking of mother baby pair (communication)	61 PMTCT sites.	Q4	Q1-Q4	Q1-Q4	SAPC, SIT
Support community based client tracking of mother baby pair (transportation)	Trained community resource persons for 61 PMTCT sites.	Q4	Q1-Q4	Q1-Q4	SAPC, SIT
Conduct 5-day training on PHDP for mentor mothers	4 mentor mothers per LGA		Q1		SAPC, SIT
Linkages/referrals					
Strengthen referral linkages, client tracking and adherence support	12 trained TBAs, mentor mothers, community volunteers, community pharmacists per LGA / quarterly meeting (96 persons)	Q4	Q1-Q4	Q1-Q4	SAPC, SIT
Link HIV positive mothers requiring ART/TB services to HIV comprehensive centres (not costed)	61 PMTCT sites.	Q4	Q1-Q4	Q1-Q4	SAPC, SIT
FOCUS AREA: HEALTH CARE COMMODITIES					
Procurement (quantification, forecasting)					
Consumables					
Distribute commodities and supplies for EID (linked with distribution plan)		Q4	Q1-Q4	Q1-Q4	SAPC, SIT
Training & capacity					
Conduct 3-day training for HCWs at SHCs and PHCs on EID	2 persons per PHC, 3 for SHCs X 3 days	Q4	Q1-Q4	Q1-Q4	SAPC, SIT, SACA
Service delivery					
Development and deployment of job aid on PMTCT documentation to facilities (linked with distribution plan)		Q4	Q1-Q4	Q1-Q4	SAPC, SIT
Regular supply of DCTs and reporting tools		Q4	Q1-Q4	Q1-Q4	SAPC, SIT, SMOH
Prints job-aides on EID for (SHCs and PHCs)	61 sites	Q4	Q1-Q4	Q1-Q4	SAPC, SIT

Prong 4: Family centered care and support

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

Objective 6: Increase provision of lifelong ART received by at least 90% of the pregnant infected women requiring treatment for their own health *(continued)*

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: PMTCT DEMAND CREATION SYSTEMS					
Mentoring & supervision					
Support PLHIV groups to conduct monthly meetings at LGA level and provide talks on ANC/HTC/PMTCT/FP/RH/IYCFand treatment adherence	15 persons per group X 2 support groups per LGA x 8 LGAs		Q1-Q4	Q1-Q4	Support Groups
Support female dominated PLHIV groups to provide mentorship to women living with HIV through health talks at ANC, community-based adherence support, and tracking of HIV positive pregnant women	2 female PLHIV per facility x 101 HFs (1 PLHIV to give talk each week x 26 weeks x 101 HFs)		Q1-Q4	Q1-Q4	Support Groups
Community services					
Establish more PLHIV support groups at LGA and community and facility levels (not costed)		Q4	Q1-4		NEPWHAN, ASWHAN, SACA, SAPC

Cross Cutting Areas

Objectives 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					
Procure and distribute 48 (solar powered) laptop to support electronic data entry and transmission M&EO of 8 LGA, DPRS *2, 1 SASCP,1 SACA,1 malaria, 1TB, 32 secondary and 2 tertiary HF)	Procure for M&EO of 8 LGAs, 2 DPRS, 1 SASCP,1 SACA,1 malaria, 1TB, 32 Secondary and 2 Tertiary HF)		Q2		Dir PHC
Provide internet support for electronic data transmission (linked to the preceding row)	48 internet modems + subscription X 27 months		Q2		
Strategic information					
Produce quarterly state/LGA scorecard/fact sheets of programme implementation performance (Select some indicators and formulate a bulletin for circulation) in either electronic or printed format to stakeholders by the SMOH		Q3-Q4	Q1-Q4	Q1-Q4	State MOH-DPRS/ SACA/SASCP M&E Officers
Promote monthly data dissemination (sharing of pivot tables with all stakeholders)	TWG including SACA/ SASCP/DPRS	Q3-Q4	Q1-Q4	Q1-Q4	State MOH-DPRS/ SACA/SASCP M&E Officers
Disseminate of program performance at quarterly program review/coordination meetings (linked to activity 1 under routine monitoring below)		Q4	Q1-Q4	Q1-Q4	
Central database					
Conduct monthly data gap & completeness analysis	State MOH-DPRS/ SACA/SASCP	Q3-Q4	Q1-Q4	Q1-Q4	State MOH-DPRS/ SACA/SASCP M&E Officers
Support monthly planned preventive maintenance (PPM) for electronic database ICT equipment; visit by state ITO	8 LGAs to be visited	Q4	Q1-Q4	Q1-Q4	State ITO
Procure multiuser antivirus protection for 50 computers (3-year subscription)	500 user antivirus at 2 month subscription				
Routine monitoring					
Conduct a quarterly integrated M&E TWG (DPHC led)- 1-day meeting for 25 persons + DPHC=26+7IPs	25 state TWG members + 1 DPHC+7IPs		Q1-Q4	Q1-Q4	Director PHC
Conduct a 1-day monthly integrated LGA M&E/HDCC meetings -coordination, data validation & collection	36 participants per LGA- 6 LGA (1LGA-TB/1 malaria/1RH/1LGA M&E/1LACA, 1PHCC) and 30 HF participants	Q3-Q4	Q1-Q4	Q1-Q4	
Quarterly forecasting, quantification, procurement & distribution of M&E data collection and reporting tools (DCRT)	171 PHCs, 18 comprehensive and 16 secondary PMTCT Sites	Q3-Q4	Q1-Q4	Q1-Q4	SACA/SASCP/DPRS M&E Officers

