CROSS RIVER STATE

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

2013 – 2015

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

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Foreword

Globally, 20% of HIV positive pregnant women have access to antiretroviral therapy (ARVs) to prevent vertical transmission of HIV to their babies – this leaves a gap of 80%. Despite efforts made by the Federal and State Governments to expand access to ARVs for HIV positive mothers for prevention of mother-to-child transmission (PMTCT), Nigeria accounts for 30% of the 80% global gap; in addition, Nigeria contributes 15% of the total number of children currently in need of ARVs. PMTCTis a practical, sustainable, effective and socially acceptable intervention against the scourge of HIV/AIDS. PMTCT additionally is an intervention which cuts across several millennium development goals in reaching the targets of saving maternal lives, improving child health and combating HIV/AIDS. PMTCT is a most rewarding and very cost effective intervention in HIV prevention. The World Health Organization's Global Plan towards the Elimination of new HIV Infection among Childrenand Keeping their Mothers Alive- in which Nigeria is a signatory - is the roadmap to ending new HIV infections in childrenworldwide by 2015.

The Cross River State PMTCT Scale up Plan is timely as the present administration under His Excellency, Senator Liyel Imoke is providing free health care for all pregnant women and children under-5 in Cross River State.The Free Maternity service breaks the barrier to access to quality antenatal care, deliveries in health facilities and postnatal care.

Produced by key PMTCT stakeholders, the *Cross River State eMTCT Operational Plan 2013 – 2015* is a comprehensive PMTCT plan for the state. The document takes into consideration the recommended four-pronged strategy to prevent HIV among infants and young children. This includes key interventions to be implemented as a component of maternal, neonatal, and child health (MCH) services and is in line with the National/State PMTCT program.

The *Cross River State eMTCT Operational Plan 2013 – 2015* is hereby recommended for use by all stakeholders with the mandate to support PMTCT in Cross River State. It is hoped that this document will guide our PMTCT partners on the support Cross River State requires and plan accordingly while ensuring the implementation of quality services devoid of duplication as we work towards the goal of elimination of mother-to-child transmission by 2015.

Very Warm Regards

Prof. Angela Oya-Ita

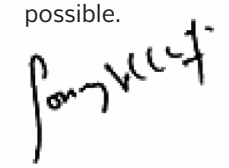
Honourable Commissioner for Health
Cross River State Ministry of Health

Acknowledgements

The Cross River State Ministry of Health (SMoH) thanks all those persons involved in the development of the *Cross River State eMTCT Operational Plan 2013 – 15*. The commitment of the HonourableCommissioner for Health, Professor Angela Oyo-Ita and the Permanent Secretary Cross River State Ministry of Health, Dr. Chris Ita has been very encouraging and they have expressed their desire to support PMTCT as much as possible. This has strengthened the resolve of the diligent Cross River State AIDS and STD Control Programme (SASCP) team to vigorously pursue the various control programs and engender ownership. We are certain that by HIS grace we will be successful.

We also acknowledge the technical support provided by FHI 360, lead PEPFAR implementing partner in Cross River State, as well as the 'Deep Dive' consultants.

Finally and most importantly, we humbly express our gratitude to GOD Almighty who has made all these possible.



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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

In Cross River State, theHIV prevalence among pregnant women is 7.1% (HSS 2010). While this is down from the peak prevalence rate of 12% in 2003, Cross River State is classified as one of the 12 + 1 high burden states in Nigeria. 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 themother-to-child transmission of HIV(MTCT) burden in Nigeria were identified as locations to concentrate prevention of mother-to-child transmission (PMTCT) efforts. This focus aligns with the "Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive" and the President's Comprehensive Response Plan for HIV/AIDS in Nigeria (PCRP) 2013-2015. These plans will ensure that 90% of HIV positive pregnant women, their babies and families have access to services that will ensure zero new HIV infections amongst children and keep their mothers alive.

In 2012, there were 172,902 pregnant women in Cross River State, of whom 12,276 were estimatedto be HIV positive. Only17% of all pregnant women in the state received HIV testing and counseling (HTC), while5.82% of HIV positive pregnant women received anti-retroviral drugs (ARVs) for PMTCT during the same period. Review of data, and a rapid health facility assessment conducted in the state in 2013found that67.5% of pregnant women received antenatal care, which is less than optimal if the targeted 90% coverage of HTC is to be achieved . Only 1.38% of HIV positive pregnant women who needed lifelong ARVs had access to treatment while 0.72% of HIV exposed infants had access to early infant diagnosis. High unmet need for family planning (FP) (31.6%), low levels of hospital delivery (43.2%) and high traditional birth attendant (TBA) patronage (30.7%) posed further barriers to universal access to PMTCT services. There were also facility coverage gaps; only 124 (12%) of ANC facilitiesprovidedARVs for PMTCT at the end of 2012. In addition, there wasa severe human resource gap in Cross RiverState. Only 16 of 488ANC facilities assessed in 2013 (six public and tenprivate) met the nationally prescribed human resource criteria for scale-up: one doctor, onenurse/midwife, twocommunity workers, one pharmacy staff, one laboratory staff andone medical records officer.

The findings from these efforts were used at a three-day planning workshop on July 23rd to25th 2013, to develop a costed elimination of mother-to-child transmission (eMTCT) scale up plan which aligned with the goals and targets contained global and national eMTCT plans including thePCRP. At the end of the meeting, a costed *Cross River State Operational Plan for the Elimination of Mother-to-Child Transmission of HIV 2013-2015*with an estimated cost of NGN 11,989,494,252 (USD 77,351,576) was developed.

A modeling exercise was completed to estimate the potential impact of meeting three 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; and
- Increase to 90%, ARV prophylaxis for PMTCT for all HIV-positive pregnant women and breastfeeding infant-mother pairs by 2015.

In summary, ***4,628*** infections among WRA, ***10,380***pregnancies among HIV-positive women***, 7,324*** **i**nfections among HIV exposed infants (HEI), ***2,728*** infant deaths, ***83*** maternal deaths will be prevented by meeting the PMTCT targets. Combined, this will result in **451,707**disability adjusted life years (DALYs) saved in Cross River State by 2015 if the scale-up plan is implemented to scale.

SECTION

1 Introduction

1.1 NIGERIA HIV SITUATIONAL ANALYSIS

Nigeria has a population of 162,265,000 and one of the highest HIV and AIDS epidemic burdens worldwide. It has a generalized epidemic with a prevalence of 4.1% , an estimated 3.1 million persons living with HIV 2, 215,130 AIDS related deaths annually and 2,229,883 total AIDS orphans. By December 2012 only 491,021 out of an estimated 1.66 million people who require ARVs received them .

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), who constitute about 1% of the adult population; contribute almost 25% of new HIV infections.

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

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

1.2 NIGERIA PMTCT SITUATION ANALYSIS

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

By the end of 2011, maternal HTC coverage was about 14% and PMTCT prophylaxis was 8% of an estimated 229,000 HIV-positive pregnant women in the country. The sub-optimal coverage of PMTCT services is evident in the fact that

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

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

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

Following the launch of the Global Plan towards the Elimination of new HIV Infections among Children and Keeping their Mothers Alive and the alignment of the National eMTCT Scale-up Plan to the global elimination targets, the Nigerian response has increased its focus on the PMTCT program. Led by the National Agency for the Control of HIV/AIDS (NACA), all stakeholders including the Federal Ministry of Health (FMOH) and the respective State Ministries of Health have re-strategized and re-focused with a view of accelerating the scale up of PMTCT services across the country.

These targets can only be achieved with the active involvement of all stakeholders including government at federal, state and LGA levels as well as the private sector with support of local and international partners. NACA establishedthe 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 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, Department for International Development, United Nations Children Emergency Fund, United Nations Joint Programme on HIV/AIDS (UNAIDS), World Health Organization (WHO), Centers for Disease Control and Prevention (CDC) and the United States Agency for International Development (USAID).

The PMTCT Scale-up Technical Committee prioritized 12 states plus the Federal Capital Territory (FCT), which account for 70% of the PMTCT burden in Nigeria,for the scale up ofPMTCT service provision. 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 reproductive age (WRA), birth rate, and HIV prevalence are expected to also guide prioritization of activities between local government areas (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) is timely as it challenges federal, state and local governments to significantly increase the resources allocated towards the HIV response in general and the PMTCT response in particular. The goal of the PCRP is to accelerate the implementation of key interventions over a two year period to bridge existing service access gaps, address key financial, health systems and coordination challenges and promote greater responsibility for the HIV response at federal, state and local levels. In addition, multilateral and bilateral organizations such as the United Nations, World Bank, United States Government, Canadian Government and the Global Fund have increased their commitment and resource envelope for PMTCT services in Nigeria. Other noteworthy opportunities include the provision of midwives at primary health centers (PHCs) under the midwifery service scheme (MSS) funded by Millennium Development Goal (MDG) mechanism and Subsidy Re-investment and Empowerment Programme (SURE-P), coordinated by the NPHCDA. There are also opportunities for increasing coverage through working with private health practitioners and investment in maternal and child health services including PMTCT through public-private partnerships (PPP).

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

SECTION

2 Cross River State

2.1 STATE PROFILE

Cross River State is situated in the South-South Zone and is divided into 18 LGAs. The present Cross River State came into being in September 1987 when the old Cross River State was split into Akwa Ibom and Cross River State.In 2006 the population of the state was2,892,988 people which at an annual growth rate of 2.98 % was projected to be approximately3,458,030at the end of 2012.

There are 760,767women of reproductive age (15-49 years old), 172,902 pregnant women in the state and669,437 and 133,887, children under five years and one year of age respectively. In 2011, it was reported that 67.5% of pregnant women received antenatal care (ANC), 43.2% of women were delivered by a skilled birth attendant while 30.7% of women were delivered by a traditional birth attendant (TBA) .

There are 932health facilities in the statewhich offerANC, the majority of these are publicly owned. Critical cadres of service providers include 56 doctors, 868 nurses, 86 pharmacy staff and 145 laboratory staff.

There were an estimated 171,902 reported deliveries in 2011 and out of all the health facilities in the State, 768 were providing MCH services including private health facilities. It is important to note that no secondary health facilities in the state provided free MCHservices, however approximately625 primary health care facilities in the state provided MCH services for free.

2.4 HIV/AIDS IN CROSS RIVER STATE

Figure 1 illustrates the trend in HIV prevalence among pregnant women in Cross River State based on ANC sentinel surveillance from 1991 to 2010, compared to the national average during the same period. The prevalence rose from 0% in 1991 to 4.1% in 1993, followed by a decline to 1.4% in 1995. However, this was followed by a consistent increase in HIV prevalence to a peak of 12% in the year 2003 and thereafter, by a decline to about 7.1% in 2010. The HIV prevalence among pregnant women in the state has been consistently above the national average and this is of particular importance to the magnitude of vertical transmission of HIV within the state.

2.5 PMTCT IN CROSS RIVER STATE

Out of the estimated 172,902 pregnant women in Cross River State in 2012, the prevalence of 7.1% would translate to about 11,883 HIV infected pregnant mothers, approximately one-third of whom would transmit the virus to their babiesin the absence of PMTCT interventions. This means that there were approximately 3,961 preventable HIV infections among infants in the state during 2012 alone. In terms of availability of PMTCT services, 185 health facilities providedHTC with other MCH services for pregnant.

