RIVERS STATE

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

2013 – 2015

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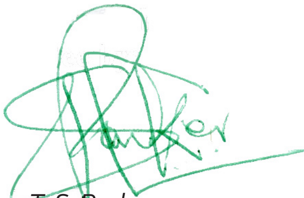
Foreword

Prevention of mother-to-child transmission of HIV (PMTCT) is a practical, sustainable, effective and socially acceptable intervention against the scourge of HIV/AIDS. PMTCT is also an intervention which cuts across several Millennium Development Goals in reaching the targets of saving maternal lives, improving child health and combating the HIV/AIDS disease. The commitment of all stake holders at this time to ensure a HIV free generation is remarkably a step in the right direction. Therefore, the interest of all health care workers towards making the service available to the people they serve is of utmost importance.

In order to pragmatically program efficiently, it becomes necessary to have a plan which is operationally simple yet sophisticated enough to conquer a complex disease which has affected nearly 34 million people all over the world, with a greater majority in Sub Saharan Africa where we are. This plan represents the beginning of work to be done in the next two years to improve the health of the mothers and the save the lives of unborn children. It is worth every effort and every investment. It significantly differs from the very common vertical programming and has the fundamental ingredient of a bottom-up approach. Very likely, it will herald a successful legacy in programming in the days to come.

No plan is perfect, yet no perfection can be achieved without a plan. I recommend that the implementation of River State eMTCT Operational Plan 2013-2015 be pursued vigorously having been locally adapted to meet special needs. It is a landmark platform with very strong historic implications for the future. It is expected therefore that we all seize this opportunity to buy in and most of all, take ownership of this process to interrupt the transmission of the virus.

Very Warm Regards



Hon T. S. Parker

Honourable Commissioner for Health
Rivers State Ministry of Health

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Similarly, here at Rivers State, the commitment of the Hon. Commissioner for Health, Hon T. S. Parker and the Permanent Secretary Rivers State Ministry of Health, Dr. G. U. Mpi has been very encouraging and they have expressed– their desire to support the PMTCT Project as much as possible. This has strengthened the resolve of the diligent Rivers SASCP team (Dr. Sibor Leelebari, Mrs. Idoniboyeobu Frances, and my humble self, Dr. Golden Owhonda) to vigorously pursue the various control measures and engender ownership. We are certain that by HIS grace we will be succeed.

We also very specially acknowledge all the support provided by FHI 360, lead implementing partner in Rivers State. This collaboration between RivSASCP and FHI 360 has flourished exemplarily. We thank as well, the 'Deep Dive' consultants of the SOML. You have all been a great backstop.

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

Thank you

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Acronyms

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

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

Executive Summary

The HIV prevalence among pregnant women is 6% in Rivers State (HSS 2010), which is higher than the national average. This situation, along with the fact that the state has a relatively large population means that Rivers State has about 114,671 people living with HIV (PLHIV) and is thus classified as one of the 12 + 1 high burden states in Nigeria. As such, Rivers State is a focus for the elimination of mother-to-child transmission of HIV (eMTCT). This increased 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 result in zero new HIV infections amongst children and keep their mothers alive.

In 2012, there were 321,480 pregnant women in Rivers State, of whom an estimated 19,289 were thought to be HIV positive. Only 7.5% of all pregnant women in the state received HIV testing and counseling (HTC), while 4.2% 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 2013 shows 80% of pregnant women received antenatal care (ANC). Less than 1% of HIV exposed infants had access to early infant diagnosis services in 2012. One in five women in Rivers State would like to use family planning to space or limit her pregnancies but did not have the means to do so. Universal access to family planning could potentially reduce MTCT by 13%. There was also facility coverage gaps; 66 (16%) of ANC facilities provided ARVs for PMTCT at the end of 2012. Impressively, 119 of 244 ANC facilities assessed in 2013 (80 public and 39 private) met the nationally prescribed human resource criteria for scale-up (one doctor, one nurse/midwife, two community workers, one pharmacy staff, one laboratory staff, one medical records officer).

The findings from these efforts were used at a 3-day planning workshop on August 20th to 22nd 2013, to develop a costed eMTCT scale-up plan which aligned with the goals and targets contained global and national eMTCT plans including the PCRP. At the end of the meeting, a costed "Rivers State Operational Plan for the Elimination of Mother-to-Child Transmission of HIV 2013-2015" with an estimated cost of NGN 13,592,874,427 (USD 87,695,964) was developed and disseminated.

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

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

In summary, **7,488** infections among WRA, **9,320** pregnancies among HIV-positive women, **12,526** infections among HIV exposed infants (HEI), **4,252** infant deaths, 75 maternal deaths will be prevented by meeting the PMTCT targets. Combined, this will result in **758,936** disability adjusted life years (DALYs) saved in Rivers State by 2015 if the scale-up plan is fully implemented.

SECTION

1 Introduction

1.1 NIGERIA HIV SITUATIONAL ANALYSIS

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

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

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

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

1.2 NIGERIA PMTCT SITUATION ANALYSIS

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

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

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

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

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

Following the launch of the Global Plan for the elimination of mother to child transmission of HIV (eMTCT), the Nigerian response has increased its focus on the PMTCT programme. Led by the National Agency for the Control of HIV/AIDS (NACA), all stakeholders including the Federal Ministry of Health (FMOH) and the respective State Ministries of Health have re-strategized and re-focused with a view of accelerating the scale up of PMTCT services across the country.

It is in the light of the above that the President accented to the "Global plan to eliminate pediatric HIV and keep their mothers alive by 2015" in June 2011. This goal can only be achieved with the active involvement of all stakeholders including government at federal, state and local governmental area (LGA) levels as well as the private sector with support of local and international partners. NACA constituted the PMTCT Scale-up Technical Committee in December 2011. The purpose was to engage the states in dialogue and provide technical support towards acceleration of PMTCT as well as to strengthen the state ownership and leadership for scale-up of PMTCT services within the states. The Secretariat was situated in NACA and membership of the Committee included the HIV/AIDS Division FMOH, National Primary Health Care Development Agency (NPHCDA), World Bank, DFID, UNICEF, United Nations Joint Programme on HIV/AIDS (UNAIDS), WHO, CDC and USAID.

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

1.4 FUNDING OPPORTUNITIES

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

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

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

Accelerating the scale up of PMTCT services requires additional resource mobilization efforts as well as effective and efficient use of these resources. A common focus of development partners is the need for ownership and sustainability of the HIV response. The President's Comprehensive Response Plan for HIV/AIDS in Nigeria (PCRP)[5] could not have come at a better time. Federal, state and local governments have been challenged by the international community to significantly increase the resources allocated towards the HIV response in general and the PMTCT response in particular. The goal of the PCRP is to accelerate the implementation of key interventions over a two year period to bridge existing service access gaps, address key financial, health systems and coordination challenges and promote greater responsibility for the HIV response at Federal, State and local levels. In addition, multilateral and bilateral organizations such as the United Nations, World Bank, United States Government, Canadian Government and the Global Fund have increased their commitment and resource envelop for PMTCT services in Nigeria. Other opportunities that are worthy of note include the provision of midwives at PHCs under the midwifery service scheme (MSS) funded by Millennium Development Goal (MDG) mechanism and Subsidy Re-investment and Empowerment Programme (SURE-P), coordinated by the NPHCDA. There are also opportunities for public-private partnerships (PPP) and investment in maternal and child health (MCH) services including PMTCT through corporate social responsibility (CSR).

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

SECTION 2 Rivers State

2.1 STATE PROFILE

Rivers State is situated in the South-South Zone and administratively divided into 23 LGAs. The total population from the 2006 census was 2,673,026 males and 2,525,690 females, which at an annual growth rate of about 3.41 % was projected at 6,429,596 people at the end of 2012.

Estimates in 2012 show there were 1,414,511 women of reproductive age (WRA), in Rivers State and the number of pregnant women was 321,480. A 2011 survey[6] revealed that 21.1% of women used a modern contraceptive method while the unmet need for contraception was 20.4%. In the same survey, it was reported 80% of women received ANC from a skilled provider while 72.4% of women were delivered by a skilled birth attendant.

There are 505 health facilities in the state, with the majority being public sector facilities and 49 other facilities in the private sector. In terms of level of care, there are five tertiary health facilities, 39 secondary health care facilities and 425 primary health care facilities. Of all the primary health care facilities, 100 were newly built and furnished Model PHCs. Critical cadres of service providers included 400 doctors, 2,000 nurses, 34 pharmacists, 56 pharmacy technicians and 151 laboratory scientists. It is important to note that all the health facilities in the state provided free MCH services.

2.2 HIV/AIDS IN RIVERS STATE

Figure 1 illustrates the trend in HIV prevalence among pregnant women in the state based on the ANC sentinel surveillance from 1995 to 2010, compared to the national average during the same period. The HIV prevalence increased rapidly from 1% in 1995 to reach a peak of 7.7% in 2001, which was followed by a decline, spike in 2008 and a further decline to 6% in 2010. The HIV prevalence has been higher than the national average since 2001.