Cross Cutting Areas

Objectives 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)*					
Routine monitoring *(continued)*					
Support monthly LGA level technical assistance and monitoring visits in 8 LGAs-(TA/monitoring and mentoring visit at 3rd week of the month)	2 teams of 5 persons	Q3-Q4	Q1-Q4	Q1-Q4	TWG Members
Support monthly LGA level onsite data collection & validation in 8 LGAs-(Validation and verification exercise) at 1st week of the month) by LGA M/EO		Q3-Q4	Q1-Q4	Q1-Q4	LGA M&E Officers
Support the quarterly state level integrated HDCC meetings for data collection, validation, feedbacks, sharing best practices.- 2days meeting- SSA Public Health, 1 rep per LGA (8 persons), 12 state officers, 1 LGSC,7 IPs	SSA Public Health, 1 representative per LGA (8 persons), 12 state officers, 1 LGSC, 7 IPs	Q3-Q4	Q1-Q4	Q1-Q4	Director PHC /SSA Public Health
Conduct quarterly supportive supervision & data quality assurance (DQA) to facilities (TWG members visit facilities quarterly)	2 teams of 5 person X 5 days visit per quarter	Q4	Q1-Q4	Q1-Q4	Director PHC /TWG
Capacity building					
Hold 3-day TOT for 25 TWG and selected 6 facility M/E FP	25 state TWG members+6 (HF M&E, FP)	Q4			Director PHC
Conduct phased facility based trainings on the use of the integrated National DCRT in 2 phases: Phase1=12 existing+16 proposed scale up, Phase 2= 6 proposed scale up	2 tertiary facilities at 20/ facility=40, 32 secondary facilities at 20 per facility =640, 4 facilitators, X 6 persons per LGA (TB/ malaria/ RH/ LGA M&E/ LACA, PHCC) for 5 days	Q4	Q1		DPRS
Conduct LGA based NHMIS DCRT training 5 staff per PHC, 6 staff per LGA on the use of the NHMIS DCRT (1 day training-TB/malaria/RH/LGA M&E/LACA, PHCC)	6 LGA staff, 5 PHC Staff in 21 PHCs = (111 participants) + 2 facilitators for 1 day.	Q4	Q1-Q3		DPRS
Conduct four-day LGA level DHIS electronic database mop up & Computer appreciation training (6 persons per LGA and, 2 staff/ facility participants = 48 LGA+68 HF participants+2 facilitators)	6 LGA+ 8 staff (2 per HF) From 4 HF-based at the LGA +2 facilitators		Q2		Director PRS
Conduct training on community NHMIS M&E tools and reporting	10 CBO M/E (NEPWHAN, Synergy, Healing, GREP. KWRDC, KAN and 4 others), 8 LGA staff (M&E and PHCC) & 8 PHC coordinators for 2 days		Q1		MWASD
Conduct a 2-day quarterly state level health data producers & users forum (targets upstream stakeholders)	9 meetings for 50 persons		Q2		
Training of TWG members on operations research and data analysis	25 TWG members for 3 days + 3 facilitators		Q3		Dir PHC
Conduct operations research (SMOH)			Q4		State MOH-DPRS/ SACA/SASCP M&E Officers

Cross Cutting Areas

Objectives 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)*					
Advocacy					
Conduct advocacy meeting to heads of health departments/agencies and units and private health practitioners on plans for integrated health data management system led by DPHC & DMS	DPRS, 8 LGAs heads of health departments, HMB, SASCP, SACA, HOD of MRs for secondary & tertiary facilities, IPs, DNS, APGMPM, LGSC	Q4			Director PHC
Others					
Inaugurate an integrated statewide M&E TWG & Review the existing integrated State M&E plan	25 state TWG members + 1DPHC+7IPs for 1 day	Q4			Director PHC
FOCUS AREA: PROGRAM MANAGEMENT					
Situation analysis					
Conduct statewide rapid health facility assessment and site selection encompassing all health facilities both public and private in Bayelsa State (done)		Q2-Q3			SIT, SMOH, FHI 360
Conduct resource mapping and gap analysis (embedded in resource mobilization training); 1 resource mapping and gap analysis has been conducted		Q3			SIT/SMT
Coordination and resource mobilization					
Activate selected sites	101 selected public-owned health facilities across all 8 LGAs in the state	Q3-Q4	Q1-Q2		SIT,SMOH, FHI 360
Conduct BYS PMTCT Diagnostic	All public and private health facilities in Bayelsa State	Q3			Deep Dives
Develop costed state PMTCT operational plan	101 selected public-owned health facilities across all 8 LGAs in the state	Q4			SMT
Print and distribute costed operational plan	1000 copies among relevant stakeholders including potential identified donor agencies	Q4			SASCP
Convene a one day stakeholder forum to disseminate operational plan	150 stakeholders	Q4	Q1-Q4	Q1-Q4	SMT
Conduct monthly mentorship to the implementing sites	27 mentorship conducted	Q3-Q4	Q1-Q4	Q1-Q4	SMT
Conduct quarterly Integrated Supportive Supervision (ISS) visits to selected sites	10 ISS visits conducted		Q4	Q4	SMoH. FHI 360
Sponsor SMT to participate in national/regional summit	20 SMT (twice through-out LOP)		Q4	Q4	SMT

Cross Cutting Areas

Objectives 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)*					
Coordination and resource mobilization *(continued)*					
Conduct bi-annual Partner/Stakeholder Forum on PMTCT	2 days non-residential CBOs, IPs, religious leaders, traditional rulers, private sector		Q2	Q2	SMT
Develop and distribute State and LGA score cards on KPIs (quarterly) to stakeholders at the local, state and national levels.		Q3-Q4	Q1-Q4	Q1-Q4	SMT
Conduct quarterly mentorship/Integrated Supportive supervision (ISS) visits to select facilities by PHC team/ LACA Coordinator		Q3-Q4	Q1-Q4	Q1-Q4	FHI 360, HMB
Develop a PMTCT staff development plan	Relevant facility staff in 101 selected public-owned health facilities across all 8 LGAs in the state	Q4			SMOH
Conduct relevant capacity building events for Government staff (SMoH staff, SASCP, SACA), CSOs, religious and traditional leaders and other relevant stakeholders on; governance and leadership training via 2 phases: Phase 1: government staff/SMT; Phase 2: CSOs/FBOs/NGOs/CBOs		Q4	Q2		SMOH, FHI 360
Conduct relevant capacity building events for government staff (SMoH staff, SASCP, SACA), CSOs, religious and traditional leaders and other relevant stakeholders on; financial management and resource mobilization via 2 phases : Phase 1: government staff/ SMT; Phase 2: CSOs/FBOs/NGOs/CBOs		Q4	Q2		SMOH, FHI 360
Conduct exchange study tours within Nigeria (twice per year)	50 staff of relevant line ministries, CSOs and relevant agencies providing HIV and AIDS services in Bayelsa State twice a year	Q4	Q2, Q4	Q2, Q4	SMT
Adapt and print relevant PMTCT policy guidelines, SoP framework for BYS	101 Selected facilities, stakeholders, gen population	Q3-Q4			SMT
Develop and facilitate the implementation of annual PMTCT operational/ implementation plans	3 Annual operational plans	Q3	Q1	Q1	SMT, FHI 360, IPs
Hire boats and procure and maintain the following: 1.Boats (at LGA health dept) and vehicles 2.Computers and generators	4 (2 buses, and 2 Hilux cars) monitoring vehicles, 101 computers and 50 5.5 KVA generators		Q1		SMT, FHI 360
Provide a framework for First Lady's award (for the best performing LGA) during annual summit on PMTCT for 2 years (cost for Annual Summit is embedded in Bi-annual Forum) at local and state levels.		Q3			SMT