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

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

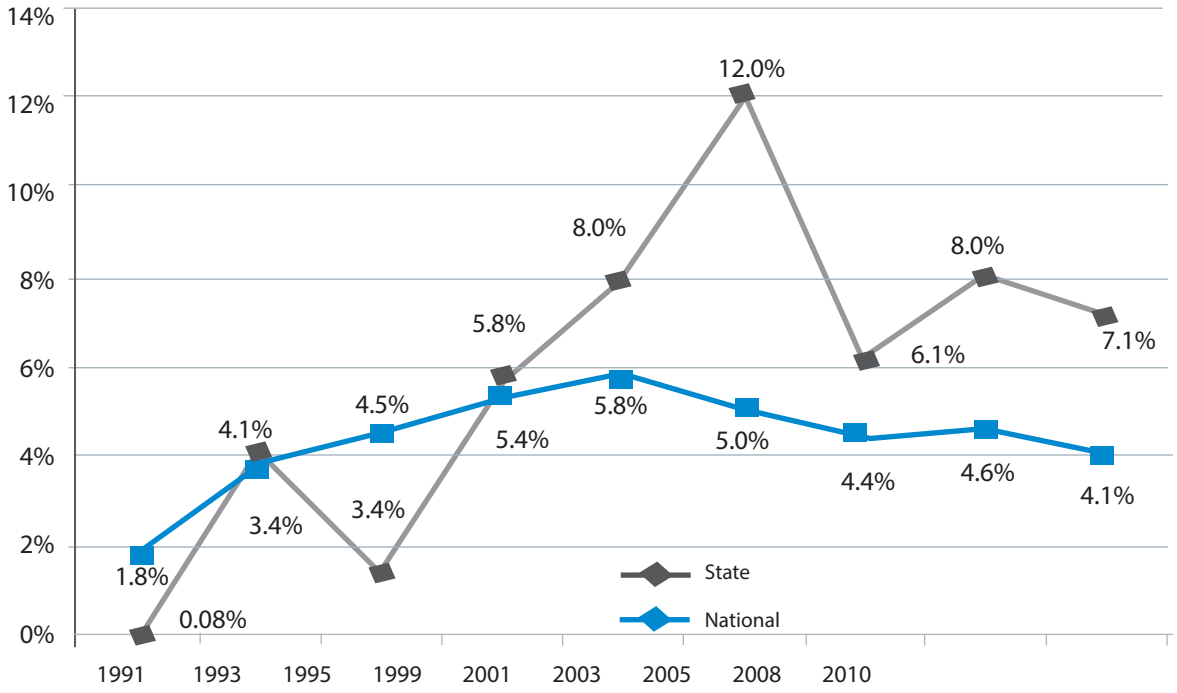

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Table 2: Uptake of PMTCT Services in Cross River State in 2012

	INDICATOR	NUMBER
1	Total number of pregnant women in the State	172,902
2	Total number of antenatal new cases reported (booking)	
3	Total number of deliveries reported (in facilities booked and unbooked)	
4	Number of pregnant women who were offered HCT for PMTCT and received their test results	28,745
5	Number of HIV positive women who received complete course of ARVs for PMTCT	715
6	Number of HIV positive mothers who received cotrimoxazole prophylaxis	N/A
7	Number of HIV exposed babies who received ARV prophylaxis	N/A
8	Number of HIV exposed babies who received cotrimoxazole prophylaxis	N/A
9	Number of HIV positive pregnant women who received infant feeding counseling	N/A
10	Number of HIV exposed babies who received PCR testing within 2 months of birth	88
11	1Number of HIV positive pregnant women whose CD4 was estimated in order to stage the HIV disease	N/A
12	Number of mothers who exclusively breast fed their babies at 3 months	N/A
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 Cross River State Ministry of Health (SMOH) and the State Agency for the Control of HIV and AIDS (SACA).

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

In order to specifically identify the health system challenges to be addressed to meet Cross River State's eMTCT targets, FHI 360with support from USAID, provided technical assistance to Cross RiverState to conduct a statewide rapid health facility assessment (RHFA). The assessment was completed in all eighteen LGAs in facilities identified as providing ANC services but not PMTCT services. The assessment covered seven domains: health human resource complement, client flow, scope of services provided, community support systems, facility health linkages, current infrastructure and future prospects for expansion. The results of this assessment (presented in Chapter 4) as well as review of other relevant documents informed the priority areas chosen and scale-up targets required to meet the eMTCT goal. 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 athree-day planning workshop convened by the SMOH,from July 23rd to July 25th 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 acosted 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.

SECTION

4 State-wide Rapid Health Facility Assessment

4.1 METHODOLOGY

A combination of quantitative and qualitative methods was used in theRHFA to determine the status of the health system to deliver PMTCT services in Cross River State.

The assessment covered all listed public and private health facilities in Cross River State which met defined criteria(see Box 1). A total facility list was obtained from the Department of Planning, Research and Statistics (DPRS), and the Department for Community Health, State Ministry of Health. In total, 932 had ANC services, 124 were currently providing ARVs for PMTCT while 12 planned for PMTCT scale-up in 2013. Thus,488 facilitieswith antenatal services but no support from implementing partners (IPs) for PMTCTor plans for PMTCT scale-up in 2013 were assessed.

4.2 FINDINGS

4.2.1 Facility Ownership and Healthcare Level

The majority (over 90%) of facilities assessed in Cross River State were publicly owned. Most public health facilities werecategorized as primary health centers. Conversely, private health facilities werepredominantly

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 pviing ANC with no PMTCT ARV support

OWNERSHIP	FACILITY TYPE		TOTAL
	PRIMARY LEVEL	SECONDARY LEVEL	
Private			
Faith Based	1	0	1
Private for profit	4	33	37
Sub-total (private)	5	33	38
Public			
Federal government	4	1	5
State government	0	2	2
LGA	443	0	443
Sub-total (public)	447	3	450
Total	452	36	488

secondary level health services. Almost all private health facilities operate on a for-profit basis with only one faith based facility documented in this survey.

4.2.2 Human resources and service utilization

The human resource for health complements and service utilization data for the 12 months preceding the assessment were assessed in each facility.In primary health centers, pharmacy staff were the least available cadre (3.3%), followed by laboratory (10.4%) and record officers (21.0%). There were morecommunity health workers than anyother cadre of health workers (93.8%) followed by doctors (21.7%) and nurses (21.0%). Human resource gaps in secondary health centers(SHCs) were narrower with pharmacy,laboratory and record staff available in 47.2%, 80.6% and 69.4 % of facilities respectively. There was at least one doctor available to provide care in all secondary health facilities while nurses were available in 83.3% of health facilities. Private facilities were better staffed across board for all cadres.

Service utilisation figures showed higher outpatient department (OPD) attendance, ANC utilisation and number of deliveries in secondary compared with primary facilities. Total ANC attendance in the 488 facilities assessed for the 12 months preceding the survey was 41,920;majority of which was recorded publicly owned PHCs(88%). Only 30% of women who received ANC ended up delivering in the health facilities assessed. On average, private facilities had more antenatal and delivery clients per facility than public facilities. In addition, the gap between antenatal and delivery was narrower for private facilities (46% of ANC clients delivered in hospital vs. 26% for public facilities). Multiple facilities (16 PHC and fourSHC) had no OPD records, new ANC or babies delivered.

4.2.3 Other domain summaries

Additional services assessed include HTC, other MCH services such as family planning and child follow up, tuberculosis (TB), laboratory, pharmacy and records. Less than 50% of facilities in the state reported having a laboratory service or support, one-third provided TB related serviced and one-tenth conducted HTC at the time of the assessment. In terms of availability of care, only 46% of PHCs provided 24 hour delivery services as opposed to 85% of SHCs. In the wider MCH context, immunization and child follow up weremore frequently providedat PHC compared to SHC.

The status ofeach facility's infrastructure was assessed. About three-quarters of facilities had existing or potential spaces for ANC rooms. The least frequently reported facility features were HTC/adherence counseling spaces (43%), laboratories (34%) and records/monitoring and evaluation (M&E) room (31%). Private facilities were twice as likely to report the presence of these infrastructure items compared withpublic facilities.

The enabling environment for MCH/PMTCT was assessed based on MDG support for MCH, presence of MSS/SURE-P midwives, free ANC and community outreach services. About 90% of facilities conducted regular monthly outreach and 75% offered free ANC services. Each ofthe enabling environment features were higher in PHCs compared to SHCs. Almost half of PHCs had MDG support for MCH and about 5% SURE-P or MSS supported midwives. Almost 90% of respondents stated women in their communities had other preferred sites (aside from health centers) for delivery. About 70% of facilities had ward committees, community development and community based organizations supporting service delivery. This community support was negligible among secondary level facilities.

4.2.4 Quantitative findings

As part of the assessment process, health workers were interviewed to explore antenatal and delivery practices in the state.The health workersreported that many women prefer the services of TBAs, private clinics and churches todeliver their babies even though these women may attend ANC at health facilities. Some of the reasons proffered for this observation include a firm traditional belief in the abilities of the TBA, protective spiritual powers derived fromchurch-based deliveries, perceived high cost of services at the health facilities and illiteracy.

4.2.5 Scenarios for Scale-up

Only 16 of 488 (9%)ANC facilities assessed in 2013 (sixpublic and tenprivate) met the nationally prescribed human resource criteria for scale-up (onedoctor, onenurse/midwife, twocommunity workers, one pharmacy staff, one laboratory staff, one medical records officer).There is a need to develop criteria that reflects the local context. There is also a need for prioritization of LGAs for scale-up to ensure equity in distribution of services. For example, LGAs like Akpabuyo, with low PMTCT service coverage and a high MTCT burden should be prioritized for scale-up (seeTable 4).

Table 4: LGA HIV burden and PMTCT service coverage gap

LGAS	MTCT BURDEN			PMTCT SERVICE COVERAGE GAP			RANK SUM FOR PRIORI-TIZATION [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)	
ABI	7.1%	611	6	52	85%	11	17
AKAMKPA	2.6%	232	3	46	76%	5	8
AKPABUYO	7.1%	1153	18	37	73%	2	20
BAKASSI	7.1%	134	2	23	74%	3	5
BEKWARA	0.6%	38	1	61	97%	18	19
BIASE	7.1%	712	8	64	84%	10	18
BOKI	7.1%	790	11	61	82%	6	17
CALABAR SOUTH	7.1%	811	12	47	85%	11	23
CALABAR-MUNICIPAL	10.4%	1139	17	65	82%	6	23
ETUNG	7.1%	339	4	14	71%	1	5
IKOM	9.4%	918	16	76	92%	14	30
OBANLIKU	7.1%	464	5	46	93%	16	21
OBUBRA	7.1%	731	10	56	86%	13	23
OBUDU	7.1%	684	7	75	92%	14	21
ODUKPANI	7.1%	817	13	38	74%	3	16
OGOJA	7.1%	727	9	62	95%	17	26
YAKURR	7.1%	831	14	36	83%	9	23
YALA	7.1%	896	15	73	82%	6	21
Total	**7.1%**	**12027**		**932**	**85%**		

SECTION

5 Cross River State eMTCT Operational Plan

5.1 RATIONALE

Mother-to-child transmission of HIV is responsible for virtually all new infections among children, thus significantly contributing towards infant morbidity and mortality. The risk of MTCT can be reduced from an average of 30 – 45% to less than 2% by comprehensive interventions that include the use of ARVs either as prophylaxis or therapy given to women in pregnancy, during labor and while breastfeeding. Consequently, the prevention of vertical transmission of HIV is one of the critical pillars for attaining the Millennium Development Goals 4 (reduced child mortality), 5 (improved maternal health and universal access to reproductive health services) 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 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 testing and counseling to at least 90% of pregnant women;
4. Provide ARV prophylaxis for PMTCT to at least 90% of all HIV positive pregnant women and breastfeeding infant-mother pairs;
5. Increase provision of early HIV diagnosis services to at least 90% of all HIV exposed infants;
6. Increase provision of lifelong ART to at least 90% of HIVinfectedpregnant women requiring treatment for their own health; and
7. Ensure effective management: coordination, resourcing, monitoring and evaluation, of the eMTCT plan.

5.3 SCALE UP TARGETS

Table 4: LGA HIV burden and PMTCT service coverage gap

INDICATORS	BASELINE (2012)	YEAR 1 (2013)	YEAR 2 (2014)	YEAR 3 (2015)	DATA SOURCE
Estimated number of women of reproductive age (WRA)	760,767	782,220	804,279	826,959	NPC 2006 projections
Estimated number of pregnant WRA (5% of total population)	172,902	177,777	182,791	187,945	NPC 2006 projections
Projected ANC attendance (67.5% of preg. WRA; MICS 2011 in 2012)	116,709	124,444	146,233	169,151	MICS4 2011 based projections
Estimated number of HIV-positive pregnant women (7.1% prevalence: 2010 sentinel survey)	12,276	12,622	12,978	13,344	Prevalence based estimates
50% reduction in HIV incidence among WRA (Estimated incidence based on adjusted prevalence of 9.1%)	0.62%	0.52%	0.41%	0.31%	National HIV Sero-prevalence Sentinel Survey
90% reduction in unmet need for family planning among women living with HIV (Based on 31.6% unmet needs: MICS 2011)	31.60%	25.00%	10.00%	3.20%	MICS4 2011 based projections

5.4 IMPLEMENTATION APPROACHES

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

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

1.1.1 PMTCT Service Supply Systems

Provision of comprehensive PMTCT services can significantly reduce the number of new paediatric infections and improve outcomes for HIV infected mothers. The PMTCT service supply systems include but are not limited to: training of health care workers;site activation for PMTCT service provision;distribution of guidelines, standard operating procedures (SOPs), job aids and information, education and communication (IEC) materials; and providing support to PMTCT sites through routine mentoring and technical supportive supervision.

Training

To ensure that quality PMTCT services are provided at the health facilities, it is essential to expand the pool of health care workers trained in integrated PMTCT and Integrated Management of Pregnancy and Childbirth (IMPAC) in the context of HIV. The type of training will depend on the health facility level and cadre of staff providing PMTCT services. Quality integrated trainings are critical to the success of PMTCT service scale up.

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

Activation of selected facilities for PMTCT service provision

Health facilities will be activated for PMTCT service provision after completion of trainings. The activation exercise involves setting up a multi-disciplinary team who will provide hands-on mentoring at the site as well as commodities and medical supplies for PMTCT service provision.

Distribution of national guidelines, SOPs, job aids and IEC materials for PMTCT

National guidelines and SOPs are critical in service delivery to ensure that health care providers deliver quality PMTCT services to clients according to national recommendations and protocols. Job aids and IECs will provide the needed information for service provision

Mentoring and supportive supervision

The five-day PMTCT training alone is not sufficient to support successful PMTCT programme implementation at facility level and therefore, there is a need to closely mentor service providers on quality PMTCT service provision. Periodic supervision, mentoring and feedback from program data will motivate service providers to improve quality of care. Joint mentoring and supportive supervision with state teams will ensure program ownership and sustainability.