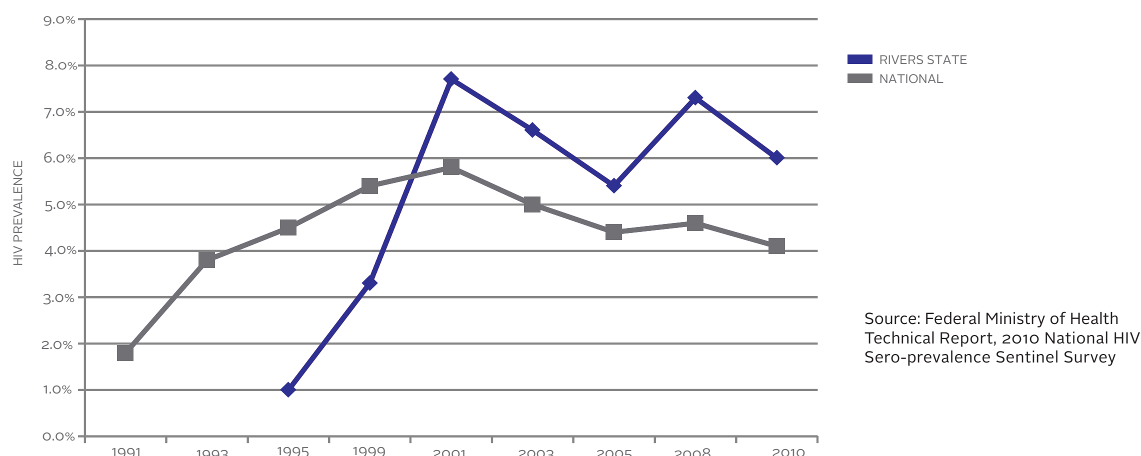
There are 413 facilities providing ANC in the state, 66 of which provide ARVs for PMTCT. The uptake of services and availability of interventions for PMTCT in the state has been summarized in the following table.

2.3 PMTCT IN RIVERS STATE

Out of the estimated 321,480 pregnant women within the Rivers State in 2012, about 19,289 were infected with HIV. Without appropriate interventions, approximately one-third would pass the virus to their babies, which means that there were approximately 6,833 preventable HIV infections among infants in the state during that year alone.

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

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



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

Table 2: Uptake of PMTCT Services in Rivers State

	INDICATOR	NUMBER
1	Total number of pregnant women in the State	321,480
2	Total number of antenatal new cases reported (booking)	22,447
3	Total number of deliveries reported (in facilities booked and unbooked)	3,197
4	Number of pregnant women who were offered HCT for PMTCT and received their test results	21,769
5	Number of HIV positive women who received complete course of ARVs for PMTCT	767
6	Number of HIV positive mothers who received cotrimoxazole prophylaxis	N/A
7	Number of HIV exposed babies who received ARV prophylaxis	359
8	Number of HIV exposed babies who received cotrimoxazole prophylaxis	153
9	Number of HIV positive pregnant women who received infant feeding counseling	1,061
10	Number of HIV exposed babies who received PCR testing within 2 months of birth	102
11	1Number of HIV positive pregnant women whose CD4 was estimated in order to stage the HIV disease	372
12	Number of mothers who exclusively breast fed their babies at 3 months	50
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 Rivers State Ministry of Health (SMOH) and the State Agency for the Control of HIV and AIDS (SACA).

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

In order to specifically identify the health system challenges to be addressed to meet Rivers State's eMTCT targets, FHI 360 with support from USAID, provided technical assistance to conduct a state-wide rapid health facility assessment (RHFA). The assessment was conducted in all facilities identified as providing ANC services but not PMTCT services. The assessment covered seven domains: facility health linkages, health human resource complement, client flow, scope of services provided, community support systems, current infrastructure and future prospects for expansion. The results of the assessment informed the priority areas chosen as well as scale-up targets required to meet the eMTCT goal. Building on the RHFA, a diagnostic (deep dive) was conducted by a team of consultants hired by the Saving One Million Lives (SOML) team.

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

To make a stronger argument for investment towards eMTCT, projections of impact based on assigned annual scale-up targets were developed. These targets and projected outputs are presented in Chapter 5. Details of calculations and assumptions made for the projections are presented in the appendix.

With the completion of all of these processes, the Rivers SMOH and SACA disseminated Rivers State's eMTCT Scale-up Plan 2013-2015 to His Excellency, Rotimi Chibuike Amaechi on August 22, 2013. The dissemination meeting was attended by all major stakeholders in the HIV/AIDS response in Rivers State, including FHI 360 (lead PEPFAR implementing partner for Rivers State).

SECTION

4 State-wide Rapid Health Facility Assessment

4.1 METHODOLOGY

Both quantitative and qualitative methodologies were used in this rapid assessment to determine the status of the health system to deliver PMTCT services in Rivers State.

A complete list of all health facilities in the state was provided by the Department of Planning, Research and Statistics (DPRS) of the Rivers SMOH. All public and private health facilities which met defined criteria were assessed. A total of 244 health facilities provided ANC but had no support to provide ARVs for PMTCT as at the time of the survey. These were fully assessed.

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)

4.2 FINDINGS

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

OWNERSHIP	FACILITY TYPE		TOTAL
	PRIMARY LEVEL	SECONDARY LEVEL	
Private			
Private for profit	1	16	17
Sub-total (private)	1	16	17
Public			
LGA	72	0	72
State government	0	12	12
Sub-total	72	12	84
Overall total	**73**	**28**	**101**

4.2.1 Facility Ownership and Healthcare Level

About a third of the 244 facilities assessed were privately owned while the remaining were public. All publicly owned PHCs in Rivers State are operated by the state government and not by LGAs as is the case in other states. About two-thirds of the facilities operate at the primary level, out of which six are health posts. The majority of the public facilities were at the primary level while most private facilities were secondary. There were no tertiary health facilities among those assessed.

4.2.2 Human resources and service utilisation

Human resources for health for the 12 months preceding the survey were assessed. Findings showed fewer staff and wider coverage gaps in primary compared to secondary health centers. Almost all secondary facilities had resident doctors (96.3%) and nurses (97.6%) whereas only 70.4% primary level facilities had access to at least a doctor and 61.7% had at least one nurse. Among the primary facilities, doctors, pharmacists or pharmacy technicians had the lowest average per facility whereas at the secondary level, records officers had the lowest average per facility. The private facilities had higher averages of almost all health worker cadres except for community health officer (CHO) and community health extension worker (CHEW) cadres that were higher among publicly-owned facilities. It is also noteworthy that unlike public facilities, most private health facilities had a doctor (98.9%) and at least a nurse (95.5%).

Service utilization statistics were similar between primary and secondary facilities in terms of having at least one outpatient department (OPD) attendance, one ANC attendance and one delivery in the last 12 months. There was however a substantial dip between the average ANC first attendees and the deliveries at both primary and secondary facilities suggesting a large dropout between ANC attendance and facility delivery.

4.2.3 Other domain summaries

Almost all sites assessed had MCH, laboratory services, dispensing, and records services available. Findings from facilities assessed show tuberculosis (TB) services, immunization and HTC services were more available in public facilities compared to the private facilities. However, only a third of the facilities provided TB services. Similarly, less than a third of assessed facilities had spaces for directly observed therapy short-course (DOTS) clinic and DOTS waiting area with the proportions lower among secondary facilities.

Enabling environment for MCH examined whether facilities had support to provide maternal health services, conduct community outreach or subsidize ANC. Less than 10% of the facilities had MDG support for MCH services and SURE-P midwives. Similarly, very few facilities reported having functional community systems. The majority of respondents reported other preferred birth place options in the community outside health facilities. This supports the earlier findings of lower delivery numbers compared with ANC attendance. Most health workers (85.3%) reported they were aware of places where women delivered other than a health facility. The most popular alternatives were traditional birth attendants (TBAs) and churches.

4.2.4 Summary of qualitative findings

Health workers were interviewed as part of the assessment process. In the key informant interviews (KII) conducted with health workers in Rivers State, respondents believed that many women prefer the services of TBAs, private clinics and churches for deliveries even though these women usually attend ANC at the health facilities. Some of the reasons proffered for this practice included a firm traditional belief in the abilities of the TBA, perceived high cost of services at the health facilities, illiteracy and superstitious beliefs.

At facilities that were well patronized, respondents' thought the provision of free medical services and a good relationship with the community - including the village development committee (VDC) - helped to maintain uptake

of services. In order to improve services in all facilities across the state, health workers suggested better staffing of facilities, capacity

building for staff as well quality infrastructure at health facilities and other social services would go a long way to improve service quality in the state.