Cross Cutting Areas

Objectives 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)*					
Coordination and resource mobilization *(continued)*					
Conduct a 1-day meeting to review membership and ToR of the current state Implementation Team to expand its composition to SMT by accommodating new members.		Q3			SIT
Conduct 1-day meeting to inaugurate the State Management Team (SMT)		Q3			SIT
Operational cost: Fueling vehicles for supervision and monitoring	All 8 LGAs	Q3	Q1-Q4	Q1-Q4	SIT
Hold quarterly review meetings of IAs (9 have already been held)		Q4	Q1-Q4	Q1-Q4	SMT
Hold monthly State Management Team meetings (27 monthly SMT meetings has been held already)		Q4	Q1-Q4	Q1-Q4	SIT/SMT
Hold quarterly SMT sub-committee meeting (including M&E, PMTCT and PSCM)- 9 quarterly sub-committee meetings has already been held across all 3 identified key thematic areas		Q4	Q1-Q4	Q1-Q4	SIT/SMT
Hold monthly cluster (5 PHCs and 1 comprehensive site) coordination meeting (27 cluster coordination meetings already been held)		Q4	Q1-Q4	Q1-Q4	SMT
Constitute BYSACA board with multi-sectoral representation by paying advocacy visits to policymakers		Q4	Q1		SMoH (PRS), SMT, FHI 360
Community mobilization					
Advocacy					
Advocacy visit to key stakeholders to facilitate employment of more health care workers: doctors, nurses, pharmacists/pharmacy technicians, lab scientists/lab technicians, and health information officers (no cost)		Q4	Q1-Q2		HMB
Conduct advocacy visit to relevant policy makers for more health workers - (CHOs, CHEWs) - based on identified needs	3 aAdvocacy visits relevant policy makers having bearing on health	Q4	Q1-2		LGSC
Conduct advocacy visit to relevant key players to recruit adequate number of staff in the right skill mix for BYSACA (10 has been recruited)			Q2		SMoH (PRS), SMT, FHI 360
Advocate to the BYS Executive Governor and identified influencers in the state for the release of SACA budgetary allocation for 2013		Q3-Q4			SMT
Develop advocacy package (targeting the State Governor, legislators and private sector, etc.)		Q3			SIT/SMT

Cross Cutting Areas

Objectives 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)*					
Community mobilization *(continued)*					
Advocacy (continued)					
Carry out advocacy to the State Governor, legislators and private sectors to facilitate the allocation and timely release of funds for the implementation of PMTCT activities	At least 2 cycles of advocacy visits to BYS Executive Governor and legislators in the State	Q4	Q1		SIT/SMT
Carry out advocacy to multi-nationals to support PMTCT implementation plan	At least 5 batches of advocacy visits to multi-nationals	Q4	Q1-Q4		SIT/SMT
Advocate to key partners like SURE-P, MDGs, multi-national Foundation so as to leverage on existing and other possible sources of funding		Q4	Q1-Q2		SIT/SMT
Capacity building					
Re-establish LACA platform (platforms already established)	All 8 LGAs in the state	Q4			SMT/SACA
Build the capacity of PHC team/ LACAs to effectively monitor and coordinate the implementation of PMTCT scale up plan	2 batches of leadership and programme management training for at 5 days for 40 PHC team/LACA across 8 LGAs		Q1,Q3		SMT, FHI 360
Build capacity of SMT on leadership and programme management (already costed above)	3 batches of leadership and programme management training for 20 SMT members	Q4	Q2,Q4		SMoH, FHI 360
Train BYSACA Board on leadership and management skills (already costed above)	2 batches of leadership and management training for BYSACA Board		Q1,Q3		SMoH (PRS), SMT, FHI 360

SECTION

8 Monitoring and Evaluation Plan

The existing Information Management System will be utilized for routine collection of programme data using the registers and reporting forms at implementing health facilities. The reporting will follow the established channels through 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 summarized in the table below.

Table 7: : Targets of the Core Indicators for Bayelsa State

Indicator	Baseline (2012)	2013	2014	2015
Number of health facilities that provide ANC plus PMTCT services	38	62	111	111
Number females age 15 – 49yrs newly tested HIV positive	3,155	6,764	5,525	4,236
Number of pregnant women counselled tested and given HIV results	6,601	18,926	41,663	90,213
Number of HIV infected women aged 15 – 49 years who accessed comprehensive family planning services	N/A	4,487	6,281	8,076
Number of pregnant women reached with antiretroviral drugs for PMTCT according to the national guidelines	173	957	5,416	9,122
Number of HIV exposed infants offered antiretroviral drugs for PMTCT according to the national guidelines	69	957	5,416	9,122
Number of HIV positive pregnant women offered quality infant feeding counseling	N/A	957	5,416	9,122
Number of HIV positive pregnant women in need of treatment initiated on ART for their own health (50% of total)	389	718	2,708	4,561
Number of HIV exposed infants offered first PCR test from 6 – 8 weeks of age	47	957	5,416	9,122

8.1 BAYELSA 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 detailed costed budget.

Table 8: Bayelsa State Summary Budget by Focus Area

THEMATIC AREAS	Year 1 (NGN)	Year 2 (NGN)	Year 3 (NGN)	Total (NGN)	Total (USD)
PMTCT service supply systems	271,529,313	848,929,668	201,060,000	1,321,518,981	8,525,929
Health care commodities	3,852,005,226	1,154,288,878	1,154,288,878	6,160,582,982	39,745,697
PMTCT demand creation system	187,342,770	-	94,028,770	281,371,540	1,815,300
Monitoring & evaluation	60,343,529	261,794,716	301,606,756	623,745,000	4,024,161
Program management	807,998,740	2,535,841,190	76,894,000	3,420,733,930	22,069,251
Grand total	**5,179,219,578**	**4,800,854,452**	**1,827,878,404**	**11,807,952,433**	**76,180,338**