1.1.2 PMTCT Health Care Commodities supply

The Cross River State logistics system for the PMTCT scale-up is designed around the current drugs lab reagents logistics cluster structure. The current logistics management and information system supports the supply of health care commodities to all health care facilities in the state. The integration of the proposed logistics management and information system into this existing structure is expected to facilitate increased efficiency; reduce operational costs; and assure project sustainability.

A summation of key considerations and strategies advanced in the costed PMTCT scale-up plan for implementation include:

Strengthening the LGA stores for effective service delivery

The current status of the LGA stores does not guarantee efficiency or quality service delivery hence the need to capacitate the stores with basic infrastructural upgrades; equipment, personnel (pharmacy specialists/lab scientists) and trainings.

Engaging pharmacist specialists and medical laboratory scientists

Pharmacist specialists and medical laboratory scientists will oversee and support logistics management and information at the LGA level. This could be facilitated through:

- Direct employment by the Government of Cross Rivers Statefrom the labor market;
- Establishment of collaborative agreements between the state government and private entities like the community pharmacists; and
- Continued advocacy for posting of National Youth Service Corps(NYSC) pharmacists/medical lab scientists to the LGA stores.

Transportation support

Support will be provided for the distribution of health commodities from LGA stores to respective facilities upon receipt from the central medical store (CMS). In the current arrangement, this process is breached as the facilities sometimes access health commodities directly from the CMS instead of through the LGA stores. This breach in the designed protocol affects reporting, timely access to drugs by patients and in some cases compromises the quality of the drugs and potency of some laboratory commodities. The harmonized plan proposes the procurement of one vehicle each for the three senatorial districts – North, Central and Southern to facilitate smooth movement of essential health care commodities. In addition, the plan will use motorcycles provided by TulsiChanrai Foundation (TCF) for LGAs health care activities.

Additional elements of the eMTCT plan include strengthening of information management systems for effective reporting; quantification and forecasting and capacity building for enhanced skills and knowledge on the effective management of health care commodities in the state. Also, storage facilities will be improved by ensuring access to an un-interrupted power supply.

1.1.1 PMTCT Demand Creation

Advocacy, community mobilization and behavior change communication will be used to increase PMTCT demand creation. A technical group comprising members of the PMTCT technical working group (TWG) and strategic behavior communication (SBC) TWG will develop advocacy kits to guide PMTCT advocacy in the state. Advocacy will be conducted at LGA and ward levels to ensurean enabling environment for demand creation project implementation.In addition, CBOs, religious and traditional leaders and village development committees will be targeted with advocacy.

The community mobilization component would be achieved through education of men and women at the community level on the benefit of PMTCT services and where to obtain the services. One on one education of women would be carried out by the interpersonal communication conductors (IPCC) identified in the villages and trained accordingly. Men will also be targeted through community dialogues facilitated by male peer educators. NGOs will be engaged to provide training, mentoring and supervisiontothe IPCC and lead community outreaches and male peer educator community dialogues.

The duties of the IPCC would be to:

- Identify pregnant women who may be in need of PMTCT services;
- Provide pregnant women with education on the benefit of PMTCT; and
- Provide referrals and follow-up for PMTCT for women, their babies and their families.

Traditional and religious leaders would be mobilized to address HIV and PMTCT related stigma and discrimination, and promote uptake of PMTCT services by targeting community members and groups that traditionally influence community norms and practices.

The behavior change communication (BCC) component would focus on motivating men and women to support or uptake PMTCT services.

To enhance community interventions, clear messages and materials will be developed, produced and disseminated. The materials will to provide information to:

- Motivate pregnant women to get tested for HIV;
- Motivate HIV-positive women to go for counseling about their family planning options;
- Inform HIV-positive expecting mothers that drugs are available to protect their children from HIV transmission during pregnancy and delivery and motivate them to use the appropriate services;
- Inform mothers about the latest breastfeeding guidelines;
- Inform HIV-positive mothers about positive living, and encourage them to visit existing support groups;
- Encourage male partners to get involved in PMTCT and MCH services;
- Address potential stigma associated with PMTCT; and
- Improve provider-client interaction through the training of service providers on interpersonal communication (IPC).

Specific messages will be disseminated throughmass media (radio jingles, commercials, radio/TV spots, documentaries or discussion programs). Messages on print materials (posters, bill boards, leaflets, pamphlets, stickers) willbe produced to support community intervention. Journalists who are members of the state HIV/AIDS committee willbe trained and sensitized on media coverage for PMTCT. Participants willbe equipped with current facts and figures on PMTCT.

To strengthen the link between the community and the health facility for PMTCT, village health workers and TBAs in the 18 focal states would be trained on IPC to facilitate client – provider interactions.

1.1.1 Monitoring and Evaluation

Currently the health management information system in Cross River State is characterized by weak coordination and parallel program data reporting systems which are largely donor driven. Although this situation may have in some ways enhanced availability of program data which enables managers to give account of stewardship government and donors, it has not been helpful in achieving a centralized Health Information System that can support effective decision making and policy formulation in the state. There are still issues of data quality, incomplete reporting from the public sector, and lack of reporting from the private health sector and community based interventions.

The combined M&E effort by the Federal Government of Nigeria, Cross River State Government, donor organizations, IPsand CSOs, has produced a number of desirable outcomes in the state including

- Establishment of a human resource base at facility, LGA and state levels;
- Introduction of harmonized national data collection and reporting tools for National Health Management Information System(NHMIS) and across disease programs;
- Introduction and scaling up of the District Health Information System (DHIS) as the platform for electronic data management;
- Existence of M&E technical groups; and
- Availability multiple funding sources.

Even though some of these results may still be insufficient or inadequate, they provide a good foundation and offer opportunities on which future planning and implementation can leverage to strengthen the HIS in the state. The planned scale up of PMTCT services for eMTCT provides a unique opportunity to strengthen the HIS through the implementation of harmonised and integrated, cost effective data management approach within NHMIS framework.

5.4.5 Coordination and Resource Mobilisation/ Programme Management

The strategies in the programme management, coordination and resource mobilization thematic area aim to strengthen efficient mobilization, coordination and management of the available resources. These strategies are:

Strengthening institutional and human capacity

Capacity at the institutional and human resource levels will be strengthened to support the scale up ofquality PMTCT service delivery through:

- Inauguration of the State Management Team;
- Review of the current membership of State Implementation Team (SIT); and
- Capacity development of these structures.

Strengthening linkages and collaboration

Effective collaboration between the various levels of care for quality PMTCT services provision will be fostered through:

- Development of a clear framework to establish the organizational relations between key stakeholder groups;
- Regular mentoring and integrated supportive supervision visits linking all levels to ensure coordinated and holistic PMTCT service provision; and
- Regular meetings of key coordinating structures to track progress and address challenges while ensuring the best practices are shared for quality improvement.

Harmonizing and expanding Private Public Partnerships

Active involvement of the private sector will be established with the relevant organizations directly involved in progress reviews, feedback mechanisms, routineupdates and implementation of improvement efforts.

SECTION

6 Benefits and Impact of Expanded Access to PMTCT Services in Cross River State

To estimate the potential impact of meeting PMTCT targets in Cross RiverState, a modeling exercise was completed. In the exercise, the number of HIV infections averted in WRA and infants, the number of infant and maternal deaths averted, as well as the disability-adjusted life year (DALY) saved from meeting threeof the four main PMTCT targets were estimated (targets and methods listed below). In sum, the infections and deaths that would result from maintaining current levels of PMTCT service provision (maintaining the status quo) were compared to meeting PMTCT targets. The difference between the two was taken as the estimate of programmatic impact (see table below).

TARGETS:

- Reduce HIV incidence among women of reproductive age by 50% by 2015
- Reduce unmet need for family planning among HIV-positive women by 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 Cross River State by 2015

TARGETS	2012	2013	2014	2015	TOTAL
1. Decrease HIV incidence among WRA	**0.62%**	**0.52%**	**0.41%**	**0.31%**	
2. Reduce unmet need for FP among HIV+ women	**31.60%**	**25.00%**	**10.00%**	**3.20%**	
3. Increaseprophylaxis for HIV+ pregnant women	**6.60%**	**30.00%**	**60.00%**	**90.00%**	
OUTCOMES					
Status Quo Maintained: New HIV infections among WRA	4,382	4,490	4,600	4,713	18,185
Targets Achieved: New HIV infections among WRA	4,382	3,741	3,070	2,364	13,557
HIV infections averted among WRA	**-**	**748**	**1,530**	**2,349**	**4,628**
Status Quo Maintained: Pregnancies among HIV+ WRA	12,276	12,522	12,777	13,040	50,616
Targets Achieved: Pregnancies among HIV+ WRA	12,276	9,131	9,274	9,555	40,236
Pregnancies averted among HIV+ WRA	**-**	**3,391**	**3,504**	**3,485**	**10,380**
Status Quo Maintained: HIV infections among HEI	3,855	3,932	4,012	4,095	15,893
Targets Achieved: New HIV infections among HEI	3,855	2,374	1,576	764	8,570
HIV infections averted among HEI	**-**	**1,558**	**2,436**	**3,330**	**7,324**
Status Quo Maintained: Infant mortalities	1,769	1,805	1,842	1,880	7,296
Targets Achieved: Infant mortalities	1,769	1,167	932	700	4,568
Infant mortalties averted among HEI	**-**	**638**	**910**	**1,180**	**2,728**
Maternal mortalties averted among HIV+ women	**-**	**27**	**28**	**28**	**83**
DALYS saved	**-**	**97,708**	**152,208**	**201,790**	**451,707**

IN SUMMARY:

4,628
infections among WRA,

10,380
pregnancies among HIV-positive women,

7,324
infections among HIV exposed infants (HEI),

2,728
infant deaths,

83
maternal deaths will be prevented by meeting the PMTCT targets.

Combined, this will result in

451,707
DALYs saved in Cross River 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 old) were calculated based on state specific estimates of HIV incidence, prevalence, and population growth as well as the size of population of WRA 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%)[5], 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[6] (state prevalence – national prevalence /100). Estimates of population growth[7] varied by state and are referenced accordingly as are estimates of the size of the population of WRA by state.

2. The number of pregnancies prevented among HIV + women was estimated by subtracting the number of pregnancies expected if unmet need was reduced by 90% from the number of expected pregnancies among HIV + women if unmet need was not reduced. The number of expected pregnancies in each scenario was based on a couple years of protection (CYP) conversion factor produced by Marie Stopes International (MSI)[8]. CYPs in each scenario were estimated based on the current contraceptive mix observed in each state[9] and assumed 1 year of use for new adopters. The CYPs for a minimum of year of use of each method were based on region-specific standards[10]. The WHO estimates of HIV

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

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

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

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

9 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

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

transmission from mother-to-child were also based on accepted standards: transmission with ARVs is expected be 5%, and without ARVs 35%[11].

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 WRA (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 oneyear 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 WRA (in step 1),

   b. the reduction in HIV infections among HIV exposed infants (in step 2), as well as expected mortality among infected children in the first year of life (35.2%) compared to un-infected infants (4.9%)[12].