4.2.5 Scenarios for eligibility of PMTCT services

There was generally good availability of human resources for health in assessed facilities with about 48% meeting the minimum national standard (one doctor, one nurse, two other health

Table 4: PMTCT Burden and Coverage Gap by LGA in Rivers State

LGAS	MTCT BURDEN			PMTCT SERVICE COVERAGE GAP			RANK SUM FOR PRIORITI-ZATION [RANK 1 + RANK 2]
	HIV prevalence	Estimated number of HIV+ pregnant women	Rank 1 (number of HIV+ pregnant women)	Number of sites with ANC services	Proportion without PMTCT services	Rank 2 (service gap)	
OYIGBO	13.0%	540	18	27	96.3%	19	37
AHOADA EAST	12.5%	689	19	16	87.5%	14	33
ETCHE	8.8%	729	20	13	84.6%	11	31
PORT HARCOURT	7.8%	1393	22	70	81.4%	8	30
OGBA-EGBEMA-NDONI	5.2%	488	15	37	89.2%	15	30
OKRIKA	4.7%	346	11	14	92.9%	18	29
GOKANA	19.8%	1535	23	11	72.7%	4	27
BONNY	4.2%	299	10	11	90.9%	17	27
ABUAL/ODUAL	4.8%	449	14	7	85.7%	12	26
OBIO/AKPOR	3.2%	490	16	68	83.8%	10	26
ANDONI	2.8%	202	5	24	100.0%	20	25
OMUMA	5.8%	193	4	4	100.0%	20	24
ELEME	3.7%	233	8	10	90.0%	16	24
KHANA	8.0%	777	21	12	58.3%	1	22
AHOADA WEST	4.4%	364	13	11	81.8%	9	22
OPOBO/NKORO	3.2%	162	2	7	100.0%	20	22
DEGEMA	6.0%	496	17	8	75.0%	5	22
OGU/BOLO	2.2%	55	1	3	100.0%	20	21
TAI	5.8%	231	7	7	85.7%	12	19
EMUOHA	3.7%	247	9	14	78.6%	7	16
IKWERRE	5.7%	357	12	17	58.8%	2	14
ASARI-TORU	2.9%	211	6	14	71.4%	3	9
AKUKU TORU	3.6%	192	3	8	75.0%	5	8
RIVERS STATE	**6.0%**	**10,680**		**413**	**84.0%**		

workers, one pharmacy staff, one lab staff, one records officer) for PMTCT service provision. A total of 50 doctors, 60 nurses, 32 CHEWs/CHOs, 35 pharmacists or pharmacy technicians and 15 laboratory scientists or technicians are needed to bring all assessed public facilities to the national standard for PMTCT service provision. The corresponding figures for private facilities are one doctor, four nurses, 68 CHEWs/CHOs, 26 pharmacists or pharmacy technicians and nine laboratory scientists or technicians

Table 4 below shows the PMTCT burden and service coverage gap for each LGA. LGAs are ranked from 1 to 23 for each variable; 23 for those with the highest gap or burden and 1 for the lowest. The scores for PMTCT burden and service coverage gap are then combined to give the rank sum. The LGAs are arranged from those with the highest rank sum to those with the lowest. LGAs with higher rank sums have the greatest need for PMTCT services.

Although Gokana LGA has the highest PMTCT burden in Rivers State, it ranks lower than Oyigbo LGA on the prioritization list because the PMTCT service coverage gap for Gokana is very narrow but quite wide in Oyigbo LGA.

4.2.6 Recommendations

Scale-up priority should be given to LGAs with the highest PMTCT service coverage gap and burden of HIV positive pregnant women. Scale-up efforts must attempt to close the gap in human resource and infrastructure that exists almost 50% of facilities. Private sector involvement in PMTCT service provision is also another critical area which should be addressed to ensure universal coverage of PMTCT services. Demand creation to increase uptake of facility services needs to feature prominently in the design of interventions for eMTCT in Rivers State.

Furthermore, community systems should be strengthened. This will include strategies to improve community involvement and ownership by establishing and strengthening existing ward and village development committees as well as community-based organizations.

SECTION

5 Rivers State eMTCT operational plan

5.1 RATIONALE

Mother-to-child transmission of HIV is currently responsible for virtually all new infections among children, thus significantly contributing towards infant morbidity and mortality. The risk of MTCT can be reduced from an average of 30 – 45% to less than 2% by comprehensive interventions that include the use of 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 State objectives, by end of the year 2015, are to:

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

5.3 SCALE UP TARGETS

Table 5: State Level Targets for the Operational Plan

INDICATORS	BASELINE (2012)	YEAR 1 (2013)	YEAR 2 (2014)	YEAR 3 (2015)	DATA SOURCE
Estimated number of WRA (22% of total population)	1,414,511	1,462,746	1,512,626	1,564,206	NPC 2006 Projections
Estimated number of pregnant women (5% of total population)	321,480	332,442	343,779	355,501	NPC 2006 Projections
Projected ANC attendance (80.3 % of estimated pregnant women; MICS 2011)	258,148	266,951	276,054	285,468	MICS4 2011 Based Projections
Estimated number of HIV-positive pregnant women (6.0% prevalence: 2010 sentinel survey)	19,289	19,947	20,627	21,330	Prevalence Based Estimates
50% reduction in HIV incidence among 15-49 year old women	0.53%	0.44%	0.35%	0.27%	National HIV Sero-prevalence Sentinel Survey
90% reduction in unmet need for FP among women living with HIV (based on 20.1% unmet need MICS 2011)	20.1%	17.50%	7.50%	2.00%	MICS4 2011 Based Projections
90% of all pregnant women have access to quality HIV counselling and testing services (Rivers health system stats, 2013)	24,160 (7.5%)	99,733 (30.0%)	240,645 (70.0%)	319,951 (90.0%)	State Routine Health data on DHIS
90% of all HIV-positive pregnant women and breastfeeding infant-mother pairs have received ARV prophylaxis for PMTCT	778 (4.2%)	5,984 (30.0%)	14,439 (70.0%)	19,197 (90.0%)	State Routine Health data on DHIS
90% of all HIV-exposed infants have access to early HIV diagnosis services	156 (0.8%)	5,984 (30.0%)	14,439 (70.0%)	19,197 (90.0%)	State Routine Health data on DHIS
90% of HIV-infected women pregnant requiring treatment for their own health have access to lifelong ART (Based on 50% of HIV positive pregnant women requiring ART)	NA	2,992 (30.0%)	7,219 (70.0%)	9,599 (90.0%)	State Routine Health data on DHIS
89% of ANC facilities provide PMTCT services	66 (16%)	166 (40%)	366 (89%)	366 (89%)	State Routine Health data on DHIS

5.4 IMPLEMENTATION APPROACHES

The primary consideration is integration of PMTCT into existing health programs including the maternal, neonatal, child and adolescent health, the nutrition-related services as well as the other HIV-related services. Consideration has also been given to the four-pronged approach to the PMTCT strategy to 1) prevent HIV in WRA, 2) prevent unintended pregnancy in women living with HIV/AIDS, 3) prevent HIV transmission from mother to child, and 4) provide ongoing care and support to mothers, their children, and families. Within the third prong, the PMTCT continuum of care considered include ANC, intra-partum and postnatal care as well as community based services.

Specifically the operational plan will be dependent upon the following major strategic outcomes:

- PMTCT service provision including capacity building, guidelines, manuals and related standards are produced and widely disseminated;
- PMTCT health care commodities including medicines, related commodities and supplies as well as the procurement supplies management system are strengthened;
- Advocacy for PMTCT with gatekeepers and influential people within the community is strengthened;
- Community education on PMTCT, including mobilization to promote the utilization of the available services, is enhanced;
- Physical infrastructure and equipment for provision of quality PMTCT services is rehabilitated;
- PMTCT program coordination, management and resource mobilization is strengthened; and
- PMTCT program monitoring and evaluation (M&E) as well as operational research are strengthened.

Based on the implementation approaches outlined above, five focus areas guided the themed group work. These areas include PMTCT service supply; PMTCT health care commodities supply; PMTCT demand creation; M&E; and program management.

5.4.1 Focus Area 1: PMTCT Service Provision

The PMTCT service provision thematic area aims at improving service delivery of PMTCT services across the selected private and public facilities. The PMTCT service supply systems include but are not limited to: (1) training of health care workers, (2) site activation for PMTCT service provision, (3) distribution of guidelines, standard operating procedures (SOPs), job aids and information/ education/communication (IEC) materials and (4) providing support to PMTCT sites through routine mentoring and technical supportive supervision.

Healthcare workers in secondary health facilities will be trained using the National Integrated PMTCT curriculum while the Integrated Management of Pregnancy and Childbirth (IMPAC) curriculum will be used for training health care workers in primary healthcare facilities. Update trainings and step down trainings will further increase standards and the pool of healthcare providers. National guidelines and SOPs, job aids and IEC materials will be provided. Mentoring and supportive supervision will be an integral part of implementation. Joint mentoring and supportive supervision with State teams will ensure program ownership and sustainability. Health facilities will be activated for PMTCT service provision and supervised by a multi-disciplinary team who will provide hands-on mentoring, coordination and commodity oversight for service provision.

5.4.2 PMTCT Health Care Commodities supply

An effective and sustainable system of providing and managing health care commodities is key to the successful implementation of the 2013–2015 Rivers State PMTCT scale-up plan. Appropriate

personnel need to be trained and commodities need to be procured, stored and distributed in such a way that pregnant women and children who need them are reached in a timely and professional manner. In creating this system however, it is very important that it aligns with existing structures within the state in order for it to receive the type of commitment and ownership that is essential for it to run effectively.