SECTION

10 Appendix - Detailed Budget

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

Strategic intervention	Activities
THEMATIC AREA: PMTCT SERVICE SUPPLY SYSTEMS	
Training & capacity	Conduct 10-day training for HCWs on HTC
	Conduct 3-day training for PHCs on logistics management
	Conduct 5-day training for secondary facilities on logistics management
	Print and distribute HTC guidelines, SOPs, job aids and flow charts
Community Services	Conduct 1-day dissemination/sensitization meeting at the state level to gatekeepers and key stakeholders
	Conduct 1 day advocacy/sensitization meeting at the LGA/Ward level to gatekeepers and key stakeholders in the community
	Conduct 1-day sensitization meeting for TBAs in the community
Mentoring & supervision	Conduct quarterly quality improvement visits to PMTCT sites
PMTCT service supply systems sub-total	
THEMATIC AREA: HEALTH CARE COMMODITIES	
Procurement	***Consumables***
	Procure Determine HIV kits (cost for 2,415,739)
	Procure Unigold HIV kits (cost for 219, 832)
	Procure Stat Pak HIV test kits (cost for 6,600)
	Procure laboratory consumables
	Procure IPAC commodities
	Procure medical consumables
	Procure male condoms for HIV prevention
	Procure female condoms for HIV prevention
	Procure DBS bundle kit
	Procure PCR reagent
	Procure PCR consumables

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)
19,218,350	57,655,050	-	76,873,400	495,957
2,815,500	5,631,000		8,446,500	54,494
4,629,100	-	-	4,629,100	29,865
1,212,000	-	-	1,212,000	7,819
855,000	-	-	855,000	5,516
11,568,000	11,568,000	11,568,000	34,704,000	223,897
1,420,000	-	-	1,420,000	9,161
1,568,000	6,272,000	6,272,000	14,112,000	91,045
43,285,950	**81,126,050**	**17,840,000**	**142,252,000**	**917,755**
115,955,472	231,910,944	231,910,944	579,777,360	3,740,499
19,784,880	39,569,760	39,569,760	98,924,400	638,222
594,000	1,188,000	1,188,000	2,970,000	19,161
377,888,626	188,944,313	188,944,313	755,777,252	4,875,982
2,450,204	4,901,281	4,901,281	12,252,766	79,050
377,888,626	188,944,313	188,944,313	755,777,252	4,875,982
81,850,867	163,701,734	163,701,734	409,254,335	2,640,351
4,003,018	8,006,035	8,006,035	20,015,088	129,130
89,880,300	179,760,600	179,760,600	449,401,500	2,899,365
-	-	-	-	-
-	-	-	-	-

SECTION
10 APPENDIX-DETAILED BUDGET

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)*

Strategic intervention	Activities
THEMATIC AREA: HEALTH CARE COMMODITIES *(continued)*	
Procurement *(continued)*	***Equipment***
	Procure PCR machines and accessories (X 1)
	Assess & upgrade of laboratories/ lab store, pharmacy /pharmacy stores for PMTCT and ART services (cost in program management)
Distribution	Distribute healthcare commodities
Stock management	Conduct 5-day logistics management training on health commodities for laboratory scientists/ technicians & pharmacists/pharmacy technicians (refer to services supply group)
Staffing	Initiate deployment of HCWs (lab scientist/technician, pharmacists/technicians) for service provision at SHCs and PHCs (refer to program management)
Training and capacity	Conduct pharmaceutical care training for pharmacist/pharmacy technicians (refer to service supply)
	Conduct 6-day lab activation training for lab scientists/technicians for ART sites (2 persons per facility X 12 facilities) (refer to service supply)
	Conduct onsite 3-day sample handling training for HCW in PMTCT sites (10 persons - nurses, doctors, laboratory staff- per facility X 3) (refer to service supply)
	Conduct PCR training for laboratory scientists (2 per facility X 10 days) (refer to service supply)
Others	Provide funds for the transportation of blood samples for laboratory analysis (CD4, chemistry and hematology)
	Provide funds for transportation of DBS samples to and from EID laboratories
	Provide funds for sputum sample transfer from facilities to TBL referral labs
	Provide funds for sputum sample transfer from TBL referral labs to Benin & Calabar
Health care commodities sub-total	
THEMATIC AREA: PMTCT DEMAND CREATION SYSTEMS	
Training on IPC	Conduct a 5-day workshop for stakeholders to develop an SBCC PMTCT strategy for Bayelsa State
	Train staff of key line ministries, agencies and CSOs on Social and Behavior Change Communication (SBCC)
	Conduct a 5-day workshop to adapt and pretest materials (print and electronic messages/ materials) for all four PMTCT prongs
	Review and finalize BCC messages (technical experts; already costed above)
	Conduct a 2-day training for support group members on interpersonal communication (IPC), public speaking and giving testimonies
	Train 240 TBAs and 24 CBOs/SGs on integrated ANC/HTC/PMTCT/IYCF for 3 days at LGA level
	Train 240 TBAs to recognize danger signs, IPAC and how to refer pregnant women to health facilities for ANC/HTC/PMTCT services as appropriate
	Train community members as peer educators to educate men and women of reproductive age on HIV Prevention including ANC/HTC/ PMTCT/IYCF

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)
-	42,354,361	-	42,354,361	273,254
2,262,400	4,524,800	4,524,800	11,312,000	72,981
-	-	-	-	-
–	-	-	-	-
-	-	-	-	-
			-	-
-	-	-	-	-
-	-	-	-	-
10,931,200	21,862,400	21,862,400	54,656,000	352,619
10,931,200	21,862,400	21,862,400	54,656,000	352,619
-	-	-	-	-
4,680,000	9,360,000	9,360,000	23,400,000	150,968
1,099,100,793	**1,106,890,941**	**1,064,536,580**	**3,270,528,314**	**21,100,183**
1,140,000	-	-	1,140,000	7,355
-	756,000	-	756,000	4,877
-	2,101,000	-	2,101,000	13,555
-	-	-	-	-
-	1,980,000	-	1,980,000	12,774
-	7,597,000	-	7,597,000	49,013
-	4,949,000	-	4,949,000	31,929
3,343,200	1,432,800	-	4,776,000	30,813