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)**[13] were estimated from several sources:

   a. reduction in HIV incidence among WRA, 2.

   b. reduced unmet need for family planning,

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

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

12 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

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

SECTION

7 Implementation Plan

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

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

Key Interventions And Activities	Target	Timeline			Responsible Party
		2013	2014	2015	
FOCUS AREA: PMTCT SERVICE SUPPLY SYSTEMS					
STAFFING					
Train HCWs for HTC (including male and female condom demonstration) from 1004 sites existing facilities (proposed by community health department) – 11-day residential training (2HWx 1000 facilities @ 35 X 57 batches + 2 facilitators per batch)	2HCW per facility = 2008		Q1-4	Q1-2	DPHS, CHD, TCF
Conduct 3-day training for HCW from 487 PMTCT(inclusive 18 HCC sites) in syndromic management of STIs (2HW X 487facilities @ 40 X 25batches + 2 facilitators per batch)	2 HCW per facility = 974		Q1-4	Q1-2	DPH, CHD, TCF
Provide HTC jobaids, SOPs, etc. (487 PMTCT/18 HCC + 800 HTC)			Q1-4	Q1-2	CRSACA,DPH, CHD, TCF
Conduct 1-day advocacy visit to religious leaders, political leaders in all LGAs (linked with demand creation)			Q1-4		CRSACA, DPH, CHD, TCF
Community services					
Sensitization					
Sensitize HCWs on PITC and multi-point HIV testing at health facilities (No cost - on-site sensitization)			Q1-4	Q1-2	DPH, CHD, TCF
Sensitization meetings for various groups including - women groups, church groups, market women, age-gradesetc. (link with demand creation)		Q1-4	Q1-4	Q1-4	CRSACA, DPH, CHD, TCF
Advocacy					
Conduct 1-day advocacy visit to religious leaders, political leaders in all LGAs- (costed for in demand creation)		Q1-4	Q1-4	Q1-4	CRSACA, DPH, CHD, TCF
Mentorship & supervision					
Conduct monthly visits to supervise and mentor sites and community services by state integrated supportive supervision (ISS) team (4 persons per team X 12 clusters X 30 months) (link to programme management)			Q1-4	Q1-4	DPH, CHD, TCF, IPs
Monthly HTC outreach testing services in facilities for 800 HTC facilities			Q1-4	Q1-4	CRSACA, DPH, CHD, TCF
Monthly HTC outreach services in LGAs (LACAs, PHC coordinators) x 18 LGAs			Q1-4	Q1-4	DPH, CHD, TCF
Ensure provision of condoms for facilities and outreaches (no cost, link with logistics) (link to commodities)			Q1-4	Q1-4	CRSACA,DPH, CHD, TCF

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

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
Ensure availability of penile models in all HTC points (link to commodities)			Q1-4	Q1-4	DPH, CHD, TCF
Ensure provision of condoms in hotels, universities and potential hot spots, PMVs, community pharmacies (link to commodities)			Q1-4	Q1-4	DPH, CHD, TCF
Establishstate ISS team comprising relevant stakeholders - including PHC coordinators, state officials - CHD, DPH, DPS, SASCP, DPRS, DMS, SACA, IPs (link to programme management)			Q1-2		DPH, CHD, TCF
FOCUS AREA: HEALTH CARE COMMODITIES					
Procurement					
Drugs					
Procure drugs for STI treatment					SMOH
Procure ARVs for post exposure prophylaxis (TDF, 3TC, AZT, EFV, LPV/r)					SMOH
Consumables					
Procure RTKs (Determine test kits) in line with national algorithm	2013(782,220 WRA); 2014(804,279); 2015 (826,959 WRA)	Q4	Q1-Q4	Q3	SMOH
Procure RTKs (Stat pack HIV test kits) in line with national algorithm	Same as above		Q1-Q4	Q3	SMOH
Procure RTKs (Unigold HIV test kits) in line with national algorithm	Same as above				SMOH
Procurelab consumables for 800 new scale-up HTC sites	960,000 tested				SMOH
Procurelab consumables for 487 new scale-up PMTCT sites	Support HIV screening of 439,827 pregnant women and 540,000 non-pregnant individuals by 487 new PMTCT sites in 3 years				SMOH
Procure male condoms for HIV prevention	120 condoms/males/ year	Q3-4	Q1-4	Q1-4	SMOH, CRSACA, FHI 360
Procure female condoms for HIV prevention		Q3-4	Q1-4		SMOH
Procure consumables (methylated spirit, cotton wool, gloves, lancet, work bench pad, jik, syringes, penile models, buffer, sharp boxes, bin liners) and ANC equipment		Q3-4	Q1-4	Q1-4	SMOH
Procure gloves, sharps boxes etc.		Q1-4	Q1-4	Q1-4	SMOH
Support collection of CD4 samples	11,000 women	Q3-4	Q1-4	Q1-4	SMOH
Equipment					
Procurement of autoclaves and sterilization equipment			Q1-4		SMOH
Distribution					
Consumables					
Distribute HIV test kits and lab consumables in line with national algorithm (to be distributed alongside other commodities)		Q3-4	Q1-4	Q1-4	SMOH

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

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

Key interventions & activities	Target	Timeline			Responsible party	Responsible party
		2013	2014	2015		
Distribute male and female condoms for HIV prevention (to be distributed alongside other commodities)		Q3-4	Q1-4		Q1-4	SMOH
Stock management (CLMS)						
Conduct 5-day training on logistics management of HIV/AIDS commodities (LMHC) for focal persons in pharmacies and laboratories		Q3-4	Q1-4			SMOH
FOCUS AREA: PMTCT DEMAND CREATION SYSTEMS						
Training on IPC						
Conduct a stakeholders' planning meeting on demand creation for PMTCT, prevention, SBC, policy and advocacy, and M&E TWG				Q1		CRSACA, SMOH
One on one education and referral by IPCC to pregnant women and WRA				Q1-4	Q1-4	CRSACA, SMOH
Supervision and mentoring of the IPCC				Q1-4	Q1-4	CRSACA, SMOH
Conduct 3-day step down training of IPCC and ward focal persons on community dialogue/mobilization for PMTCT			Q1-4			CRSACA, SMOH
IPCtraining for health workers including VHCWs and TBAs				Q1-4		CRSACA, SMOH, ENR
Community mobilization						
Sensitization						
Conduct 1-day advocacy and sensitization meeting to LGA officials including LGA Chairmen, Vice Chairmen, Secretaries, Supervisors for Health, PHC Coordinators, HOLGA, Ward Councilors				Q3	Q1	CRSACA, SMOH, ENR
Conduct 1-day sensitization and advocacy meetings to religious and traditional leaders				Q3	Q1	CRSACA, SMOH, ENR
Conduct 1-day sensitization and advocacy meetings to ward and village development committees in each ward				Q3	Q1	CRSACA, SMOH, ENR
Advocacy						
Conduct workshop on development of advocacy kit				Q1	Q1	CRSACA, SMOH, ENR
Conduct training on advocacy and community mobilization for stakeholders which include; SMO, information officers, LGA PMTCT desk officer, and LACA CMO				Q2		CRSACA, SMOH, ENR
Conduct a training on advocacy and community mobilization for CSOs				Q2		CRSACA, SMOH, ENR
Conduct drama and song development workshop for pregnant women, WRA and TBAs				Q2		CRSACA, SMOH, ENR
Conduct community outreach (education, HTCand referrals) to enhance demand for PMTCT				Q3-Q4	Q1-4	CRSACA, SMOH, ENR

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 & activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: PMTCT SYSTEM SUPPLY SERVICES					
Training & capacity					
Train providers on FP (dual method) service delivery as appropriate for cadre * integrate into HTC training as appropriate for cadres - 2 HCW X 1000 facilities = 2000 in 57 batches (cost linked to HTC training in prong 1)	same as HTC target above - 2008		Q1-4	Q1-2	DPH
Conduct CLMS training for providers - integrate into logistics training for group 3 - extended by 1 day	1 provider per site x487 sites		Q1-4	Q1-2	DPH
Train selected support group members for FP counseling and referral - 1 person per ward support group to act as CBD/counselor (integrate into PHDP training for support groups in prong 4)	1 person per support group x 197 wards		Q1-4	Q1-2	DPH
Conduct RH LGA focal persons monthly supervision visits to sites, as part of ISS team (no cost, attached to cost for ISS under prong 1)	1 RH person x 12 Cluster ISS Teams	Q4	Q1-4	Q1-4	DPH
Monitoring & supervision					
Provision of FP SOPs, guidelines, job aids, etc.	487 facilities - 1 copies of each SOP/guideline/ job aids		Q1-4	Q1-4	DPH
Service delivery					
Sensitization meetings for LGA RH focal persons - single meeting, 25 participants	1 take-off meeting - 1 person per LGA X 18 LGAs		Q2		DPH
Integrate HTC/PMTCT outlets into regular/ monthly FP review and resupply meetings - monthly transport for 1 person per facility x 200 facilities x 30 months	monthly transportation allowances for 200 facilities		Q1-4	Q1-4	DPH
FOCUS AREA: HEALTH CARE COMMODITIES					
Procurement					
Consumables					
Procure FP commodities, (including condoms, COC, POP, injectable - Depo, Noristerat, Implants - Jadelle, Implanon, IUCD)		Q4	Q1-4	Q1-4	DPH
Equipment					
Procure equipment for FP (clinic couches, angle lamp, sterilization units, IUCD insertion kits, weighing scale, BP apparatus, stethoscope, Jadelle insertion kits, sharps boxes, furniture etc.)			Q1-4		DPH
Distribution					
Consumables					
Provide support to transport & distribute FP commodities from state stores to SDPs (to be distributed alongside other commodities)		Q4	Q1-4	Q1-4	DPH

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

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

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

Key interventions & activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: PMTCT SERVICE SUPPLY SYSTEM					
Training & capacity					
Conduct 6-day integrated PMTCT training (18 LGA doctors + 18 HCC facility doctors + 27 doctors in private facilities @ 32 per batch + 5 facilitators per batch)	63 HW and LGA doctors	Q4	Q1-4	Q1-2	DPH, FHI 360
Conduct 5-day IMAI/IMPAC PMTCT training for (2 nurses/ midwives/CHEWS per facility X 487 facilities @40 per batch X 25 batches + 2 facilitators + 1 EPT/5 trainees=for 2 days)	974health workers	Q4	Q1-4	Q1-2	DPH, FHI 360
Laboratory training for 1 HCW per facility x 487 sites x 3 days = 487 persons in 10 cycles + 2 facilitators per cycle	487health workers	Q4	Q1-4	Q1-2	DPH, FHI 360
Conduct 5-day pharm care training for LGA pharmacists (2 per LGA) & community pharmacists preceptors (PHC =1 per 5 sites, SHC = 2 per site + 4 Facilitators) in 3 batches	Pharmacy staff = (800/5) + 36+36	Q4	Q1-4	Q1-2	DPH, HU-PACE
Conduct 2-day ARV dispensing and documentation for pharmacy technicians, nurses CHO and CHEWs (2HW X 487 Sites + 2 facilitators) in 25 batches	974	Q4	Q1-4	Q1-2	DPH, HU-PACE
Conduct 5- day onsite pharmacy follow-up best-practice training including logistics (1 facilitator per site X 487)	487 sites	Q4	Q1-4	Q1-2	DPH, HU-PACE
Provision of PMTCT SOPs, job aids, etc.	3 copies of each x 487 facilities	Q4	Q1-4	Q1-4	DPH, FHI 360
Linkages/referrals					
Provision of referral forms, registers, PMM tools (no cost - link with M&E)		Q4	Q1-4	Q1-4	CRSACA, DPH, FHI 360
Mentoring & supervision					
Monthly facility meetings covering487 PMTCT sites for10 TBAs per LGA (covering 197 wards)	1 meeting per ward/ LGA covering TBAs in catchment area	Q4	Q1-4	Q1-4	DPH, CHD, TCF
Conduct monthly meetings for mother-to-mother groups (10 per LGA)	180 support groups x 30 monthly meetings	Q4	Q1-4	Q1-4	CHD, TCF
External quality assurance for lab		Q4	Q1-4	Q1-4	
Conduct monthly phone calls from facility for patient tracking	Weekly phone calls x 30 months	Q4	Q1-4	Q1-4	CHD, TCF
Home visits by support group members for contact tracking + psychosocial support	1 visit per month X 30 months	Q4	Q1-4	Q1-4	CHD, TCF

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

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

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

Key interventions & activities	Target	Timeline			Responsible party
		2013	2014	2015	
Monthly supportive supervision visits to sites (5 persons per team X 12 clusters) (No cost, link with ISS in activity #10)	30 visits	Q4	Q1-4	Q1-2	CRSACA, DPH
Train peer educators (male) to support partner testing (link with demand creation)		Q4	Q1-4	Q1-2	CRSACA, DPH
Site activation					
Pre-activation site assessments (no cost, covered by group 1)	487 PMTCT sites	Q4	Q1-4	Q1-2	DPH, FHI 360
Pre-activation upgrades - no cost. (link with program management)		Q4	Q1-4	Q1-2	DPH, FHI 360
Site activation meetings (PMTCT sites) - 2 days duration x 487 sites x 2 persons per site, by groups of 10 = 18 cycles of activation meetings + 4 facilitators per cycle	487 PMTCT sites	Q4	Q1-4	Q1-2	DPH, FHI 360
Site activation meetings (HTC sites) - 1 day x 800 sites x 2 persons per site by groups of 10 = 80 cycles + 4 facilitators per cycle	800 HTC sites	Q4	Q1-4	Q1-2	DPH, FHI 360
On-site adherence training 2 health workers per facility X 487 sites + 2 facilitators per site	487 sites	Q4	Q1-4	Q1-2	DPH, FHI 360
Service delivery					
Promote partner testing and disclosure in ANC (link with demand creation)			Q1-4	Q1-4	DPH, FHI 360
Community services					
Provide HTC services in TBAs, churches and maternity homes (by JCHEWS in PHCs)			Q1-4	Q1-4	DPH, CHD, TCF
Provide logistics for peer educator activities					CRSACA, DPH
FOCUS AREA: HEALTH CARE COMMODITIES					
Procurement (quantification, forecasting)					
Drugs					
Procure ARVs for triple prophylaxis (TDF + 3TC + EFV) for infected pregnant women 90%		Q4	Q1-4	Q1-4	SMOH, FHI 360
Procure ARVs for triple prophylaxis (other regimen like LPV/r) 5%		Q4	Q1-4	Q1-4	SMOH, FHI 360
Procure ARVs (NVP suspension) for HIV exposed infants		Q4	Q1-4	Q1-4	SMOH, FHI 360
Procure cotrimoxazole for infected women		Q4	Q1-4	Q1-4	SMOH, FHI 360
Procure cotrimoxazole for HIV exposed infants		Q4	Q1-4	Q1-4	SMOH, FHI 360
Procure hematinics for pregnant women		Q4	Q1-4	Q1-4	SMOH
Procure other drug commodities (antibiotics, antifungals, etc.)		Q4	Q1-4	Q1-4	SMOH
Consumables					
Procure DBS kits		Q4	Q1-4	Q1-4	SMOH, FHI 360