It is worthy of note that the Rivers State government has continued to show commitment towards ending MTCT. In August 2013, the state procured ARVs that will be available for HIV-infected pregnant women to use until October 2014. Free medical health care funds in the state are readily available for pregnant women and children to access. Support has also come from different partners in the state such as Clinton Health Access Initiative (CHAI) and FHI 360. They have provided rapid test kits (RTK), drugs and trained key personnel at the LGA and facility levels. However, enormous gaps still exist; health care facilities still experience stock outs of test kits and commodities or have expired drugs. There is still a dearth of capacity at the human resource level and inadequate storage facilities. It is therefore important to close these gaps and help strengthen the state's existing logistics management system to achieve its target set for ending MTCT by 2015.

5.4.3 PMTCT Demand Creation

The Rivers State eMTCT demand creation intervention is based on the multi-pronged social and behavior change communication (SBCC) strategy. This theory based strategy involves systematic application of interactive and research driven communication process that addresses key elements for social and behavior change at individual, community and social context. Influenced by the socio-ecological model, the strategy examines cultural, economic, political and other social factors within the individual's environment to address specific barriers to uptake of PMTCT. The work plan recommends three major approaches: (1) advocacy to persuade policy change and action; (2) social and community mobilization for promotion of new norms and wider participation, to increase knowledge, and (3) influence attitudes change among men, women, family members and health care workers.

Several activities are proposed to be implemented at three levels, running from the state level, to local government and community levels. The state level interventions will focus on high level policy makers targeting the state administrators, faith base leaders, and opinion leaders. At the LGA level interventions will target local government administrators, and council members. At the community level, interventions will reach traditional institutions, community members and health care providers and key frontline mobilizers such as Mother's Support Group, Men. Care Forum (men that care), women leaders and health care providers within the primary health structures.

Key recommended activities include advocacy and sensitization meetings with policymakers, opinion leaders and influencers at all levels. It is expected the campaign will be formally launched at the state level by the First Lady, to provide government an opportunity to make formal pronouncement of its commitment to eMTCT. This event will also be conducted in each LGA where the chairmen and key community leaders will confirm their commitment. This is supported with broad-based social and community mobilization activities that include community dialogues and focus group discussions involving key stakeholders and frontline mobilizers. These activities will encourage group discussions, mobilize wider family and community participation, promote new norms among men, strengthen partnerships with community institutions and establish ownership among community members. Communication and behavior change materials such as posters, leaflets, job aids; as well as media messaging via radio and TV programs will complement all the interventions for accelerated scale-up and linking communities to available services.

Rivers State eMTCT demand creation will also intensify efforts to empower key frontline providers and mobilizers through trainings on interpersonal communication, and community dialogue facilitation skill so as to enable them to provide sustainable quality service

5.4.4 Monitoring and Evaluation

River State's current M&E and health data management system needs to be strengthened. Weaknesses inherent in the system include parallel data reporting structures (e.g. data flow), poor data quality, limited HR and technical capacity for M&E, incomplete reporting from all health facilities in the state (especially the private-for-profit sector) as well as lack of information sharing amongst the actors are amongst issues that needed to be addressed. Multiple funding streams are available from various sources (such as: World Bank, WHO, Global Fund, USG, UNICEF and the State Government) each with its own reporting requirements. This leads to fragmented reporting.

In order to ensure that routine health data generated at facility-level are collated, reported and made available for decision and policy making at LGAs and state-level there is a need for Integrated Health Data Management (IHDM). To this end, the stakeholders, using the eMTCT plan development window, have resolved to strengthen the M&E and health data management system in the state.

An established strong M&E system and standard data management processes will ensure that: (1) inefficiencies in data collection and reporting is minimized, (2) PMTCT intervention process, outputs and outcomes are better tracked for the purpose of evaluating the impact of the program and (3) answers are provided to operational questions from the stakeholders. To this end, the M&E system proposed for the scale-up will address identified deficiencies in the areas of M&E coordination at all levels. These include establishing and maintaining a central routine health database, procurement & supply chain management for M&E tools, establishing systems for mentoring and supportive supervision and data quality assurance (DQA) system, and building human resource capacity for M&E as well as information use and data sharing.

5.4.5 Coordination and resource mobilization

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

The coordination structure in the state includes the State Management Team (SMT), the Joint State Implementation Team (JSIT) and LGA structures. Strengthening the coordination of eMTCT activities will create linkages and collaboration between the various levels of care for quality eMTCT services provision is achieved. Illustrative coordination activities include quarterly eMTCT Technical Working Groups meetings, monthly SMT meetings, monthly LGA Technical Committee meetings and monthly cluster coordination meetings. These meetings will track progress and address challenges with the aim of ensuring the implementation of quality PMTCT services across the state.

Strengthening institutional and human capacity for quality eMTCT service delivery will be achieved through: institutionalization of continuous quality improvements (CQI), infrastructural upgrades, procurement and supply of office equipment for SMOH and facilities, recruitment of doctors and other health care workers and strengthening the capacity of the SMT.

Resource mobilization strategies will be employed to generate resources to implement the eMTCT operational plan. A key aspect of the strategy involves harmonizing and expanding private public partnerships. Organizations to be targeted through resource mobilization efforts include oil companies and the Niger Delta Development Company. In addition, the Association of General & Private Medical Practitioners of Nigeria (AGPMPN) will be engaged to ensure private facilities are fully involved in eMTCT scale-up. Regular progress reviews and feedback mechanisms will be established to track mobilization efforts.

SECTION 6

Benefits & Impact of Expanded Access to PMTCT Services in Rivers State

To estimate the potential impact of meeting PMTCT targets in Rivers State, 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 three of the four main PMTCT targets were estimated (targets listed below). The methods for estimation are described below. In brief, the infections and deaths that would result from maintaining current levels (maintaining the status quo) compared to meeting PMTCT targets were estimated. The difference between the two was taken as the estimate of programmatic impact (see table below).

TARGETS:

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

Table 6: Potential Impact of Meeting eMTCT Targets in Rivers State by 2015

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

IN SUMMARY:

7,488

infections among WRA

9,320

pregnancies among HIV-positive women

12,526

infections among HIV exposed infants (HEI)

4,252

infant deaths

75

maternal deaths will be prevented by meeting the PMTCT targets.

Combined, this will result in

758,936

DALYs saved in Rivers State by 2015 if the scale-up plan is implemented to scale.

Impact Estimation Methodology and Assumptions

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

2. **The number of pregnancies prevented among HIV + women** was estimated by subtracting the number of pregnancies expected if unmet need was reduced by 90% from the number of expected pregnancies among HIV + women if unmet need was not reduced. The number of expected pregnancies in each scenario was based on a couple-year of protection (CYP) conversion factor produced by MSI[10]. CYPs in each scenario were estimated based on the current contraceptive mix observed in each state and assumed 1 year of use for new adopters. The CYPs for a minimum of year of use of each method were based on region-specific standards[12]. The World Health Organization estimates of HIV transmission from mother-to-child were also based on accepted standards: transmission with ARVs is expected be 5%, and without ARVs 35%[13].

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

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

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

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

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

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

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

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

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

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

    b. reduction in HIV infections among HIV exposed infants (in step 2), as well as expected mortality among infected children in the first year of life (35.2%) compared to un-infected infants (4.9%)[14].

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

6. **Disability-adjusted life disability (DALYs)**[15] were estimated from several sources:

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

    b. reduced unmet need for family planning,

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

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

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

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

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

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

SECTION

7 Implementation Plan

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

Objective 1: 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 1: PMTCT SERVICE SUPPLY SYSTEMS					
Training & capacity					
Train HCWs and community volunteers (including retired HCWs, community pharmacists) for HTC (including male and female condom demonstration) from all (160 i.e. non gov. and non-PMTCT) facilities- 11-day residential training; 2 trainees per facility = 320 persons in 9 cycles of 35	320 HCWs	Q4	Q1-Q4	N/A	SMOH
Conduct 3-day training for HCW on syndromic management of STIs for 160 facilities. 2 persons per facility = 320persons in 9 cycles of training with 35 participants		Q4	Q1-Q4	N/A	SMOH
Community services					
Provision of HTC and STI job-aids, SOPs, etc. (505 facilities)		Q4	Q1-Q4	N/A	SMOH
Mentoring & supervision					
Conduct twice-monthly HTC outreach testing services from primary (250) and secondary facilities (30) giving total of 280 already existing public facilities		Q3-Q4	Q1-Q4	Q1-Q4	SMOH
Conduct quarterly visits to supervise and mentor sites and community services by SIT. Covering 280 sites - assuming 10 teams (2 persons per team) x 2 facilities per day x 5 days/ month = 60 days per year x 2.5 years		Q4	Q1-Q4	Q1-Q4	SMOH, FHI 360
Condom promotion					
Ensure placement of condom dispensing machines in strategic locations (hotels, hostels, community hall, youth centers, hot spots, etc.) and community pharmacies (link to logistics group)			Q4		