SECTION
10 APPENDIX-DETAILED BUDGET

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)*

Strategic intervention	Activities
THEMATIC AREA: PMTCT DEMAND CREATION SYSTEMS *(continued)*	
Community Mobilization	***Sensitization***
	Conduct 1-day sensitization and advocacy meetings at the state level
	Conduct 1-day sensitization and advocacy to gatekeepers and influential people at LGA level
	Conduct a 1-day sensitization meeting for religious leaders (pastors, imams)
	Advocacy
	Conduct high level advocacy visit to the First Lady/ Governor of Bayelsa State
	Conduct focused advocacy to gatekeepers and influential people at community level
	Conduct 1-day training on advocacy and community mobilization on PMTCT for 24 CSOs (CBOs and support groups)
Media engagement	Produce and broadcast radio messages
	Broadcast messages via community radio
	Produce and broadcast TV messages
	Broadcast mobile phone bulk messages
	Broadcast messages via social media
	Establish/strengthen community radio systems to disseminate PMTCT messages
	Conduct training for journalists including community radio broadcasters to mainstream ANC/HTC/PMTCT/RH/FP messages into their programs
Mentoring & supervision	Conduct quarterly community outreaches in communities, FBOs, TBA homes and during festival activities
	Support trained peer educators to conduct peer sessions, mentor peers and refer for ANC/ HTC/FP/ RH/ PMTCT services
IEC materials	Produce SBCC materials, posters, pamphlets, fliers, pens, t-shirts, etc.)
	Distribute SBCC materials (at no cost)
Others	Launch Bayelsa State eMTCT Implementation Plan at state level
Community services	Demonstrate use of and distribute condoms through CBOs, community health workers and TBAs
	Provide grants to CBOs and support groups to implement integrated community PMTCT programmes
	Conduct community dialogues with all stakeholders including TBA, community leaders, men and women
	Create calendar of festivals in various communities/LGAs
	Conduct a 5-day training for community health workers on integrated ANC/HTC/ PMTCT service delivery
	Establish male care forums at community level to champion male involvement in ANC/HTC/ PMTCT service
PMTCT demand creation system sub-total	
Objective 1 sub-total	

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)
305,000	-	-	305,000	1,968
4,170,000	-	-	4,170,000	26,903
940,000	-	-	940,000	6,065
5,000	-	-	5,000	32
-	-	-	-	-
3,428,000	-	-	3,428,000	22,116
-	4,192,000	4,192,000	8,384,000	54,090
-	630,000	3,030,000	3,660,000	23,613
-	3,960,000	3,960,000	7,920,000	51,097
-	2,700,000	5,400,000	8,100,000	52,258
-	174,000	174,000	348,000	2,245
-	3,552,000		3,552,000	22,916
-	6,278,500		6,278,500	40,506
-	1,280,000	2,560,000	3,840,000	24,774
-	3,840,000	3,840,000	7,680,000	49,548
-	14,172,000	9,448,000	23,620,000	152,387
-	-	-	-	-
805,000	-	-	805,000	5,194
-	583,500	-	583,500	3,765
-	24,000,000	24,000,000	48,000,000	309,677
-	1,536,000	2,560,000	4,096,000	26,426
-	5,000	-	5,000	32
5,745,143	5,745,143	-	11,490,286	74,131
			-	-
19,881,343	**91,463,943**	**59,164,000**	**170,509,286**	**1,100,060**
1,162,268,086	**1,279,480,934**	**1,141,540,580**	**3,583,289,600**	**23,117,997**

SECTION
10 APPENDIX-DETAILED BUDGET

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

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

Strategic intervention	Activities
THEMATIC AREA: PMTCT SERVICE SUPPLY SYSTEMS	
Training & capacity	Conduct 5-day training of HCW & 8 LGA FP focal persons on SRH/HIV integration in all activated sites.
	Conduct 2-day training on CLMS for 8 LGA FP focal persons and 54 persons from newly activated sites + 2 SMOH + 2 facilitators
Site Activation	Activate family planning SDPs in all the facilities
Service delivery	Print and distribute SRH/HIV guidelines, service providers' curriculum and manual to all facilities
PMTCT service supply systems sub-total	
THEMATIC AREA: HEALTH CARE COMMODITIES	
Distribution	***Consumables***
	Provide financial support to transport family planning commodities from state stores to SDPs (cost in distribution plan)
Stock management	Conduct training of LGA focal persons on Contraceptive Logistics Management information tools (CLMIS) (cost for 64 persons) (refer to services supply)
Others	Print national guideline on pharmaceutical operations
	Print laboratory manuals, SOPs and job aids (X 12 HCC site)
	Print SOPs and job aids on sample collection/sample transfer for PMTCT (X 61)
Health care commodities sub-total	
THEMATIC AREA: PMTCT DEMAND CREATION SYSTEMS	
Community services	Train 202 frontline health workers on family planning methods to integrate into community outreaches
PMTCT demand creation system sub-total	
Objective 2 sub-total	

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)
4,607,000	9,214,000	-	13,821,000	89,168
2,060,200	2,060,200	-	4,120,400	26,583
-	-	-	-	-
1,818,000	-	-	1,818,000	11,729
8,485,200	**11,274,200**	**-**	**19,759,400**	**127,480**
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	**-**	**-**	**-**	**-**
7,072,143	7,072,143	-	14,144,286	91,253
7,072,143	**7,072,143**	**-**	**14,144,286**	**91,253**
15,557,343	**18,346,343**	**-**	**33,903,686**	**218,733**

SECTION
10 APPENDIX-DETAILED BUDGET

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: Provide ARV prophylaxis for PMTCT to at least 90% of all HIV positive pregnant women and breastfeeding infant-mother pairs

Strategic intervention	Activities
THEMATIC AREA: PMTCT SERVICE SUPPLY SYSTEMS	
Training & capacity	Conduct 6-day IMPAC training for HCWs in PHCs
	Conduct 6-day Integrated PMTCT/EID training for HCWs in secondary facilities
	Conduct 6-day HCC training for HCWs in secondary facilities
	Conduct 5-day pharmaceutical care training for LGA pharmacists (2 per LGA) & community pharmacists preceptors
	Conduct 2-day ARV dispensing and documentation for pharmacy technicians, nurses CHO and CHEWs
	Conduct 5-day onsite pharmacy best-practice training for HCWs
	Conduct 6-day laboratory training for 2 HCW in secondary facilities
	Conduct 2-day laboratory training for HCWs in PHCs
Linkages/referrals	Conduct 2-day onsite training on adherence counseling and client tracking/referrals
	Conduct 2-day training for TBAs on universal precautions and modified obstetric practices (including referrals and client tracking)
Mentoring & supervision	Conduct monthly mentoring and supportive supervision of PMTCT facilities
	Support monthly meetings for TBAs at the LGA
	Support quarterly meetings for TBAs at the state
	Conduct 2-day training for mentor mothers, CBOs community volunteers and community pharmacists on adherence counseling, referrals, client tracking
Site activation	Activate 61 sites for PMTCT service provision (2 days per site)
Service delivery	Print and distribute PMTCT and EID National guidelines, SOPs, job aids and service flow charts
	Print and distribute IMPAC training materials for PHCs
	Conduct bimonthly community outreaches to TBAs, churches, fishing camps, youth groups, markets in collaboration with the WDCs
PMTCT service supply systems sub-total	