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

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

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

Key interventions & activities	Target	Timeline			Responsible party
		2013	2014	2015	
Procure pharmacy consumables (dispensing envelop, dispensing bags, dispensing trays, spatulas etc.)		Q4	Q1-4	Q1-4	SMOH, FHI 360
Distribution					
Drugs					
Distribute ARVs for HIV infected pregnant women & exposed infants (to be distributed alongside other commodities)		Q4	Q1-4	Q1-4	SMOH, FHI 360
Redistributecotrimoxazole for infected women & HIV exposed infants		Q4	Q1-4	Q1-4	SMOH, FHI 360
RedistributeARVs for infected pregnant women & HIV exposed infants		Q4	Q1-4	Q1-4	SMOH, FHI 360
Logistics					
Set up logistics for DBS sample collection, transport and result retrieval					SMOH, FHI 360
Focus area: PMTCT demand creation systems					
Linkages & referrals					
Provide incentive package for TBAs who complete referral of positive mothers (quarterly award to best TBAs)			Q1-4	Q1-4	SMOH, CHD, TCF
Train TBAs on HCT, referrals and follow-up	200 TBAs		Q1		SMOH, CHD, TCF
Mapping of 200 TBAs in 18 LGAs to determine eligibility to conduct HIV testing and counseling (PHCC and LGA M&E)			Q1		SMOH, CHD, TCF

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 HIV infected pregnant women requiring treatment for their own health

Key interventions & activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: PMTCT SERVICE SUPPLY SYSTEMS					
Training					
Conduct 5-day PHDP training for support group members (10 per LGA/Comprehensive site)	180 SG members		Q1-4	Q1-2	CHD, TCF, FHI 360
Identify and train mentor mothers on adherence counseling, referrals and client tracking in PMTCT (10 per LGA/ comprehensive site)	180 SG members		Q1-4	Q1-2	CHD, TCF, FHI 360
Conduct 6-day HCC ART/ PHDP training for HWs at 18 comprehensive health centers (5HW per facility X 18 facilities + 1 doctor per LGA @ 35 per batch in 4 batches + 3 facilitators)	108 HWs		Q1-4	Q1-2	DPH, FHI 360
Conduct 5-day laboratory quality management systems training for (1 HW/Site X 18 sites + 1 staff per LGA @ 36 per batch in 1 batch + 3 facilitators)	36 HWs		Q1-4	Q1-2	DPH, FHI 360
Site activation					
Conduct 5-day onsite equipment users training for lab activation (1 HW/Site X 18 sites + 1 staff per LGA@ 36 per batch in 1 batch + 2 facilitators)	36 HWs		Q1-4	Q1-2	DPH, FHI 360
Conduct 15-day onsite pharmacy trainings for ART sites (7HCWs X 18 sites)	126 HWs		Q1-4	Q1-2	DPH, HU-PACE
Conduct 5-day site activation for HCC sites (10 HW X 18 sites + 6 facilitators per facility)	180 HWs		Q1-4	Q1-2	
Mentoring & supervision					
Monthly contact tracking phone calls from facilities (see activity in prong 3)	18 HCC facilities		Q1-4	Q1-4	DPH, FHI 360
Home visits conducted by (facility) support group members (see activity in prong 3)	18 HCC facilities		Q1-4	Q1-4	DPH, FHI 360

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 HIV infected pregnant women requiring treatment for their own health

Key interventions & activities	Target	Timeline			Responsible party
		2013	2014	2015	
Linkages/referrals					
Print and distribute EID job aids (link with PMTCT job aids in prong 3)			Q1-4	Q1-4	DPH, FHI 360
Refer HIV positive women requiring lifelong ART to comprehensive sites (no cost)			Q1-4	Q1-4	DPH, FHI 360
Laboratory services					
Transfer DBS samples weekly to referral lab (link to commodities)			Q1-4	Q1-4	DPH, FHI 360
Others					
Transfer of samples for lab services (link to commodities)		Q4	Q1-4	Q1-4	DPH, FHI 360
Upgrade MDR-TB lab to provide EID testing and viral load (link to commodities)			Q-4		DPH, FHI 360
Support power generation for lab and pharmacy services in general hospitals(link to commodities)			Q1-4	Q1-2	SMOH
FOCUS AREA: HEALTH CARE COMMODITIES					
Procurement (quantification, forecasting)					
Drugs					
Procurenutritional support (plumpynuts) for exposed infants		Q4	Q1-4	Q1-4	DPH, FHI 360
Consumables					
Procurelab consumables, covering an estimated number of 50,000 samples over a period of 3years in 18 new comprehensive centers		Q4	Q1-4	Q1-4	DPH, FHI 360
Procurelaboratory reagents, covering an estimated number of 50,000 samples over a period of 3years in 18 new comprehensive centers		Q4	Q1-4	Q1-4	DPH, FHI 360
Procure test kits for couple counseling(captured in prong 1)		Q4	Q1-4	Q1-4	DPH, FHI 360
Equipment					
Procure air-conditioners &refrigerators for lab and pharmacy to maintain cold chain			Q1-4		DPH, FHI 360
Procure 25 KVA generator for facility (18 secondary health facilities in the state,i.e. 1 per LGA)		Q4	Q1-4		SMOH

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 HIV infected pregnant women requiring treatment for their own health

Key interventions & activities	Target	Timeline			Responsible party
		2013	2014	2015	
Procure vehicle for distribution & reverse logistics of health commodities		Q4	Q1-4		SMOH
Procure motor cycles/tricycles and engine boats for distribution & reverse logistics of health commodities to hard to reach and riverine areas in the state		Q4	Q1-4		SMOH
Implement planned preventive maintenance		Q4	Q1-4		DPH, FHI 360
Procure basic laboratory items required for the activation of laboratory services in 487 PHCs selected for PMTCT in line with the national guidelines for setting up PMTCT centers	.	Q4	Q1-4		DPH, FHI 360
Procurelab equipment for 18 new HIV comprehensive centers for the provision of comprehensive laboratory services which will serve as hubs for the 487 facilities		Q4	Q1-4		DPH, FHI 360
Supervision					
Support logistics for TWG meetings			Q2-4	Q1-4	DPH, FHI 360
Conduct supportive supervisory visit for logistics management of HIV/AIDS commodities		Q4	Q1-4	Q1-4	DPH, FHI 360
Conduct bimonthly logistics peer review meetings		Q4	Q1-4	Q1-4	DPH, FHI 360
Conduct bi-monthly data quality assurance (DQA) to ensure data/ service quality in PMTCT sites		Q4	Q1-4	Q1-4	DPH, FHI 360
Infrastructure					
Infrastructural upgrade of pharmacy &lab stores			Q1-4		DPH, FHI 360
Support CD4/haematology/ chemistry sample transfer logistics from PHCs to secondary facilities to ensure that all HIV positive pregnant women accessing services at PHCs receive comprehensive laboratory services through sample referral system		Q4	Q1-4	Q1-4	DPH, FHI 360
Infrastructural upgrade of LGAs'pharmacy stores			Q1-4		SMOH, FHI 360

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 HIV infected pregnant women requiring treatment for their own health

Key interventions & activities	Target	Timeline			Responsible party
		2013	2014	2015	
Renovation of PHC labs forbasic laboratory investigations and services (e.g. VDRL, HBS Ag, PCV, FBS, TB microscopy, MP, Widal etc.) in public facilities selected for PMTCT servicesin line with the national guidelines for setting up PMTCT centers			Q1-4		SMOH, FHI 360
Training & capacity					
Conduct training on warehousing, debunking & safe disposal of waste/expired commodities for facility focal persons and store keepers at CMS & LGAs			Q1		SMOH, FHI 360
Stock management					
Print and disseminate registers and LMIS tools for management of HIV/ AIDS commodities			Q2	Q1	SMOH, FHI 360

Prong 4: Family centered care and support

Objective 7: Ensure effective management: coordination, resourcing, monitoring and evaluation, of the eMTCT plan

Key interventions and activities	Target	Timelines			Responsible party
		2013	2014	2015	
FOCUS AREA: MONITORING AND EVALUATION					
Data Quality Assurance					
Conduct quarterly supportive supervision & DQA to facilities		Q4	Q1-Q4	Q1-Q4	Director DPRS,SMOH, FHI 360
Identify data entry clerks to support electronic data entry and transmission at the LGAs (2 per LGA) = 36 persons		Q4			Director DPRS,SMOH
Procure and distribute 24 (solar powered) laptop to support electronic data entry and transmission (M&E officerof 18 LGA, DPRS X 2, SASCP,SACA, malaria & TB)		Q4	Q1-Q4		Director DPRS,SMOH
Provide internet support for electronic data transmission (18 internet modems + subscription X 27 months)		Q4	Q1-Q4	Q1-Q4	Director DPRS,SMOH
Inaugurate an integrated state wide M&E TWG (1 day meeting for 36 persons) &review the existing integrated state M&E plan	36 member Cross River State M&E TWG		Q1		Director DPRS,SMOH
Hold a consensus building meeting with M&E stakeholders on integrated health data management.	1 meeting for all stakeholders		Q1		Director DPRS,SMOH
Conduct sensitization meeting with the leadership of Association for General Medical Practitioners of Nigeria (AGMPN)/all private sector health practitioners on integrated M&E system			Q1		Director DPRS,SMOH
Conduct advocacy visits to heads of health departments/agencies/units on plans for integrated health data management system.	1 visit to each health department/agency/ unit	Q4	Q1-Q4	Q1-Q4	Director DPRS,SMOH
Strategic information					
Produce quarterly state/LGA scorecard/fact sheets of programme implementation performance			Q1,Q2 & Q4	Q2 &Q4	Director DPRS,SMOH
Promote monthly data dissemination (sharing of pivot tables with all stakeholders)					Director DPRS,SMOH
Disseminate of program performance at quarterly program review/coordination meetings			Q2 &Q4	Q2 &Q4	Director DPRS,SMOH
Central database					
Support monthly planned preventive maintenance (PPM) for electronic database ICT equipment		Q4	Q1-Q4	Q1-Q4	Director DPRS,SMOH
Provide antivirus for protection of electronic data transmission (18 antivirus + subscription X 12 months)		Q4	Q1-Q4	Q1-Q4	Director DPRS,SMOH
Conduct monthly data gap & completeness analysis					Director DPRS,SMOH

Prong 4: Family centered care and support

Objective 7: Ensure effective management: coordination, resourcing, monitoring and evaluation, of the eMTCT plan

Key interventions and activities	Target	Timelines			Responsible party
		2013	2014	2015	
Routine monitoring					
Quarterly forecasting, quantification, procurement & distribution of M&E data collection and reporting tools (DCRT)		Q3-4	Q1-4	Q1-4	Director DPRS,SMOH, SPHCDA
Support monthly LGA level onsite data collection & validation in 18 LGAs		Q4	Q1-4	Q1-4	DPRS, CRSACA, SPHCDA
Support the existing monthly LGA level HDCC meetings for data collection, validation, feedbacks, sharing best practices		Q3-4	Q1-4	Q1-4	DPRS
Support the existing monthly state level integrated HDCC meetings for data collection, validation, feedbacks and sharing of best practices		Q3-4	Q1-4	Q1-4	DPRS
Conduct monthly data gap & completeness analysis		Q3-4	Q1-4	Q1-4	DPRS
Conduct a quarterly integrated M&E TWG (DPRS led), 1-day meeting for 30 persons	8 meetings	Q4	Q1-Q4	Q1-Q4	Director DPRS,SMOH
Conduct quarterly supportive supervision & DQA to facilities	9 cycles				
Capacity building					
Train 552 persons- 146 secondary/ 2 tertiary(secondary &tertiary) facility staff on the use of the integrated national DCRT (5 days x 3 persons per facility x 6 persons per LGA-TB/ malaria/RH/LGA M&E/LACA, PHCC)	552 persons		Q1		DPRS SMOH, CrSACA, SASCP
Train 964 persons- PHC facility staff on the use of the NHMIS DCRT (5 days X1 persons per facility X6 persons per LGA-TB/malaria/RH/ LGA M&E/LACA, PHCC)	964 persons		Q2		DPRS SMOH, CrSACA, SASCP
Conduct DHIS electronic database mop up training -36 personsat LGA level (5 days X1 persons per LGA)	90 persons		Q4		DPRS SMOH, CrSACA, SASCP
Train 86 persons (10 CBOs M&E Off icers(NEPHWAN,SWAAN,AOON,NY NETHA & 36 LGA M&E & PHCC) on community NHMIS M&E tools and reporting, 2-days in 2 batches	86 persons		Q2		SA CommunityHealth
Provide basic computer appreciation training to LGA M&E officers &assistants	36 persons		Q1		Director DPRS,SMOH
Conduct a 1-day monthly integrated LGA M&E/HDCC meetings - coordination, data validation & collection	28 meetings		Q1		LGA HMIS/M&E OFFICERS
Conduct a 2- day quarterly state level health data producers & users forum	9 meetings for 50 persons		Q1		
Advocacy					
Support advocacy for enabling policy to promote regular reporting by private health facilities		Q4	Q1	Q1	Director DPRS,SMOH