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% (continued)

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA 2: HEALTH CARE COMMODITIES					
Procurement					
Drugs					
Procure drugs for STI treatment: Amoxicillin, Ciprofloxacin, Ceftriazone	(781, 458)50% of 1,562,915. Amoxicillin 625, 166 dose (80% of 781, 458) = Ciprofloxacin (60%) 468, 875 doses; Ceftriazone 312, 583doses (40%)	Q4	Q1-4	Q1-4	SMOH
Procure ARVs for post exposure prophylaxis (TDF, 3TC, AZT, EFV, LPV/r)	219,832 (9.1% positivity rate + trainings, quality controls & repeat testing)	Q4	Q1-Q4	Q1-Q4	SMOH
Consumables					
Procure RTKs (Determine test kits) in line with national algorithm	2013: 3, 203 packs (320, 273 WRA); 2014 : 3, 308 packs (330, 778 WRA); 2015: 3,416 packs (341,628 WRA)	Q4	Q1-Q4	Q1-Q4	SMOH
Procure RTKs (Unigold HIV test kits) in line with national algorithm	2013: 1, 117 packs (22,327 est. HIV-positive pregnant women + 10% wastages + 10% for couple counseling); 2014: 1, 153 packs (23, 059); 2015: 1, 230 packs (24, 598)	Q4	Q1-Q4	Q1-Q4	SMOH
Procure RTKs (Stat pack HIV test kits) in line with national algorithm	2013 : 558 packs(11, 164 est. 5% of confirmatory test)- unigold; 2014 : 577 packs (11, 530); 2015: 615 packs (11,300)	Q4	Q1-Q4	Q1-Q4	SMOH
Procure lab consumables for 308 new scale-up PMTCT sites	Support HIV testing for 384, 328 estimated pregnant women 2013; 396,934 in 2014 and 409,954 in 2015	Q4	Q1-Q4	Q1-Q4	SMOH
Distribute HIV test kits and lab consumables in line with national algorithm (to be distributed alongside other commodities)	Bimonthly distribution X 12 X 3 years	Q4	Q1-Q4	Q1-Q4	SMOH
Procure male condoms for HIV prevention	144 condoms/males/yr X 90 % estimated WRA 1,562, 915 (2,250,598 packs)	Q4	Q1-Q4	Q1-Q4	SMOH
Procure female condoms for HIV prevention	(1,125,299) 5 % of male condoms-low female condom use due to cultural belief	Q4	Q1-Q4	Q1-Q4	SMOH
Procure IPAC consumables (methylated spirit, cotton wool, gloves, lancet, work bench pad, bleach, syringes, penile models, buffer, sharp boxes, bin liners) and ANC equipment	308 facilities per quarter	Q4	Q1-Q4	Q1-Q4	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% (continued)

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA 2: HEALTH CARE COMMODITIES *(continued)*					
Procurement					
Equipment					
Procure autoclaves and sterilization equipment (cost in IPAC commodities)	308 sterilization equip-ment	Q4	Q1-Q2	N/A	N/A
Distribution					
Consumables					
Distribute male and female condoms for HIV prevention (to be distributed alongside other commodities)		Q4	Q1-Q4	Q1-Q4	N/A
Training & capacity					
Conduct 2-day centralized training on logistics management of HIV/AIDS commodities (LMHC). Cost for 46 participants (TOT) from 23 LGA	To train lab / pharmacy personnel in 23 facilities	Q4	Q1		GSIT, lab and pharmacy
Conduct 2-day step-down training on logistics management of HIV/AIDS commodities (LMHC) at LGA level. Cost for 2 participants per facility per LGA	To train lab / pharmacy personnel in 308 facilities	Q4	Q1		GSIT, lab and pharmacy
Conduct 5-day pharmaceutical care training for pharmacist/pharmacy technicians. Refer to service supply		Q4	Q1-Q3		SMOH
Conduct 6-day lab activation training for lab scientists/ technician for ART sites (2 persons per facility X 12 facilities). Refer to service supply		Q4	Q1-Q3		SMOH
Conduct onsite 3-day sample handling training for HCW in PMTCT sites (10 persons - nurses, noctors, laboratory staff- per facility X 3) Refer to Service supply group		Q4	Q1-4		SMOH
Provide funds for the transportation of blood samples for laboratory analysis (CD4, chemistry and haematology)		Q4	Q1-Q3		SMOH
Conduct PCR training for laboratory scientists (2 persons facility X 10 days). Refer to Service supply		Q4	Q1-Q3		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% (continued)

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA 3: PMTCT DEMAND CREATION SYSTEMS					
Training on IPC					
Conduct 2-day stakeholders' planning meeting on demand creation for PMTCT TWG, Prevention TWG, and (Network of People living with HIV/AIDs in Nigeria) NEPWHAN.			Q1		SACA
Conduct 3-day LGA level IPC training for 30 health care workers per LGA			Q2-Q4		SACA
Conduct 3-day message material & message adaption workshops for 20 persons			Q2		SACA
Community mobilization					
Sensitization					
Hold state PMTCT launch /1-day state high level sensitization meeting with first lady & 60 women leaders and influential stakeholders which include: commissioners (Women Affairs, Information and Health), wives of LGA chairmen and women leaders.			Q2		SACA
Convene 1-day sensitization meeting with chairmen and head of personnel of the 23 LGAs at the state level	Chairmen of 23 LGAs		Q2		SACA
Convene 1-day sensitization meeting for traditional leaders in 23 LGAs			Q2		SACA
Convene 1-day state level sensitization meeting for religious leaders which include representatives of Christian Association of Nigeria (CAN), Jama'atu Nasril Islam (JNI)/Muslim clerics			Q2		SACA
Conduct 2-day training for community mobilization skills on demand creation of integrated ANC/PMTCT demand for RH/FP providers, CSOs	50 (2 batches of 25 each)	Q4			SACA
Conduct quarterly community sensitization on free medical care program and registration for free passport for free medical care in 319 wards		Q4			SACA

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

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA 3: PMTCT DEMAND CREATION SYSTEMS *(continued)*					
Community mobilization *(continued)*					
Advocacy					
Conduct 5-day advocacy and mobilization TOT for 25 persons for prevention officers from SACA, PHC Board, NGOs, SMOH			Q2		SACA
Conduct a 3-day LGA level advocacy and community mobilization training for 23 participants (desk officers, LGA PMTCT desk officers, LACA CMOs, CDCs)			Q2		SACA
Conduct 1-day LGA level advocacy and sensitization meeting for LGA officials level - ward, community leaders, chairmen, vice chairmen, supervisors, PHC coordinators, community development officers, councilors, youth leaders, women leaders			Q2		SACA
Media engagement					
Conduct 3-day training for 30 journalists (news editors, health correspondents, etc.) on media coverage for PMTCT at state level	2 messages X 4 Prongs X 4 languages and aired twice daily X 7 days a month		Q3		SACA/SMOH
Adapt and produce PMTCT radio jingles	7 days per month X 101 communities		Q3		SACA/SMOH
Broadcast radio jingles	1 message X 4 prongs X 1 language; aired four times daily x 7 days per month		Q3	Q1-Q4	SACA/SMOH
Produce radio programs	1 message x 4 prongs X 1 language; monthly		Q3	Q1-Q4	SACA/SMOH
Broadcast radio programs	2 messages x 4 prongs X 1 language		Q3	Q1-Q4	SACA/SMOH
Produce & broadcast TV spots	32 community radios		Q3	Q1-Q4	SACA/SMOH
Produce & broadcast TV programs	60 journalists (state/LGA/ community Info officers); 303 community radio workers x 2 days at LGA level in 10 batches (totaling 363 participants)		Q3	Q1-Q4	SACA/SMOH
IEC materials					
Provide 280 cameras for 280 PMTCT sites in the state			Q2	Q1-Q3	SMOH
Develop and produce posters, leaflets, cue cards, T-shirts & fez caps, billboards			Q2		SMOH/SACA

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

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA 3: PMTCT DEMAND CREATION SYSTEMS *(continued)*					
Mentoring & Supervision					
Hold 1-day quarterly roundtable (Men. Care Forum) - male champions, faith based champions, for male involvement in PMTCT demand creation in 23 LGAs	30 persons		Q2	Q1-Q4	SMOH/SACA
Conduct 2-day training of 10 mother-mentor on home visits to mobilize on ANC/PMTCT services per 23 LGA	10 mother-mentors		Q1-Q4	Q1-Q2	SMOH/SACA
Support mother - mentors to provide mentorship to pregnant women living with HIV through community based adherence counseling (stipends)			Q3-Q4		SMOH/SACA
Support quarterly PHCs - Frontline Health providers forum for active involvement in demand creation for 20 persons per 23 LGA			Q2	Q1-Q4	SACA, SAPC
Others					
Conduct 2-day desk review/ mapping of social structures to determine resources and characteristics of beneficiaries for PHC coordinators and LACAs	46 persons		Q1		
Community services					
Conduct quarterly community dialogue sessions in 319 wards		Q3-Q4	Q1-Q4		
Conduct community outreach (HTC and referrals) to enhance demand for PMTCT (kits needed, transport refreshments, canopy)		Q2-Q4	Q1-Q4	Q1-Q4	