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)
5,869,967	11,739,933	-	17,609,900	113,612
6,335,400	6,335,400	-	12,670,800	81,747
6,335,400	6,335,400	-	12,670,800	81,747
2,577,000	2,577,000	-	5,154,000	33,252
1,898,100	3,796,200	-	5,694,300	36,737
5,720,000	16,087,500	-	21,807,500	140,694
5,102,400	-	-	5,102,400	32,919
1,865,800	1,865,800	-	3,731,600	24,075
1,833,600	5,157,000	-	6,990,600	45,101
4,319,400	4,319,400	4,319,400	12,958,200	83,601
6,384,000	25,536,000	25,536,000	57,456,000	370,684
9,019,200	36,076,800	36,076,800	81,172,800	523,695
1,460,000	5,840,000	5,840,000	13,140,000	84,774
6,656,200	6,656,200	6,656,200	19,968,600	128,830
3,545,600	9,972,000	-	13,517,600	87,210
1,220,000	-	-	1,220,000	7,871
697,500	-	-	697,500	4,500
3,636,000	14,544,000	14,544,000	32,724,000	211,123
74,475,567	**156,838,633**	**92,972,400**	**324,286,600**	**2,092,172**

SECTION
10 APPENDIX-DETAILED BUDGET

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)*

Strategic intervention	Activities
THEMATIC AREA: HEALTH CARE COMMODITIES	
Procurement	***Drugs***
	Procure ARVs for infected pregnant women (cost by regimen & product AZT/3TC, NVP, TDF/3TC, EFV, LPV/R)
	Procure ARVs for treatment of HIV positive individuals for 12 HCC sites (cost by regimen & product AZT/3TC, NVP, TDF/3TC, EFV, LPV/R)
	Procure ARVs for treatment of HIV positive children for 12 HCC sites (cost by regimen & product AZT/3TC, NVP, TDF/3TC, EFV, LPV/R)
	Procure ARVs for HIV exposed infants (cost by regimen & product NVP syrup)
	Procure cotrimoxazole for infected women and other OIs
	Procure cotrimoxazole for HIV exposed infants
	Consumables
	Procure CD4, hematology and chemistry reagents (cost per equipment)
	Procure Hep B, C and VDRL kits
	Procure pregnancy test kits
	Equipment
	Procure CD4 count machines, hematology and chemistry equipment (cost separately)
	Procure CD4 POC
Distribution	***Consumables***
	Print the national guidelines for PMTCT and HCT (refer to service supply)
	Disseminate job-aides to all health facilities (cost in distribution plan)
Mentoring & supervision	Conduct monthly technical supportive supervisory visits to PMTCT sites (cost for 5 per X 5 days)
	Conduct bimonthly LMIS data verification and validation exercise (cost for 5 per X 5 days)
Health care commodities sub-total	

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)
25,280,176	50,560,352	50,560,352	126,400,879	815,490
418,233,455	836,466,910	836,466,910	2,091,167,275	13,491,402
-	-	-	-	-
-	-	-	-	-
40,016,224	80,032,447	80,032,447	200,081,119	1,290,846
-	-	-	-	-
17,489,304	34,978,608	34,978,608	87,446,520	564,171
12,486,042	24,972,084	24,972,084	62,430,210	402,776
			-	-
81,168,786	81,168,786	-	162,337,572	1,047,339
6,799,800	6,799,800	-	13,599,600	87,739
-	-	-	-	-
-	-	-	-	-
784,000	1,568,000	1,568,000	3,920,000	25,290
784,000	1,568,000	1,568,000	3,920,000	25,290
603,041,787	**1,118,114,987**	**1,030,146,401**	**2,751,303,175**	**17,750,343**

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)*

Strategic intervention	Activities
THEMATIC AREA: PMTCT DEMAND CREATION SYSTEMS	
Training on IPC	Conduct a 1-day training for clergy (pastors and imams) to include HIV/HTC/PMTCT messages in their sermons
Linkages and referrals	Train referral focal persons and establish referral network of health facilities, CBOs and TBAs
	Provide incentive package to TBAs who complete referral of pregnant women to health facilities for ANC/PMTCT
	Conduct monthly TBA network coordination meeting
	Update, print and disseminate referral directory of service delivery points for ANC/HTC/ PMTCT/RH/FP services
Others	Brand PMTCT service centers as user- friendly centers
	Establish male care forums at community level to champion male involvement in ANC/HTC/ PMTCT service
PMTCT demand creation system sub-total	
Objective 3 & 4 sub-total	

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)
-	1,115,000	-	1,115,000	7,194
1,087,000	-	-	1,087,000	7,013
-	3,984,000	3,984,000	7,968,000	51,406
-	3,360,000	3,360,000	6,720,000	43,355
-	505,000	-	505,000	3,258
-	1,010,000	-	1,010,000	6,516
-	-	-	-	-
1,087,000	**9,974,000**	**7,344,000**	**18,405,000**	**118,742**
678,604,353	**1,284,927,620**	**1,130,462,801**	**3,093,994,775**	**19,961,257**

SECTION
10 APPENDIX-DETAILED BUDGET

Prong 4: Family centered care and support

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

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

Strategic intervention	Activities
THEMATIC AREA: PMTCT SERVICE SUPPLY SYSTEMS	
Site activation	Link activated sites to the National PCR lab
Mentoring & supervision	Support facility based client tracking of mother baby pair (communication)
	Support community based client tracking of mother baby pair (transportation)
	Conduct 5-day training on PHDP for mentor mothers
Linkages/Referrals	Strengthen referral linkages, client tracking and adherence support
	Link HIV positive mothers requiring ART/TB services to HIV comprehensive centers.
PMTCT service supply systems sub-total	
THEMATIC AREA: HEALTH CARE COMMODITIES	
Distribution	Consumables
	Distribute commodities and supplies for EID
Training and capacity	Conduct 3-day training for HCWs at SHCs and PHCs on EID (cost for 2 per PHCs, 3 for SHCs)
Service delivery	Development and deployment of job aid on PMTCT documentation to facilities
	Regular supply of DCTs and reporting tools
	Prints job aides on EID for (SHCs and PHCs) (cost for 61)
Health care commodities sub-total	
THEMATIC AREA: PMTCT DEMAND CREATION SYSTEMS	
Mentoring and supervision	Support PLHIV groups to conduct monthly meetings at LGA level and provide talks on ANC/ HTC/PMTCT/FP/RH/IYCF and treatment adherence
	Support female dominated PLHIV groups to provide mentorship to women living with HIV through health talks at ANC, community-based adherence support, and tracking of HIV positive pregnant women
Community services	Establish more PLHIV support groups at LGA and community and facility levels
PMTCT demand creation system sub-total	
Objectives 5 & 6 sub-total	