Prong 4: Family centered care and support

Objective 7: Ensure effective management: coordination, resourcing, monitoring and evaluation, of the eMTCT plan

Key interventions and activities	Target	Timelines			Responsible party
		2013	2014	2015	
FOCUS AREA: PROGRAMME MANAGEMENT					
Situation analysis					
Statewide rapid health facility assessment and site selection		Q2			FHI360 /NACA/FMOH
Coordination and resource mobilization					
Develop costed state PMTCT operational plan		Q3			SMOH/FMOH/NACA/FHI360
Print and distribute the costed operational plan	150 copies	Q4			SMOH
Convene a stakeholder forum/ dissemination of operational plan	One forum x 350 persons	Q3			SMOH
Conduct monthly mentorship to the implementing sites	29 mentorship visits conducted	Q3-Q4	Q1-4	Q1-4	SIT
Conduct quarterly ISS visits	10 ISS visits	Q3-Q4	Q1-4	Q1-4	SIT
Conduct annual summit on HIV/AIDS	2 annual summits x 350 persons		Q1	Q1	SACA
Conduct bi-annual partner/stakeholder Forum on HIV/AIDS	5 fora	Q4	Q2,Q4	Q4	SACA
Develop and distribute state and LGA score cards on KPIs (Quarterly)	10 batches of 350 scorecards	Q3-4	Q1-4	Q1-4	SACA M&E
Conduct quarterly mentorship/ISS visits by PHC team/ LACA Coordinator	Merged with row 63 above	Q3-4	Q1-4	Q1-4	LGA/PHC team
Provide a framework for First Lady's award (for the best performing LGA) during annual summit on HIV/AIDS for 2 years in 5 thematic areas	Frameworks provided		Q2	Q2	SMT
Hold quarterly review meetings of state management team (SMT)	10 SMT review meetings held	Q3-4	Q1-4	Q1-4	Comm. for Health/DG SACA
Review membership and TOR of the current State Implementation Team		Q3			SMT
Hold monthly State Implementation Team meetings	29 meetings held	Q3	Q1-4	Q1-4	SIT
Hold cluster coordination meeting (monthly)	29 cluster coordination meetings held	Q3	Q1-4	Q1-4	GF/SACA/DIDC/SMOH
Hold quarterly PMTCT TWG	10 PMTCT TWG review meetings held	Q3	Q1-4	Q1-4	SMOH
Procure & maintain 4x4 wheel drive vehicle for supervision and monitoring	Four vehicles procured		Q2		PEPFAR/SACA/SMOH
Conduct resource mapping and gap analysis		Q3			SACA/DIDC
Harmonize and expand PPPs within the state		Q3			SACA/SMOH/DIDC/ FHI360
Conduct validation meeting of resource plan			Q1		
Infrastructure					
CRS PMTCT diagnostic		Q3			FMOH/NACA
Assess infrastructure needs and develop Bill of Quantity (BOQ)	998 facilities (800 HTC; 487 PMTCT; 18 ART)	Q3			SMOH/FHI360
Carry out infrastructural upgrades	Infrastructural upgrade for 998 facilities carried out	Q3-4	Q1-4		SMOH/FHI360

Prong 4: Family centered care and support

Objective 7: Ensure effective management: coordination, resourcing, monitoring and evaluation, of the eMTCT plan

Key interventions and activities	Target	Timelines			Responsible party
		2013	2014	2015	
Purchase of equipment and accessories (projectors, cameras)			Q1		SMOH
HR & Staffing					
Draft a justification memo for the recruitment of more health workers based on identified needs	Justification memo drafted	Q4			SMOH/Community health/ LGSC
Inaugurate aSMT	SMT (10 member team) inaugurated	Q3			HE
Community mobilization					
Advocacy					
Develop advocacy package (one for state governor, one for private sector etc.)	Two advocacy packages developed	Q3			SMT
Carry out advocacy to the state governor to facilitate the allocation and timely release of funds for the implementation of PMTCT activities	Advocacy conducted		Q4		SMT
Carry out advocacy to multi-nationals to support PMTCT implementation plan	Advocacy visit conducted		Q4		SMT
Sensitization					
Organize 5-day training for CSOs on resource mobilization,2batches of trainings for CSOs in the state conducted (40 participants per batch)	80 participants	Q4			SACA
Capacity building					
Build the capacity of PHC team/ LACAs to effectively monitor and coordinate the implementation of PMTCT scale up plan	Workshop conducted	Q3			SMT
Build capacity of SMT on leadership and program management	Workshop for SMT conducted	Q3			SACA/IP
Build capacity of SIT on supervision, mentoring and monitoring	Capacity workshop conducted	Q3			SMOH/IP

SECTION

8 Monitoring and Evaluation Plan

The existing Information Management System will be utilized for routine program data collectionthrough registers and reporting forms at implementing health facilities. The reporting will follow the established channels from health facility toLGA to the state level, where data will be compiled and shared for use in planning and policy decision making processes. The core program targets are summarisedTable7.

Table 7: Targets for Core Indicators for Cross River State

Indicator	2012 (Baseline)	2013	2014	2015
Number of health facilities that provide ANC plus PMTCT services	124	196	336	336
Number WRA newly tested HIV positive	4,381	3,741	3,069	2,364
Number of pregnant women tested, counseled and given HIV results	28,745	53,333	109,674	169,151
Number of HIV infected WRA who accessed comprehensive family planning services	N/A	5,133	5,303	5,275
Number of pregnant women reached with ARVs for PMTCT according to the national guidelines	715	3,787	7,787	12,010
Number of HIV positive pregnant women in need of treatment initiated on ART for their own health	85	1,893	3,893	6,005
Number of HIV exposed infants offered first PCR test from 6 – 8 weeks of age	88	3,787	7,787	12,010

CROSS RIVER STATE PMTCT SCALE-UP PLAN FRAMEWORK

GOAL	IImproved 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 WRA	Un-intended pregnancy prevented among women living with HIV	Mother-to-child transmission of HIV prevented	Family-centerd HIV care, treatment and support provided
STATE OBJECTIVES	Reduced HIV incidence among WRA by at least 50% by 2015	The unmet need for family planning among women living with HIV reduced by 90%	• Quality HIV counseling 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 • Lifelong ART received by at least 90% of the pregnant, infected women requiring treatment for their own health
STATE INDICATORS	Percentage of WRA 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 ARVs for PMTCT according to the national guidelines • No. & proportion of HIV positive pregnant women offered quality infant feeding counseling	• 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 in Nigerian Naira is presented in the table below. Please see appendix for detailed budget.

Table 8: Budget Summary Table

THEMATIC AREAS	Year 1 (NGN)	Year 2 (NGN)	Year 3 (NGN)	Total (NGN)	Total (USD)
PMTCT supply service system	271,529,313	848,929,668	201,060,000	1,321,518,981	8,525,929
Health care commodities	3,890,214,586	1,173,653,478	1,169,153,478	6,233,021,542	40,213,042
PMTCT demand creation system	250,070,121	91,837,614	100,870,264	442,777,999	2,856,632
Monitoring and evaluation	61,005,329	261,794,716	301,606,756	624,406,800	4,028,431
Program management	789,337,740	2,506,689,190	71,742,000	3,367,768,930	21,727,541
Total	**5,262,157,089**	**4,882,904,666**	**1,844,432,498**	**11,989,494,252**	**77,351,576**

SECTION

10 Appendix - Detailed Budget

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

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

Strategic intervention	Activities
THEMATIC AREA: PMTCT SERVICE SUPPLY SYSTEMS	
Training & capacity	Train HCWs for HTC (including male and female condom demonstration) from 1004 sites existing facilities (proposed by community health department) - 11 day residential training (2HWx 1000 facilities @ 35 x 57 batches + 2 facilitators per batch)
	Conduct 3-day training for HCW from 487 PMTCT(inclusive 18 HCC sites) in syndromic management of STIs (2HW X 487facilities @ 40 X 25batches + 2 facilitators per batch)
	Conduct 1-day advocacy visit to religious leaders, political leaders in all LGAs
	Provision of HTC jobaids, SOPs, etc. (487 PMTCT/18 HCC + 800 HTC)
Community services	Sensitize HCWs on PITC and multi-point HIV testing at health facilities (no cost, onsite sensitization)
	Sensitization meetings for various groups including - women groups, church groups, market women, age-grades etc.
Advocacy	Conduct 1-day advocacy visit to religious leaders, political leaders in all LGAs (costed in demand creation)
Mentoring & supervision	Conduct monthly visits to supervise and mentor sites and community services by state ISS team (4 persons per team x 12 clusters x 30 months)
	Monthly HTC outreach testing services in facilities for 800 HTC facilities
	Monthly HTC outreach services in LGAs (LACAs, PHC coordinators) x 18 LGAs
Condom promotion	Ensure provision of condoms for facilities and outreaches (no cost link with logistics)
	Ensure availability of penile models in all HTC points
	Ensure provision of condoms in hotels, universities and potential hot spots, PMVs, community pharmacies
	Constitute State ISS team comprising relevant stakeholders - including PHC coordinators, state officials - CHD, DPH, DPS, SASCP, DPRS, DMS, SACA, IPs,
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)
108,778,750	326,336,250	-	435,115,000	2,807,194
5,775,528	20,476,872	-	26,252,400	169,370
			-	-
1,540,000	5,460,000	-	7,000,000	45,161
			-	-
			-	-
11,520,000	23,040,000	23,040,000	57,600,000	371,613
3,600,000	28,800,000	28,800,000	61,200,000	394,839
324,000	648,000	648,000	1,620,000	10,452
			-	-
			-	-
			-	-
			-	-
131,538,278	**404,761,122**	**52,488,000**	**588,787,400**	**3,798,628**

SECTION

10 APPENDIX-DETAILED BUDGET

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

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

Strategic intervention	Activities
THEMATIC AREA: HEALTH CARE COMMODITIES	
Procurement (quantification, forecasting)	***Drugs***
	Procure drugs for STI treatment
	Procurement of ARVs for post exposure prophylaxis (TDF, 3TC, AZT, EFV, LPV/r)
	Consumables
	Procurement of RTKs (Determine test kits) in line with national algorithm
Procurement (quantification, forecasting)	Procurement of RTKs (Stat pack HIV test kits) in line with national algorithm
	Procurement of RTKs (Unigold HIV test kits) in line with national algorithm
	Procurement of lab consumables for 800 new scale-up HTC sites
Procurement (quantification, forecasting)	Procurement of lab consumables for 487 new scale-up PMTCT sites
	Procure male condoms for HIV prevention
	Procure female condoms for HIV prevention
	Procurement of consumables (methylated spirit, cotton wool, gloves, lancet, work bench pad, jik, syringes, penile models, buffer, sharp boxes, bin liners) and ANC equipment
	Procurement of gloves, sharps boxes etc
	Equipment
	Procurement of autoclaves and sterilization equipment
Distribution	***Consumables***
	Distribute HIV test kits and lab consumables in line with national algorithm (to be distributed alongside other commodities)
	Distribute male and female condoms for HIV prevention (to be distributed alongside other commodities)
Stock management (CLMS)	Conduct 5-day training on LMHC
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)
			-	-
6,000,000	-	-	6,000,000	38,710
13,009,200	-	-	13,009,200	83,930
			-	-
1,038,743,449	1,038,743,449	1,038,743,449	3,116,230,347	20,104,712
33,151,467	33,151,467	33,151,467	99,454,400	641,641
21,217,280	21,217,280	21,217,280	63,651,840	410,657
24,152,000	-	-	24,152,000	155,819
11,177,300	3,725,767	3,725,767	18,628,833	120,186
7,653,333	-	-	7,653,333	49,376
2,730,537	-	-	2,730,537	17,616
Already costed except penile model and ANC equipment	-	-	-	-
Already costed (see field U11 & U12 above)	-	-	-	-
	-	-	-	-
	-	-	-	-
170,000	170,000	170,000	510,000	3,290
170,000	170,000	170,000	510,000	3,290
18,607,667	27,911,500	27,911,500	74,430,667	480,198
1,176,782,233	**1,125,089,462**	**1,125,089,462**	**3,426,961,157**	**22,109,427**