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

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA 1: PMTCT SYSTEM SUPPLY SERVICES					
Training & capacity					
Train providers on FP (dual method) service delivery as appropriate for cadre, integrate into HTC training and extend by 1 day. No cost – integrated into HTC training to give 11 days	2020		Q1-Q4		SMOH
Conduct advocacy visit to the Chairman of hospital management board (HMB) to ensure the establishment of functional FP units within all secondary facilities (no cost attached)		Q4			SMOH
Conduct FP technology training for nurses in secondary facilities - 1 person per facility, 6-week training with 2 weeks residential component and 4 weeks field component/mentoring = 28 persons, 1 training cycle	28		Q1-Q4		SMOH
Conduct mentoring for nurses trained on FP technology (above) - weekly mentoring (2-day) visits to secondary sites (23 sites) = x facilitators and 92 visits	28	Q1-Q4			SMOH
Conduct quarterly meeting of site and LGA RH focal persons - LGA based, 1 every quarter = 23 meetings per quarter x 280 HCW (1 per facility) = 92 meetings per annum x 2.5 years		Q1-Q4	Q1-Q2	Q1-Q4	SMOH
Mentoring & supervision					
Conduct monthly supportive supervision visits (linked to integrated supportive supervision)					SMOH
Service delivery					
Facilitate creation of community-based support groups in LGAs where there are no support groups		Q3-Q4	Q1-Q4		SMOH
Sensitize support group members on FP and dual method use. 1 sensitization per LGA (23) x 30 persons per LGA	30 persons/ LGA	Q3-Q4	Q1-Q2		SMOH
Community services					
Provide FP SOPs, guidelines, job aids, etc. All sites (280)		Q3-Q4	Q1-Q4	Q1-Q4	SMOH
FOCUS AREA 2: HEALTH CARE COMMODITIES					
Procurement					
Consumables					
Procure FP commodities, (including condoms, oral contraceptive pills, Injectables, Implants, intrauterine contraceptive device) No cost; key into national program	308 facilities	Q3-Q4	Q1-Q4	Q1-Q4	SMOH

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% *(continued)*

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA 2: HEALTH CARE COMMODITIES *(continued)*					
Equipment					
Procure Equipment for FP (clinic couches, angle lamp, sterilization units, IUCD insertion kits, weighing scale, BP apparatus, stethoscope, implant insertion kits, sharps boxes, furniture etc). - No cost; key into national program	308 facilities	Q3-Q4	Q1-Q4		SMOH
Distribution					
Consumables					SMOH
Transport & distribute FP commodities from state stores to service delivery points (SDPs) (to be distributed alongside other commodities)	308 facilities				SMOH
Training & capacity					
Conduct 5-day residential Contraceptive Logistics Management System (CLMS) training	To train FP personnel in 23 facilities				SMOH
Conduct 5-day step down non - residential CLMS training	To train FP personnel in 308 facilities				SMOH

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 all 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 and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA 1: PMTCT SERVICE SUPPLY SYSTEM					
Training & capacity					
Conduct trainings for HCWs in sites as appropriate (see section below for listing)					SMOH
Conduct 6-day integrated PMTCT training for all sites = 280 doctors (from all scale-up PMTCT and CC sites) in 8 cycles of training x 35 persons per cycle	280	Q3-Q4	Q1-Q4		SMOH
Conduct 5-day IMPAC training for ANC nurses/CHEWS = 2 nurses + 2 CHEWs x 280 facilities= 1120 participants in 32 cycles of training with 35 participants per training	280	Q3-Q4	Q1-Q4		SMOH
Conduct laboratory training - 1 person per facility x 280 facilities. 8 cycles of training x 35 persons per cycle,6 days	280	Q3-Q4	Q1-Q4		SMOH
Conduct 5-day pharmcare training for pharmacists and community pharmacists - 28 hospital facilities (2 per GH + 3 in tertiary) and preceptors (1CP per 5 PHCs/PH = 50 CPs) = 109 trainees in 3 cycles of 37 persons (residential)	109	Q3-Q4	Q1-Q4		SMOH
Conduct 2-day ARV dispensing and documentation for pharmacy technicians, nurses CHO and CHEWs. 2 per site x 280 sites = 560 participants (residential). 16 cycles of training x 35 persons per cycle	560	Q3-Q4	Q1-Q4		SMOH
Conduct training of trainers (TOT) for pharmacists (master trainers) to conduct onsite best practice training. 1-day orientation x 40 consultants/master trainers. 1 cycle x 1 day	40	Q3-Q4	Q1-Q4		SMOH
Conduct 5-day onsite pharmacy follow-up best practice training including logistics. Assume 10 persons per site	2800	Q3-Q4	Q1-Q4		SMOH
Conduct onsite adherence training in 280 sites. 1-day meeting involving 20 persons per site	280	Q3-Q4	Q1-Q4		SMOH
Conduct LMIS training for all facilities. 5-day training x 2 persons (nurses/CHEWs/pharm tech) per facility = 560 persons. 16 cycles of training x 35 persons per cycle	560	Q3-Q4	Q1-Q4		SMOH
Conduct sample handing training for HCW - 3 persons per facility x 280 facilities = 840 persons, 3-day training, 24 cycles	840	Q3-Q4	Q1-Q4		SMOH
Integrate HTC into ongoing home base care initiative for MCH and scale-up current system implemented by CHEWS to other (20) LGAs (currently in 3 LGAs) by conducting training for all (23) LGAs - linked to HTC training in prong 1		Q3-Q4	Q1-Q4		SMOH

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 all pregnant women *(continued)*

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA 1: PMTCT SERVICE SUPPLY SYSTEM *(continued)*					
Mentoring & supervision					
Support community-based support group monthly meetings for applicable facilities - 1 meeting per month per LGA (20 persons) = 23 meetings per month = 276 meetings per year x 2.5 years		Q3-Q4	Q1-Q4	Q1-Q4	SMOH
Support group volunteers to carry out tracking and adherence support through monthly phone calls and home visits - 2 persons (1 facility focal person + 1 support group volunteer) x 280 facilities x monthly communication + monthly transport		Q3-Q4	Q1-Q4	Q1-Q4	SMOH
Conduct quarterly visits to supervise and mentor sites and community services by SIT. Covering 280 sites - assuming 10 teams (2 persons per team) x 1 facilities per day x 10 days/month = 120 days per year x 2.5 years	20	Q3-Q4	Q1-Q4	Q1-Q4	SMOH
Site activation					
Facilitate pre-activation assessments for 280 sites	280	Q3-Q4	Q1-Q4		SMOH
Site activation meetings (PMTCT sites) – 1-day duration x 252 sites x 10 persons per site	280	Q3-Q4	Q1-Q4		SMOH
Conduct onsite adherence training in 280 sites. 1-day meeting involving 20 persons per site	280	Q3-Q4	Q1-Q4		SMOH
Service delivery					
Provide PMTCT SOPs, job aids, etc. in all (280) facilities x 3 copies/facility		Q3-Q4	Q1-Q4	Q1-Q4	SMOH
Support sample transfer for mothers - no cost, linked to logistics		Q3-Q4	Q1-Q4	Q1-Q4	SMOH
External quality assurance for lab - no cost, linked to logistics		Q3-Q4	Q1-Q4	Q1-Q4	SMOH

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 all pregnant women *(continued)*

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA 2: HEALTH CARE COMMODITIES					
Procurement (quantification, forecasting)					
Drugs					
Procure ARVs for triple prophylaxis (other regi-men like LPV/r)	53, 605 women (90% of HIV positive pregnant women)	Q4	Q1-Q4	Q1-Q4	SMOH
Procure ARVs (NVP suspension) for HIV exposed infants	5, 361 women (10% failure of fist line prophylaxis)	Q4	Q1-Q4	Q1-Q4	SMOH
Procure ARVs (NVP suspension) for HIV exposed infants	41, 917 NVP suspension	Q4	Q1-Q4	Q1-Q4	SMOH
Procure cotrimoxazole for infected pregnant women	7,147 tins for 53, 605 women (90% of HIV positive pregnant women)	Q4	Q1-Q4	Q1-Q4	SMOH
Procure cotrimoxazole for HIV exposed infants	38, 110 bottles of CTX (10% of positive children)	Q4	Q1-Q4	Q1-Q4	SMOH
Procure haematinics for pregnant women	992,679 (90% pregnant women + 10% buffer)	Q4	Q1-Q4	Q1-Q4	SMOH
Procure other drug commodities (antibiotics, antifungals, anti-helmintics etc.)	5,956(10% of estimated positive pregnant women)	Q4	Q1-Q4	Q1-Q4	SMOH
Consumable					
Procure dried blood spot (DBS) bundle kits	DBS (41,917 exposed infants)	Q4	Q1-Q4	Q1-Q4	SMOH
Procure PCR reagents	1 facility for the state				SMOH
Procure pharmacy consumables (dispensing envelop, dispensing bags, dispensing trays, spatulas etc.)	308 facilities	Q4	Q1-Q4	Q1-Q4	
Equipment					
Procure PCR machine and accessories (X 1)	1 machine for the state		Q1		SMOH