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)
-	-	-	-	-
915,000	3,660,000	3,660,000	8,235,000	53,129
7,320,000	29,280,000	29,280,000	65,880,000	425,032
-	4,558,200	-	4,558,200	29,408
1,776,000	7,104,000	7,104,000	15,984,000	103,123
-	-	-	-	-
10,011,000	**44,602,200**	**40,044,000**	**94,657,200**	**610,692**
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	**-**	**-**	**-**	**-**
-	2,976,000	2,976,000	5,952,000	38,400
-	7,272,000	7,272,000	14,544,000	93,832
-	-	-	-	-
-	**10,248,000**	**10,248,000**	**20,496,000**	**132,232**
10,011,000	**54,850,200**	**50,292,000**	**115,153,200**	**742,924**

SECTION

10 APPENDIX-DETAILED BUDGET

Cross cutting areas: Prevention of mother to child transmission of HIV

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

Strategic intervention	Activities
THEMATIC AREA: MONITORING & EVALUATION	
Data Quality Assurance	Procure and distribute 48 (solar powered) laptop to support electronic data entry and transmission M&EO of 8 LGA, DPRS *2, 1 SASCP,1 SACA,1 malaria, 1TB, 32 secondary and 2 tertiary HF)
	Provide internet support for electronic data transmission (48 internet modems + subscription *27 months)
Strategic Information	Produce quarterly State/LGA scorecard/fact sheets of programme implementation performance (select some indicators and formulate a bulletin for circulation)-Electronic or paper to stakeholders
	Promote monthly data dissemination (sharing of pivot tables with all stakeholders)
	Disseminate of program performance at quarterly programme review/coordination meetings
Central Database	Conduct, monthly data gap & completeness analysis.
	Support monthly planned preventive maintenance (PPM) for electronic database ICT equipment; visit by State ITO
	Procure multiuser antivirus protection for 50 computers (3 year subscription)
Routine Monitoring	Conduct a quarterly integrated M&E TWG (DPHC led); 1 day meeting for 25 persons + DPHC=26+7 IPs
	Conduct a 1-day monthly integrated LGA M&E/HDCC meetings; coordination, data validation & collection, 6 (1 LGA-TB/1 malaria /1 RH/1 LGA M&E/ 1 LACA, 1 PHCC) 30 HF participants
	Quarterly forecasting, quantification, procurement & distribution of M&E data collection and reporting tools (DCRT)-171 PHCs, 18 comprehensive, 16 PMTCT secondary
	Support monthly LGA level technical assistance and monitoring visits) in 8 LGAs; TA/ monitoring and mentoring visit at 3rd wk of the month
	Support monthly LGA level onsite data collection & validation in 8 LGAs; validation and verification exercise at 1st week of the month
	Support the quarterly state level integrated HDCC meetings for data collection, validation, feedbacks, sharing best practices; 2days meeting- SSA Public Health,1 rep per LGA(8 persons), 12 state officers, 1 LGSC,7 IPs
	Conduct quarterly supportive supervision & data quality assurance (DQA) to facilities; TWG members visit facilities quarterly (5 days visit -5 TWG members per Team - 2 teams)

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)
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
1,260,000	5,040,000	5,040,000	11,340,000	73,161
-	135,000	-	135,000	871
-	-	-	-	-
262,500	630,000	630,000	1,522,500	9,823
-	-	-	-	-
-	-	-	-	-
150,000	360,000	360,000	870,000	5,613
-	-	-	-	-
720,000	2,880,000	2,880,000	6,480,000	41,806

SECTION
10 APPENDIX-DETAILED BUDGET

Cross cutting areas: Prevention of mother to child transmission of HIV

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

Strategic intervention	Activities
THEMATIC AREA: MONITORING & EVALUATION *(continued)*	
Capacity Building	Hold 3-day TOT for 25 TWG and selected 6 facility M&E FP
	Conduct phased facility based trainings on the use of the integrated National DCRT (32 secondary & 2 tertiary) (5 days * 20 persons per facility * 6 persons per LGA-TB/Malaria/RH/ LGA M&E/LACA, PHCC); Phase1: 28 HF, Phase2: 6, 4 facilitators
	Conduct LGA based NHMIS DCRT training 5 staff per PHC, 6 staff per LGA on the use of the NHMIS DCRT; 1-day Training-TB/Malaria/RH/LGA M&E/LACA, PHCC
	Conduct LGA level DHIS electronic database mop up & computer appreciation training; 6 persons per LGA, 2 staff facility = 34 participants (2 tertiary/32 secondary HF) 4 days training (in Yr 2); 48 LGA + 68 HF participants +2 Facilitators
	Train 26 persons (10 CBOs M&E Officers [NEPHWAN, SYNERGY, HEALING, GREP, KWRDC, KAN and 4 others] & 8 LGA M&E & 8 PHCC) on community NHMIS M&E tools and reporting; 2-day training
	Conduct a 2-day quarterly state level health data producers & users forum (targets upstream stakeholders); 9 meetings for 50 persons
	Training of TWG members on operations research and data analysis (25 persona, 3 days + 3 facilitators)
	Conduct operations research
Advocacy	Conduct advocacy meeting to heads of health departments/agencies and units and Private Health practitioners on plans for integrated health data management system led by DPHC & DMS
Other	Inaugurate an integrated statewide M&E TWG (1 day meeting for 25 persons) & review the existing integrated state M&E plan
Monitoring and evaluation sub-total	
THEMATIC AREA: PROGRAM MANAGEMENT	
Situation analysis	Conduct statewide rapid health facility assessment and site selection
	Conduct resource mapping and gap analysis (embedded in resource mobilization training)
Coordination & Resource mobilization	Activate selected sites
	Conduct BYS PMTCT Diagnostic (done)
	Develop costed state PMTCT operational plan
	Print and distribute costed operational plan
	Convene a 1-day stakeholder forum to disseminate operational plan
	Conduct monthly mentorship to the implementing sites
	Conduct quarterly integrated supportive supervision (ISS) visits to selected sites
	Sponsor SMT to participate in national/regional summit
	Conduct bi-annual Partner/Stakeholder Forum on PMTCT