SECTION

10 APPENDIX-DETAILED BUDGET

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

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

Strategic intervention	Activities
THEMATIC AREA: PMTCT DEMAND CREATION SYSTEMS	
Training on IPC	Conduct a stakeholders' planning meeting on demand creation
	One on one education and referral by IPCC
	Supervision and mentoring of the IPCC
	Conduct 3-day step down training of IPCC and ward focal persons on community dialogue/ mobilisationfor PMTCT
	IPC training for HWs
Community mobilisation	***Sensitization***
	Conduct 1-day advocacy and sensitization meeting to LGA officials
	Conduct 1-day sensitization and advocacy meetings to religious and traditional leaders
	Conduct 1-day sensitization and advocacy meetings in each ward
	Advocacy
	Conduct workshop on development of advocacy kit
	Conduct a training on advocacy and community mobilization for stakeholders
	Conduct a training on advocacy and community mobilization for CSOs
	Conduct Drama and song development workshop
	Conduct community outreach (education, HCT and referrals) to enhance demand for PMTCT
	Community dialogue
	Conduct road shows and drama campaigns at community level
Media engagement	Production of radio messages (jingles and spots)
	Production of TV messages (spots, documentaries, vox-pop)
	Conduct training for journalists on media coverage for PMTCT
IEC materials	Conduct material development workshop (leaflets, posters, pamphlets, fliers)
	Pre-testing of developed message materials
	Review and finalization of IEC
	Production of print materials (leaflets, posters, pamphlets, fliers)

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)
417,000		5,000	422,000	2,723
54,000,000	22,500,000	-	76,500,000	493,548
864,000	360,000	5,000	1,229,000	7,929
2,737,600	1,368,800	-	4,106,400	26,493
3,405,750	3,296,000	3,405,750	10,107,500	65,210
			-	-
1,029,000	1,029,000	7,500,000	9,558,000	61,665
1,389,000		-	1,389,000	8,961
2,989,000		-	2,989,000	19,284
			-	-
605,000		300,000	905,000	5,839
9,820,800		28,000	9,848,800	63,541
3,243,400		660,000	3,903,400	25,183
3,160,500	3,160,500	-	6,321,000	40,781
21,168,000	9,000,000	260,000	30,428,000	196,310
21,168,000	9,000,000	288,000	30,456,000	196,490
360,000	720,000	90,000	1,170,000	7,548
2,388,571	7,165,714	7,165,714	16,719,999	107,871
13,210,800	13,210,800	13,210,800	39,632,400	255,693
1,834,000	1,834,000	344,000	4,012,000	25,884
2,955,500		54,000,000	56,955,500	367,455
660,000			660,000	4,258
1,633,000			1,633,000	10,535
7,800,000			7,800,000	50,323

SECTION
10 APPENDIX-DETAILED BUDGET

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

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

Strategic intervention	Activities
Community services	Conduct orientation of PLHIV support groups in each LGA on PMTCT including infant feeding counseling, treatment Support the PLHIV groups to conduct bi-monthly meetings of 10 persons per support group for 1 day per cluster
	Conduct orientation of PLHIV support groups in each LGA on PMTCT including infant feeding counseling, treatment adherence counseling
	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
	Perform identification and training of male peer educators at ward level
	Support the trained male peer educators to conduct male involvement outreach
PMTCT demand creation systems sub-total	
Objective 1 sub-total	
THEMATIC AREA: PMTCT SERVICE SUPPLY SYSTEMS	
Training & capacity	Train providers on FP (dual method) service delivery as appropriate for cadre * integrate into HTC training as appropriate for cadres - 2 HCW X 1000 facilities = 2000 in 57 batches (cost linked to HTC training in prong 1)
	Conduct CLMS training for providers - integrate into logistics training for group 3 - extended by 1 day
	Train selected support group members for FP counselling and referral - 1 person per ward support group to act as CBD/counsellor (integrate into PHDP training for support groups in prong 4)
	Conduct RH LGA focal persons monthly supervision visits to sites, as part of ISS team (no cost, attached to cost for ISS under prong 1)
Mentoring & supervision	Provision of FP SOPs, guidelines, job aids, etc.
Service delivery	Sensitization meetings for LGA RH focal persons - single meeting, 25 participants
	Integrate HTC/PMTCT outlets into regular/monthly FP review and resupply meetings - monthly transport for 1 person per facility x 200 facilities x 30 months
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)
14,190,000	5,676,000	-	19,866,000	128,168
12,240,000	3,347,200	12,240,000	27,827,200	179,530
2,736,000	1,140,000	1,368,000	5,244,000	33,832
3,947,200	1,973,600	-	5,920,800	38,199
14,112,000	7,056,000	-	21,168,000	136,568
204,064,121	**91,837,614**	**100,870,264**	**396,771,999**	**2,559,819**
1,512,384,632	**1,621,688,198**	**1,278,447,726**	**4,412,520,556**	**28,467,875**
-	-	-	-	-
			-	-
-	-	-	-	-
-	-	-	-	-
4,400,000	-	-	4,400,000	28,387
87,500	-	-	87,500	565
2,400,000	4,800,000	4,800,000	12,000,000	77,419
6,887,500	**4,800,000**	**4,800,000**	**16,487,500**	**106,371**

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: HEALTH CARE COMMODITIES	
Procurement (qualification, forecasting)	***Consumables***
	Procure FP commodities,(including condoms, COC, POP, injectables- Depo, Noristerat, Implants - Jadelle, Implanon, IUCD)
	Equipment
	Procure equipment for FP (clinic couches, angle lamp, sterilization units, IUCD insertion kits, weighing scale, BP apparatus, stethoscope, Jadelle insertion kits, sharps boxes, furniture etc)
Distribution	***Consumables***
	Provide support to transport & distribute FP commodities from state stores to SDPs (to be distributed alongside other commodities)
Health care commodities 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)
			-	-
-	-	-	-	-
			-	-
-	-	-	-	-
			-	-
-	-	-	-	-
-	-	-	-	-
6,887,500	4,800,000	4,800,000	16,487,500	106,371

SECTION

10 APPENDIX-DETAILED BUDGET

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

Objective 3: Increase access to quality HIV testing and counseling 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 integrated PMTCT training (18 LGA doctors + 18 HCC facility doctors + 27 doctors in private facilities @ 32 per batch + 5 facilitators per batch)
	Conduct 5-day IMAI/IMPAC PMTCT training for (2 nurses/ midwives/CHEWS per facility X 487 facilities @ 40 per batch X 25 batches + 2 facilitators + 1 EPT/5 trainees=for 2 days)
	Laboratory training for 2 HCW per facility x 487 sites x 3 days = 360 persons in 10 cycles + 2 facilitators per cycle
	Conduct 5-day pharmcare training for LGA pharmacists (2 per LGA) & community pharmacists preceptors (PHC =1 per 5 sites, SHC = 2 per site + 4 facilitators) in 3 batches
	Conduct 2-day ARV dispensing and documentation for pharmacy technicians, nurses CHO and CHEWs (2HW x487 Sites + 2 facilitators) in 11 batches
	Conduct 5- day onsite pharmacy follow-up best-practice training including logistics (1 facilitator per site x487)
	Provision of PMTCT SOPs, job aids, etc.
Linkages/ referrals	Provision of referral forms, registers, PMM tools (no cost, link with M&E)
Mentoring & supervision	Monthly facility meetings covering487 PMTCT sites: for 10 TBAs each per LGA (covering 197 wards)
	Conduct monthly meetings for mother-to-mother groups
	External quality assurance for lab
	Conduct monthly phone calls from facility for patient tracking
	Home visits by support group members for contact tracking + psychosocial support
	Monthly supportive supervision visits to sites (5 persons per team X 12 clusters) (no cost, link with ISS)
	Train peer educators (male) to support partner testing
Site activation	Pre-activation site assessments (no cost, covered by programme management)
	Pre-activation upgrades (no cost, covered by programme management)
	Site activation meetings (PMTCT sites) - 2 days duration x 487 sites x 2 persons per site, by groups of 10 = 18 cycles of activation meetings + 4 facilitators per cycle
	Site activation meetings (HTC sites) - 1 day x 800 sites x 2 persons per site by groups of 10 = 80 cycles + 4 facilitators per cycle
	Onsite adherence training 2 health workers per facility x487 sites + 2 facilitators per site

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)
1,194,908	4,236,492	-	5,431,400	35,041
10,135,752	35,935,848	-	46,071,600	297,236
8,167,280	28,956,720	-	37,124,000	239,510
3,096,720	10,979,280	-	14,076,000	90,813
6,632,912	23,516,688	-	30,149,600	194,514
10,375,200	36,784,800	-	47,160,000	304,258
2,646,000	-	-	2,646,000	-
-	-	-	-	-
3,564,000	32,400,000	32,400,000	68,364,000	441,058
3,900,600	35,460,000	35,460,000	74,820,600	482,714
			-	-
1,188,000	10,800,000	10,800,000	22,788,000	147,019
520,080	4,728,000	4,728,000	9,976,080	64,362
			-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
950,400	3,369,600	-	4,320,000	27,871
4,800,000	14,400,000	-	19,200,000	123,871
4,254,140	15,082,860	-	19,337,000	124,755

SECTION
10 APPENDIX-DETAILED BUDGET

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

Objective 3: Increase access to quality HIV testing and counseling 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
Service delivery	Promote partner testing and disclosure in ANC
Community services	Provision of HTC services in TBAs, churches and maternity homes (by JCHEWS in PHCs)
	Provide logistics for peer educator activities
PMTCT service supply systems sub-total	
THEMATIC AREA: HEALTH CARE COMMODITIES	
Procurement (quantification, forecasting)	***Drugs***
	Procure ARVs for Triple prophylaxis (TDF + 3TC + EFV) for infected pregnant women 90%
	Procurement of ARVs for triple prophylaxis (other regimen like LPV/r) 5%
	Procure ARVs (NVP suspension) for HIV exposed infants
	Procure cotrimoxazole for infected women
Procurement (quantification, forecasting)	Procure cotrimoxazole for HIV exposed infants
	Procurement of haematinics for pregnant women
	Procurement of other drug commodities (antibiotics, antifungals, etc.)
	Consumables
	Procurement of DBS kits
	Procure Pharmacy consumables (dispensing envelop, dispensing bags, dispensing trays, spatulas etc.)
Distribution	***Drugs***
	Distribute ARVs for HIV infected pregnant women & exposed infants (to be distributed alongside other commodities)
	Redistribution of cotrimoxazole for infected women & HIV exposed infants
	Redistribution of ARVs for infected pregnant women & HIV exposed infants
Logistics	Set up logistics for DBS sample collection, transport and result retrieval
Health care commodities sub-total	
THEMATIC AREA: PMTCT DEMAND CREATION SYSTEMS	
Linkages and referrals	Provision of incentive package for TBAs who complete referral of positive mothers
	Training of TBAs on HTC, referrals and follow-up
	Mapping of 200 TBAs in 18 LGAs to determine eligibility to conduct HTC (PHCC and LGA M&E)
PMTCT demand creation systems sub-total	
Objective 3 and 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)
-	-	-	-	-
56,832,000	60,384,000	60,384,000	177,600,000	1,145,806
-	-	-	-	-
118,257,992	**317,034,288**	**143,772,000**	**579,064,280**	**3,735,899**
			-	-
1,687,469,952	-	-	1,687,469,952	10,886,903
53,058,240	17,686,080	17,686,080	88,430,400	570,519
3,606,336	3,606,336	3,606,336	10,819,008	69,800
409,419,328	-	-	409,419,328	2,641,415
17,502,576	-	-	17,502,576	112,920
5,342,800	2,671,400	2,671,400	10,685,600	68,939
4,500,000	4,500,000	-	9,000,000	58,065
			-	-
-	-	-	-	
5,823,200	5,823,200	5,823,200	17,469,600	112,707
			-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
1,872,000	624,000	624,000	3,120,000	20,129
2,188,594,432	**34,911,016**	**30,411,016**	**2,253,916,464**	**14,541,397**
-			-	-
45,534,000			45,534,000	293,768
472,000			472,000	3,045
46,006,000	**-**	**-**	**46,006,000**	**296,813**
2,352,858,424	**351,945,304**	**174,183,016**	**2,878,986,744**	**18,574,108**

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 HIV infected pregnant women requiring treatment for their own health

Strategic intervention	Activities
THEMATIC AREA: PMTCT SERVICE SUPPLY SYSTEMS	
Training	Conduct 5-day PHDP training for support group members (10 per LGA/comprehensive site)
	Identify and train mentor mothers on adherence counseling, referrals and client tracking in PMTCT (10 per LGA/comprehensive site)
	Conduct 6-day HCC ART/PHDP Training for HWs at 18 comprehensive health centers (5HW per facility X 18 facilities + 1 doctor per LGA @ 35 per batch in 4 batches + 3 facilitators)
	Conduct 5-day laboratory quality management systems training for (1 HW/Site X 18 sites + 1 staff per LGA @ 36 per batch in 1 batch + 3 facilitators)
Site activation	Conduct 5-day onsite equipment users training for lab activation (1 HW/Site X 18 sites + 1 staff per LGA@ 36 per batch in 1 batch + 2 facilitators)
	Conduct 15-day onsite pharmacy trainings for ART sites (7HCWs X 18 sites)
	Conduct 5-day site activation for HCC sites (10 HW X 18 sites + 6 facilitators per facility)
Mentoring & supervision	Monthly contact tracking phone calls from facilities (see activity in Prong 3)
	Home visits conducted by (facility) support group members (see activity in Prong 3)
Linkages and referrals	Print and distribute EID job aids (link with PMTCT job aids in prong 3)
	Refer HIV positive women requiring lifelong ART to comprehensive sites (no cost)
Laboratory services	Transfer DBS samples weekly to referral lab
Others	Transfer of samples for lab services
	Upgrade MDR-TB lab to provide EID testing and viral load
	Support power generation for lab and pharmacy services in general hospitals
PMTCT service supply systems sub-total	
THEMATIC AREA: HEALTH CARE COMMODITIES	
Procurement (quantification, forecasting)	***Drugs***
	Procurement of nutritionalsupport (plumpynuts) for exposed infants
	Consumables
	Procurement of lab consumables for 18 new HIV comprehensive centers
	Procurement of laboratory reagents for 18 new comprehensive centers
	Procure test kits for couple counseling
	Equipment
	Procurement of air-conditioners &refrigerators for lab and pharmacy to maintain cold chain
	Procurement of 25 KVA generator for facility (18 secondary health facilitiesin the state i.e. 1 per LGA)