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 all pregnant women *(continued)*

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA 2: HEALTH CARE COMMODITIES *(continued)*					
Distribution					
Drug					
Distribute ARVs for HIV infected pregnant women & exposed infants (to be distributed alongside other commodities), Key into distribution plan	308 facilities	Q4	Q1-Q4	Q1-Q4	SMOH
Redistribute ARVs for infected pregnant women & HIV exposed infants	308 facilities	Q4	Q1-Q4	Q1-Q4	SMOH
Redistribute cotrimoxazole for infected women & HIV exposed infants	308 facilities	Q4	Q1-Q4	Q1-Q4	SMOH
Others					
Provide funds for DBS sample transfer to and from Uyo	28 round trips for 308 facilities	Q4	Q1-Q4	Q1-Q4	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 and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA 1: PMTCT SERVICE SUPPLY SYSTEMS					
Training & capacity					
Training of 2 lab scientists on DNA PCR – 10-day training plus local transport for 4 trainees	2	Q3-Q4	Q1-Q4		SMOH
Conduct 5-day positive health dignity and prevention (PHDP) training (master training) for support group members. 5 persons per LGA x 23 LGAs = 115 persons in 3 cycles of 39 persons	115	Q3-Q4	Q1-Q4		SMOH
Conduct trainings (see section below for listing)		Q3-Q4	Q1-Q4		SMOH
Integrated ART training (adult, paediatric, OIs, etc) for 28 sites - 10 days x 5 per facility = 140 persons in 4 cycles of 35 persons	140	Q3-Q4	Q1-Q4		SMOH
TB/HIV training for 28 sites -5 persons per site x 5 days x 28 facilities in 4 training cycles		Q3-Q4	Q1-Q4		SMOH
Pharmacy training -5 days x 2 persons x 28 facilities = 56 persons in 2 cycles of 28	56	Q3-Q4	Q1-Q4		SMOH
SITE ACTIVATION					
Pre-activation assessments for 28 sites - link to program management		Q3-Q4	Q1-Q4		
Site activation meetings (ART sites) - 5 days duration x 28 sites x 10 persons per site	280	Q3-Q4	Q1-Q4		
MENTORING & SUPERVISION					
Support the provision of provider-initiated testing (and subsequent referral as appropriate) at immunization points for mothers coming for Pentavalent 1 - no cost		Q4	Q1-Q4	Q1-Q4	SMOH
Support group volunteers (including mentor mothers) to carry out tracking and adherence support through monthly phone calls and home visits (linked to prong 3 above) cost linked to prong 3		Q3-Q4	Q1-Q4	Q1-Q4	SMOH
LINKAGES/REFERRALS					
Provision of DBS collection services in all facilities - linked to logistics		Q3-Q4	Q1-Q4	Q1-Q4	SMOH
Support referral of DBS samples - linked to logistics		Q3-Q4	Q1-Q4	Q1-Q4	SMOH
Print and distribute early infant diagnosis (EID) job aids - linked to PMTCT job aids in prong 3		Q3-Q4	Q1-Q4	Q1-Q4	SMOH
Refer HIV positive women requiring lifelong ART to comprehensive sites (no cost)		Q3-Q4	Q1-Q4	Q1-Q4	SMOH
LABORATORY SERVICES					
Laboratory training for ART -6 days x 28 facilities x 2 persons per facility = 56 persons in 2 cycles of 28	56	Q3-Q4	Q1-Q4		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 *(continued)*

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA 2: HEALTH CARE COMMODITIES					
Procurement					
Drugs					
Procure ARVs for ART	28 HCC sites	Q3-Q4	Q1-Q4	Q1-Q4	SMOH
Consumables					
Establish more PLHIV support groups at LGA and community and facility levels (not costed)	7,622 estimated no of malnourished children (20% of exposed children)	Q3-Q4	Q1-Q4	Q1-Q4	SMOH
Procure other rapid test kits (syphilis, Hepatitis B & C and pregnancy tests)	308 facilities	Q3-Q4	Q1-Q4	Q1-Q4	SMOH
Equipment					
Procure air conditioners & refrigerators for lab and pharmacy to maintain cold chain		Q4	Q1-Q4		SMOH
Procure 25 KVA generator for facility (18 secondary health facilities in the state i.e. 1 per LGA)		Q4	Q1-Q4		SMOH
Procure laboratory reagents for 28 new comprehensive centers	28 HCC site	Q4	Q1-Q4	Q1-Q4	SMOH
Procure lab equipment for 10 new HIV comprehensive centers + accessories	10 HCC site	Q4	Q1-Q4		SMOH
Procure point of care (POC) CD4 machine	23 facilities	Q4	Q1-Q4		SMOH
DISTRIBUTION					
Consumables					
Print and disseminate registers and LMIS tools for management of HIV/AIDS commodities, refer to M&E		Q4	Q1-Q4	Q1-Q4	SMOH
Equipment					
Procure vehicle for distribution & reverse logistics of health commodities		Q4	Q1-Q4	Q1-Q4	SMOH
Procure motorcycles/tricycles and engine boats for distribution & reverse logistics of health commodities to hard to reach and riverine areas in the state		Q4	Q1-Q4	Q1-Q4	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 *(continued)*

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
SUPERVISION					
Conduct bi-monthly DQA /SQA to ensure data/service quality in PMTCT sites refer to service supply		Q4	Q1-Q4	Q1-Q4	SMOH
Conduct bimonthly State Logistics TWG meetings	One per quarter	Q4	Q1-Q4	Q1-Q4	SMOH
Conduct supportive supervisory visit for logistics management of HIV/AIDS commodities	2 GSIT bi monthly	Q4	Q1-Q4	Q1-Q4	SMOH
Conduct bimonthly logistics peer review meetings	308 facilities	Q4	Q1-Q4	Q1-Q4	SMOH
INFRASTRUCTURE					
Infrastructural upgrade of facilities' pharmacy & lab stores		Q4	Q1-Q4		
Infrastructural upgrade of LGAs' pharmacy stores		Q4	Q1-Q4		
Renovate facility labs to provide comprehensive ART services in 28 health facilities selected for HCC services. Refer to program management		Q4	Q1-Q4		
TRAINING & CAPACITY BUILDING					
Conduct residential training (TOT) on warehousing, dejunking & safe disposal of waste/expired commodities	To train lab / pharmacy personnel in 23 facilities	Q4			
Conduct step down training on warehousing, dejunking & safe disposal of waste/expired commodities	To train lab / pharmacy personnel in 308 facilities	Q4	Q1-Q4		
Conduct 3-day planned preventive maintenance training for engineers and equipment operators	To train 92 equipment engineer & operators (2 per facility X 46 facilities)	Q4	Q1-Q4		
LABORATORY SERVICES					
Support sputum sample transfer to testing sites		Q4	Q1-Q4	Q1-Q4	
Set up TB laboratory refer to program mgt		Q4	Q1-Q4		
STOCK MANAGEMENT					
Provide funds for CD4/hematology/chemistry sample transfer logistics from PHCs to secondary facilities	31,360 travels (4 per monthly X 12 X 2.4 yrs) per 280 facilities	Q4	Q1-Q4	Q1-Q4	

Cross Cutting Areas

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA 4: MONITORING AND EVALUATION					
Data Quality Assurance					
USG Lead M&E IP in the state to organize capacity of the state IHDM team on data analysis and Information dissemination	1 capacity-building session on data analysis and information dissemination held	Q4			FHI 360
Strategic information					
Set up an inventory system for M&E tools in SMOH		Q4			SASCP, SACA, SMoH-DPRS and SPHCMB
Set up IHDM team at the state level		Q4			SMOH-DPRS and PHS
Set up IHDM team at the LGA level	23 LGA IHDM team established	Q4	Q1		SMOH-DPRS AND PHS
Central database					
Design the template for the e-factsheet and service coverage report		Q4			FHI 360
Produce 4 editions of e-factsheet and service coverage report	4 e-factsheet and service coverage reports disseminated	Q4	Q2 &Q4	Q2 & Q4	SASCP, SACA, SMoH-DPRS and SPHCMB
Routine monitoring					
Set up a system to update list on quarterly basis		Q4	Q1-Q4	Q1-Q4	SMOH-DPRS
Conduct 5-day per month mentoring & supportive supervision to HFs in the 23 LGAs	27 quarterly M&E mentoring and supportive supervision visits held at LGA level		Q1-Q4	Q1-Q4	SPHCMB and SMOH
Organize quarterly mentoring & supportive supervision and DQA visits to LGAs & HFs in the state	9 quarterly M&E mentoring and supportive supervision visits held at state level	Q4	Q1-Q4	Q1-Q4	SPHCMB and SMOH