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)
72,500	-	-	72,500	468
840,000	180,000	-	1,020,000	6,581
240,000	720,000	-	960,000	6,194
-	108,000	-	108,000	697
-	-	-	-	-
			-	-
	-		-	-
	-		-	-
15,000			15,000	97
-	-	-	-	-
3,560,000	**10,053,000**	**8,910,000**	**22,523,000**	**145,310**
-	-	-	-	-
-	-	-	-	-
43,587,600	166,048,000	-	209,635,600	1,352,488
-	-	-	-	-
-	--	-	-	-
1,150,000	-	-	1,150,000	7,419
-	-	-	-	-
1,430,000	-	-	1,430,000	9,226
4,360,000	17,440,000	17,440,000	39,240,000	253,161
-	5,620,000	5,620,000	11,240,000	72,516
4,070,000	4,070,000	-	8,140,000	52,516

SECTION
10 APPENDIX-DETAILED BUDGET

Cross cutting areas: Prevention of mother to child transmission of HIV

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

Strategic intervention	Activities
THEMATIC AREA: PROGRAM MANAGEMENT *(continued)*	
Coordination & Resource mobilization *(continued)*	Develop and distribute state and LGA score cards on KPIs (quarterly) (integrated into ISS)
	Conduct quarterly mentorship/ISS visits to select facilities by PHC team/ LACA coordinator
	Develop a PMTCT staff development plan
	Conduct relevant capacity building events for government staff, CSOs, and other relevant stakeholders on governance and leadership training
	Conduct relevant capacity building events for government staff, CSOs, and other relevant stakeholders on financial management and resource mobilization
	Conduct exchange study tours within Nigeria (twice per year)
	Adapt, print and relevant PMTCT Policy guidelines, SoP framework for BYS
	Develop and facilitate the implementation of annual PMTCT operational/ implementation plans
	Hire boats and procure and maintain the following: 1.Boats (at LGA health dept) and vehicles 2.Computers and generators
	Provide a framework for First Lady's award (for the best performing LGA) during annual summit on PMTCT for 2 years (cost for Annual Summit is linked with Bi-annual Forum)
	Conduct a 1-day meeting to review membership and ToR of the current State Implementation Team to expand its composition to SMT
	Conduct 1-day meeting to inaugurate the State Management Team (SMT)
	Operational cost: fueling vehicles for supervision and monitoring
	Hold quarterly review meetings of IAs
	Hold monthly State Management Team meetings
	Hold quarterly SMT sub-committee meeting (M&E, PMTCT, and PSCM)
	Hold monthly cluster (5 PHCs and 1 comprehensive site) coordination meeting
	Constitute BYSACA board with multi-sectoral representation
Infrastructure	Assess infrastructure needs and develop BoQ
	Carry out infrastructural upgrades of selected sites
	Upgrade for EID services

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)
-	-	-	-	-
-	-	-	-	-
130,000	-	-	130,000	839
6,632,000	6,632,000	-	13,264,000	85,574
6,632,000	6,632,000	-	13,264,000	85,574
-	-	-	-	-
1,150,000	-	-	1,150,000	7,419
4,070,000	4,070,000	4,070,000	12,210,000	78,774
-	43,550,000	-	43,550,000	280,968
-	-	-	-	-
130,000	-	-	130,000	839
57,500	-	-	57,500	371
360,000	1,440,000	1,440,000	3,240,000	20,903
36,630,000	-	-	36,630,000	236,323
360,000	1,440,000	1,440,000	3,240,000	20,903
51,000	204,000	204,000	459,000	2,961
165,000	660,000	660,000	1,485,000	9,581
-	-	-	-	-
872,000	1,430,000	-	2,302,000	14,852
355,000,000	300,000,000	-	655,000,000	4,225,806
-	25,000,000	-	25,000,000	161,290

SECTION
10 APPENDIX-DETAILED BUDGET

Cross cutting areas: Prevention of mother to child transmission of HIV

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

Strategic intervention	Activities
THEMATIC AREA: PROGRAM MANAGEMENT *(continued)*	
Community Mobilization	***Advocacy***
	Advocacy visit to facilitate employment of more health care workers: doctors, nurses, pharmacists/pharmacy technicians, lab scientists/lab technicians, and health information officers (no cost)
	Conduct advocacy visit to relevant policy makers for more health workers - (CHOs, CHEWs) based on identified needs
	Conduct advocacy visit to relevant key players to recruit adequate number of staff in the right skill mix for BYSACA
	Advocate for release of SACA budgetary allocation for 2013
	Develop advocacy package (State Governor, private sector, etc)
	Carry out advocacy to the State Governor, legislators and private sector to facilitate the allocation and timely release of funds for the implementation of PMTCT activities
	Carry out advocacy to multi-nationals to support PMTCT implementation plan
	Advocate to key partners to leverage on existing and other possible sources of funding
Capacity Building	Re-establish LACA platform
	Build the capacity of PHC team/ LACAs to effectively monitor and coordinate the implementation of PMTCT scale up plan
	Build capacity of SMT on leadership and programme management (already costed above)
	Train BYSACA Board on leadership and management skills (cost in activity above)
Programme management sub-total	
Objective 7 sub-total	
Grand total	

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)
-	-	-	-	-
-	-	-	-	-
17,000	-	-	17,000	110
17,000	-	-	17,000	110
6,632,000	-	-	6,632,000	42,787
25,000,000	-		25,000,000	161,290
120,000	-	-	120,000	774
57,500	-	-	57,500	371
1,440,000	-	-	1,440,000	9,290
-	13,264,000	-	13,264,000	85,574
-	-	-	-	-
-	-	-	-	-
500,120,600	**597,500,000**	**30,874,000**	**1,128,494,600**	**7,280,610**
503,680,600	**607,553,000**	**39,784,000**	**1,151,017,600**	**7,425,920**
5,179,219,578	**4,800,854,452**	**1,827,878,404**	**11,807,952,433**	**76,180,338**

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