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)
792,000	2,808,000	-	3,600,000	23,226
316,800	1,123,200	-	1,440,000	9,290
4,923,468	17,455,932	-	22,379,400	144,383
1,845,954	6,544,746	-	8,390,700	54,134
1,916,816	6,795,984	-	8,712,800	56,212
4,327,884	15,344,316	-	19,672,200	126,917
722,621	72,262,080	-	72,984,701	470,869
			-	-
			-	-
			-	-
			-	-
			-	-
			-	-
14,845,543	**122,334,258**	**-**	**137,179,801**	**885,031**
			-	-
15,000,000	5,000,000	5,000,000	25,000,000	161,290
			-	-
144,912,000	-	-	144,912,000	934,916
33,452,640	-	-	33,452,640	215,823
-	-	-	-	-
			-	-
6,480,000	2,160,000	2,160,000	10,800,000	69,677
14,400,000	-	-	14,400,000	92,903

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 HIV infected pregnant women requiring treatment for their own health

Strategic intervention	Activities
Procurement (quantification, forecasting)	Procure vehicle for distribution & reverse logistics of health commodities
	Procure motor cycles/tricycles and engine boats for distribution & reverse logistics of health commodities to hard to reach and riverine areas in the state.
	Implement planned preventive maintenance
	Procurement of basic laboratory items required for the activation of laboratory services in 487 PHCs selected for PMTCT
	Procurement of lab equipment for 18 new HIV comprehensive centers
Supervision	Support logistics for TWG meetings
	Conduct supportive supervisory visit for logistics management of HIV/AIDS commodities
	Conduct bimonthly logistics peer review meetings
	Conduct bi-monthly DQA/SQA to ensure data/service quality in PMTCT sites
Infrastructure	Infrastructural upgrade of pharmacy &lab stores
	Support CD4/hematology/chemistry sample transfer logistics from PHCs to secondary facilities
	Infrastructural upgrade of LGAs'pharmacy stores
	Renovation of PHC labs for basic laboratory investigations in 487 facilities selected for PMTCT services
Training and capacity	Conduct training on warehousing, de-junking & safe disposal of waste/expired commodities
Stock management	Print and disseminate registers and LMIS tools for management of HIV/AIDS commodities
Health care commodities sub-total	
Objective 5 and 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)
15,000,000	-	-	15,000,000	96,774
833,333	-	-	833,333	5,376
1,800,000	600,000	600,000	3,000,000	19,355
132,390,000	-	-	132,390,000	854,129
141,171,392	-	-	141,171,392	910,783
123,000	123,000	123,000	369,000	2,381
3,101,278	-	-	3,101,278	20,008
7,303,000	-	-	7,303,000	47,116
750,000	750,000	750,000	2,250,000	14,516
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
3,101,278	-	-	3,101,278	20,008
5,020,000	5,020,000	5,020,000	15,060,000	97,161
524,837,921	**13,653,000**	**13,653,000**	**552,143,921**	**3,562,219**
539,683,464	**135,987,258**	**13,653,000**	**689,323,722**	**4,447,250**

SECTION

10 APPENDIX-DETAILED BUDGET

Prong 4: Family centered care and support

Objective 7: Ensure effective management: coordination, resourcing, monitoring and evaluation, of the eMTCT plan

Strategic intervention	Activities
THEMATIC AREA: MONITORING & EVALUATION	
Data quality assurance	Identify data entry clerks to support electronic data entry and transmission at the LGAs (2 per LGA)- 36 persons
	Procure and distribute 24 (solar powered) laptop to support electronic data entry and transmission (M&EO of 18 LGA, DPRS X 2, SASCP,SACA, malaria & TB)
	Provide internet support for electronic data transmission (18 internet modems + subscription X 27 months)
	Inaugurate an integrated statewide M&E TWG (1-day meeting for 36 persons) &review the existing integrated state M&E plan
	Hold a consensus building meeting with M&E stakeholders on integrated health data management.
	Conduct sensitization meeting with the leadership of APGMPN/all private sector health practitioners on integrated M&E system
	Conduct advocacy visits to heads of health departments/agencies/units on plans for integrated health data management system
Strategic information	Produce quarterly state/LGA scorecard/fact sheets of programimplementation performance
	Promote monthly data dissemination (sharing of pivot tables with all stakeholders)
	Disseminate of programme performance at quarterly program review/coordination meetings.
Central database	Support monthly PPM for electronic database ICT equipment.
	Provide antivirus for protection of electronic data transmission (18 Antivirus + subscription X 12 months)
	Conduct monthly data gap & completeness analysis
Routine monitoring	Quarterly forecasting, quantification, procurement & distribution of M&E DCRT
	Support monthly LGA level onsite data collection & validation in 18 LGAs
	Support the existing monthly LGA level HDCC meetings for data collection,validation,feedbacks, sharing best practices
	Support the existing monthly state level integrated HDCC meetings for data collection,validation, feedbacks, sharing best practices.

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)
-		-	-	-
4,800,000		-	4,800,000	30,968
450,000	1,080,000	1,080,000	2,610,000	16,839
596,800			596,800	3,850
310,000			310,000	2,000
165,600			165,600	1,068
240,000			240,000	1,548
1,400,000	5,600,000	5,600,000	12,600,000	81,290
-	-	-	-	-
	x	-	-	-
342,000	1,368,000	1,368,000	3,078,000	19,858
180,000	2,160,000	-	2,340,000	15,097
-		-	-	-
28,800,000	172,800,000	230,400,000	432,000,000	2,787,097
1,040,000	4,160,000	4,160,000	9,360,000	60,387
-		-	-	-
-	-	-	-	-

SECTION

10 APPENDIX-DETAILED BUDGET

Prong 4: Family centered care and support

Objective 7: Ensure effective management: coordination, resourcing, monitoring and evaluation, of the eMTCT plan

Strategic intervention	Activities
THEMATIC AREA: MONITORING & EVALUATION	
Routine monitoring	Conduct monthly data gap & completeness analysis
	Conduct sensitization meeting with the leadership of AGMPN/all private sector health practitioners on integrated M&E system
	Hold a consensus building meeting with M&E stakeholders on integrated health data management
	Conduct a quarterly integrated M&E TWG (DPRS led), 1-day meeting for 30 persons
	Conduct quarterly supportive supervision &DQA to facilities
Capacity building	Train 552 persons- 146 secondary/ 2 tertiary(secondary &tertiary) facility staff on the use of the integrated National DCRT (5 days x 3 persons per facility x 6 persons per LGA-TB/Malaria/RH/LGA M&E/LACA, PHCC)
	Train 964 persons- PHC facility staff on the use of the NHMIS DCRT (5 days x 1 persons per facility x 6 persons per LGA-TB/malaria/RH/LGA M&E/LACA, PHCC)
	Conduct DHIS electronic database mop up training -36 persons-at LGA level (5 days x 1 persons per LGA)
Capacity building	Train 86 persons (10 CBOs M&E Officers(NEPHWAN,SWAAN,AOON,NYNETHA & 36 LGA M&E & PHCC) on community NHMIS M&E tools and reporting - 2 days in 2 batches
	Provide basic computer appreciation training to LGA M&E officers & Assistants (2 persons in 18 LGAs for 5days)
	Conduct a 1-day monthly integrated LGA M&E/HDCC meetings -coordination, data validation & collection
	Conduct a 2-day quarterly state level health data producers & users forum (targets upstream stakeholders)--9 meetings for 50 persons
Advocacy	Support advocacy for enabling policy to promote regular reporting by private health facilities
	Conduct advocacy visits to heads of health departments/agencies/units on plans for integrated health data management system
Others	Inaugurate an integrated statewide M&E TWG (1-day meeting for 36 persons) &review the existing integrated state M&E plan
Monitoring and evaluation 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)
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
596,800	2,127,200	2,127,200	4,851,200	31,298
4,104,000	16,416,000	16,416,000	36,936,000	238,297
3,010,680	7,024,920	-	10,035,600	64,746
4,592,760	10,716,440	-	15,309,200	98,769
-	2,926,800	-	2,926,800	18,883
-	4,769,800	-	4,769,800	30,773
3,532,800	-	-	3,532,800	22,792
6,540,000	29,430,000	39,240,000	75,210,000	485,226
303,889	1,215,556	1,215,556	2,735,000	17,645
-	-	-	-	-
-			-	-
-	-	-	-	-
61,005,329	**261,794,716**	**301,606,756**	**624,406,800**	**4,028,431**

SECTION

10 APPENDIX-DETAILED BUDGET

Prong 4: Family centered care and support

Objective 7: Ensure effective management: coordination, resourcing, monitoring and evaluation, of the eMTCT plan

Strategic intervention	Activities
THEMATIC AREA: PROGRAMME MANAGEMENT	
Situation analysis	Statewide rapid health facility assessment and site selection
Coordination &resource mobilisation	Develop costed state PMTCT operational plan
	Print and distribute the costed operational plan
	Convene a stakeholder forum/dissemination of operational plan
	Conduct monthly mentorship to the implementing sites
	Conduct quarterly ISS visits
	Conduct annual summit on HIV/AIDS
	Conduct bi-annual partner/stakeholder Forum on HIV/AIDS
	Develop and distribute state and LGA score cards on KPIs (quarterly)
	Conduct quarterly mentorship/ISS visit by PHC team/ LACA Coordinator
	Provide a framework for First Lady's award (for the best performing LGA) during annual summit on HIV/ AIDS for 2 years
	Hold quarterly review meetings of SMT
	Review membership and TOR of the current SIT
	Hold monthly SIT meetings
	Hold LGA cluster coordination meeting (monthly)
	Hold quarterly PMTCT TWG meetings
	Procure & maintain 4x4 wheel drive vehicle for supervision and monitoring
	Conduct resource mapping and gap analysis
	Harmonize and expand the PPPs within the state
	Conduct validation meeting of resource plan
Infrastructure	CRS PMTCT Diagnostic
	Assess infrastructure needs and develop BOQ by team of 3 persons(1pharmacy, 1 lab and 1 Arc) - to be done in 18 LGAs
	Carry out infrastructural upgrades
	Purchase of equipment and accessories (projectors, cameras)
HR & staffing	Draft a justification memo for the recruitment of more health workers based on identified needs
	Inaugurate a SMT
Community mobilization	***Advocacy***
	Develop advocacy package (state governor, private sector etc)
	Carry out advocacy to the state governor 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
	Sensitization
	Organize 5-day training for CSOs on resource mobilization
Capacity building	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 program management
	Build capacity of SIT on supervision, mentoring and monitoring
Program 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)
-	-	-	-	-
			-	-
375,000			375,000	2,419
800,000			800,000	5,161
12,600,000	30,240,000	30,240,000	73,080,000	471,484
9,540,000	19,080,000	19,080,000	47,700,000	307,742
-	945,000	945,000	1,890,000	12,194
238,000	476,000	476,000	1,190,000	7,677
708,000	1,416,000	1,416,000	3,540,000	22,839
-			-	-
	25,000	25,000	50,000	323
60,000	120,000	120,000	300,000	1,935
			-	-
200,000	480,000	480,000	1,160,000	7,484
7,200,000	17,280,000	17,280,000	41,760,000	269,419
840,000	1,680,000	1,680,000	4,200,000	27,097
	65,400,000		65,400,000	421,935
316,500	-		316,500	2,042
60,000			60,000	387
129,000			129,000	832
-			-	-
4,050,000			4,050,000	26,129
734,156,340	2,369,547,190		3,103,703,530	20,023,894
1,040,000			1,040,000	6,710
-			-	-
40,000			40,000	258
			-	-
466,500			466,500	3,010
30,000			30,000	194
30,000			30,000	194
			-	-
8,340,000			8,340,000	53,806
4,340,400			4,340,400	28,003
2,269,000	-		2,269,000	14,639
1,509,000			1,509,000	9,735
789,337,740	**2,506,689,190**	**71,742,000**	**3,367,768,930**	**21,727,541**
850,343,069	**2,768,483,906**	**373,348,756**	**3,992,175,730**	**25,755,972**
5,262,157,089	**4,882,904,666**	**1,844,432,498**	**11,989,494,252**	**77,351,576**

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