Cross Cutting Areas

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA 4: MONITORING AND EVALUATION *(continued)*					
Capacity building					
Hold 1-day meeting for all stakeholders in the state to harmonize facility list in the state	1 state-level stakeholder's meeting held	Q4			SMOH-DPRS
Hold 2-day non-residential meeting for all stakeholders in the state to establish an IHDM team	State-level Integrated Health Data Management Team established	Q4			SMOH-DPRS
Hold a step down meeting for all stakeholders in the LGA level to establish an IHDM team	23 LGA-level Integrated Health Data Management Teams established	Q4			State IHDM Team, SMOH-DPRS and PHS
Hold quarterly IHDM meeting at the state level	9 Quarterly IHDM Meeting held	Q4	Q1-Q4	Q1-Q4	SMOH-DPRS and PHS
Hold monthly IHDM meeting at the LGA levels	27 Monthly IHDM meetings held	Q4	Q1-Q4	Q1-Q4	SPHCMB
Hold 6-day enhanced M&E & IHDM training for 45 state level officers.2 persons per programme area)	45 State-level M&E officers trained in enhanced M&E and IHDM	Q4			SMOH-DPRS and PHS
Hold 6-day enhanced M&E & IHDM training for 230 LGA level officers(10 per LGA)	230 LGA-level M&E officers trained in enhanced M&E and IHDM	Q4			SMOH-DPRS and PHS
Conduct a 4-day TOT training on all data collection & reporting tools for 46 LGA officers(2 per LGA)	46 LGA master-level trainers trained on all DC&RTs	Q4			SMOH-DPRS and PHS
Conduct a 3-day training on all data collection & reporting tools for 505 Health facilities	505 health facility workers trained on all DC&RTs	Q4			SMOH-DPRS and PHS
Conduct two operations research (OR) studies related to PMTCT and IMNCH	2 OR studies on PMTCT and IMNCH conducted	Q4		Q1-Q3	SMOH-DPRS
ADVOCACY					
Advocacy to relevant government agencies to support the funding, procurement & supply of M&E tools	1 high-level advocacy visit conducted	Q4			SASCP, SACA, SMoH-DPRS and SPHCMB Not applicable

Cross Cutting Areas

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA 4: MONITORING AND EVALUATION *(continued)*					
OTHERS					
Mapping & revalidation of existing facilities	1 state-level mapping & revalidation exercise conducted	Q4			
Publish the finalized comprehensive list of facilities in SMOH website	1 comprehensive facility list for the state	Q4			
Set up a state level sub-committee (SACA,SMOH,PHCMB, development partners) to manage the forecasting, procurement & supply of M&E tools	1 state-level PSCMS sub-committee on M&E tools instituted	Q3-Q4			
Procure 5 project vehicles (Toyota Hilux) for the IHDM Teams at the State level (each for SASCP, SHMB, SPHCMB, SACA and State DPRS)	5 project vehicles (Toyota Hilux) procured	Q4	Q1		
Procure & supply M & E tools to HFs	5 quarterly bulk-printing of M&E tools process completed	Q4	Q2, Q4	Q2, Q4	SASCP, SACA, SMoH-DPRS and SPHCMB
FOCUS AREA 5: PROGRAM MANAGEMENT					
Situation analysis					
Implement recommendations of training needs assessment report	90% of TNA implemented across all thematic areas	Q3-Q4			SMT
Sign MOUs with private facilities on eMTCT services	30 facilities in 1st year and 66 in 2nd year	Q4			SMT
Review existing HIV/AIDS State Policy (including implementation) within the system affecting access to quality service delivery and make recommendations on gaps	90% of relevant policies reviewed	Q4			SASCP
Coordination and resource mobilization					
Identify and facilitate back stops support for resource-deprived facilities	23 MOH in 23 LGAs	Q3			
Conduct training of 15 SMT on workforce analysis and human resource planning leadership and supervision as well as program and financial management.	15 SMT members trained		Q1		
Conduct annual review of human resource gaps (resource availability and HR capacity development) - done during annual review meetings	2 annual reviews		Q1 & Q4	Q3	SMT
Procure identified equipment (fridge, air conditioners, computers, furniture, pallets) for 210 SDPs	Procurement of needed equipment for 210 facilities	Q4	Q1		

Cross Cutting Areas

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA 5: PROGRAM MANAGEMENT *(continued)*					
Coordination and resource mobilization *(continued)*					
Conduct CQI assessment across the facilities and develop capacity building plans	4 CQI Assessments in 1year		Q1-Q4	Q1-Q4	SMT
Inaugurate CQI teams at the facilities	308 CQI teams across all the facilities		Q1-Q2		
Conduct monthly mentorship & supportive supervisory visit meetings	24 visits	Q4	Q1-Q4	Q1-Q4	SMT
Disseminate reviewed (approved) policies to relevant stakeholders		Q4			SMT
Conduct quarterly review meeting with stakeholders of eMTCT scale-up program	8 quarterly review meetings	Q4	Q1-Q4	Q1-Q4	SMT
Adopt & domesticate the State eMTCT Plan at the for all 23 LGAs in partnership with the PHC Board	100% domestication	Q4	Q1		SMT
Develop and harmonize costed work plan from various focus areas/groups developed during the eMTCT workshop		Q3			
Disseminate costed eMTCT work plan to relevant stakeholders in the state		Q3			
Print and distribute the costed work plan for eMTCT scale-up		Q3			
Conduct flag off meeting of PPP initiative for eMTCT scale-up in the state	1	Q4			
Conduct quarterly SMT review & tracking meeting of Scale-up Plan and produce report	8 quarterly review meetings	Q3-Q4	Q1-Q4	Q1-Q4	SMT
Support quarterly eMTCT Technical Working Groups meetings	8 TWG meetings	Q3-Q4	Q1-Q4	Q1-Q4	SMT
Conduct monthly SIT meetings	24 monthly SIT meetings	Q3-Q4	Q1-Q4	Q1-Q4	SMT
Conduct monthly HIV desk officers meeting at the state level for the 23 LGAs	24 monthly SIT meetings	Q3-Q4	Q1-Q4	Q1-Q4	SMT

Cross Cutting Areas

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

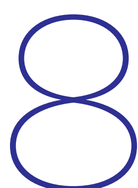
Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA 5: PROGRAM MANAGEMENT *(continued)*					
Coordination and resource mobilization *(continued)*					
Conduct monthly cluster coordination meetings	24 monthly SIT meetings	Q3-Q4	Q1-Q4	Q1-Q4	SMT
Conduct annual review meeting with all stakeholders	2 annual reviews	Q3-Q4	Q1-Q4	Q1-Q3	SMT
Write proposals to prospective partners					SMT
Publish progress score card on eMTCT activities in the state media/ recognition of excellence	8	Q3-Q4	Q1-Q4	Q1-Q3	SMT
Develop monthly, quarterly, financial resource need for eMTCT scale-up plan by sending fund requests to funding partners	24 monthly, 8 quarterly	Q3-Q4	Q1-Q4	Q1-Q3	SMT
Community mobilization					
Advocacy					
Conduct advocacy for recruitment of required health care personnel by 15 SMT members.	One advocacy visit to the Governor	Q3	Q1		Rivers State Government
Conduct advocacy to Association of General & Private Medical Practitioners of Nigeria (AGPMPN) & Association of Pharmacist of Nigeria (APN) Rivers State & others on eMTCT scale-up plan	one visit	Q3			SMT
Develop advocacy kit & conduct advocacy to relevant stakeholders on policy implementation	Need based advocacy kits developed		Q4		SMT
Conduct advocacy to the Governor on eMTCT State Work plan to secure resource allocation to fund the implementation of the plan	1	Q3			SMT
Carry out advocacy to multi-nationals/private organizations to support eMTCT scale-up plan in the State	24 advocacy visits	Q3			SMT
CAPACITY BUILDING					
Capacity building for 96 staff of the private sector on work plan development and financial management in eMTCT	66 private facilities trained	Q4	Q1-Q4		SMT
Train 15 SMT, TWG and facility personnel on CQI	100 people trained on CQI	Q1			SMT
Implement capacity building plans	90% of capacity building plans implemented across all the facilities		Q1-Q4	Q1-Q4	SMT
Train 15 SMT on grant or resource support	15 SMT Members trained	Q4			SMT

Cross Cutting Areas

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
INFRASTRUCTURE					
Develop bill of quantities (BOQ) for 308 service delivery points for renovation based on current infrastructure assessment	308 BOQs developed	Q4	Q1		SMT
Carry out renovation of 308 health facilities	Renovation of 308 facilities		Q1-Q2		SMT
Conduct yearly review of infrastructure	2 yearly reviews	Q4	Q3		SMT
HR & STAFFING					
Recruit required health care personnel (60 doctors, 100 nurses, 80 CHOs & CHEWs, 50 record officers, 40 lab scientist/technicians and 70 pharmacists/ pharmacy technician) over 2 years	60 doctors,100 nurses, 80 CHOs, 50 records officers,40 lab scientists and 70 pharmacists	Q4	Q1		Rivers State Government

SECTION



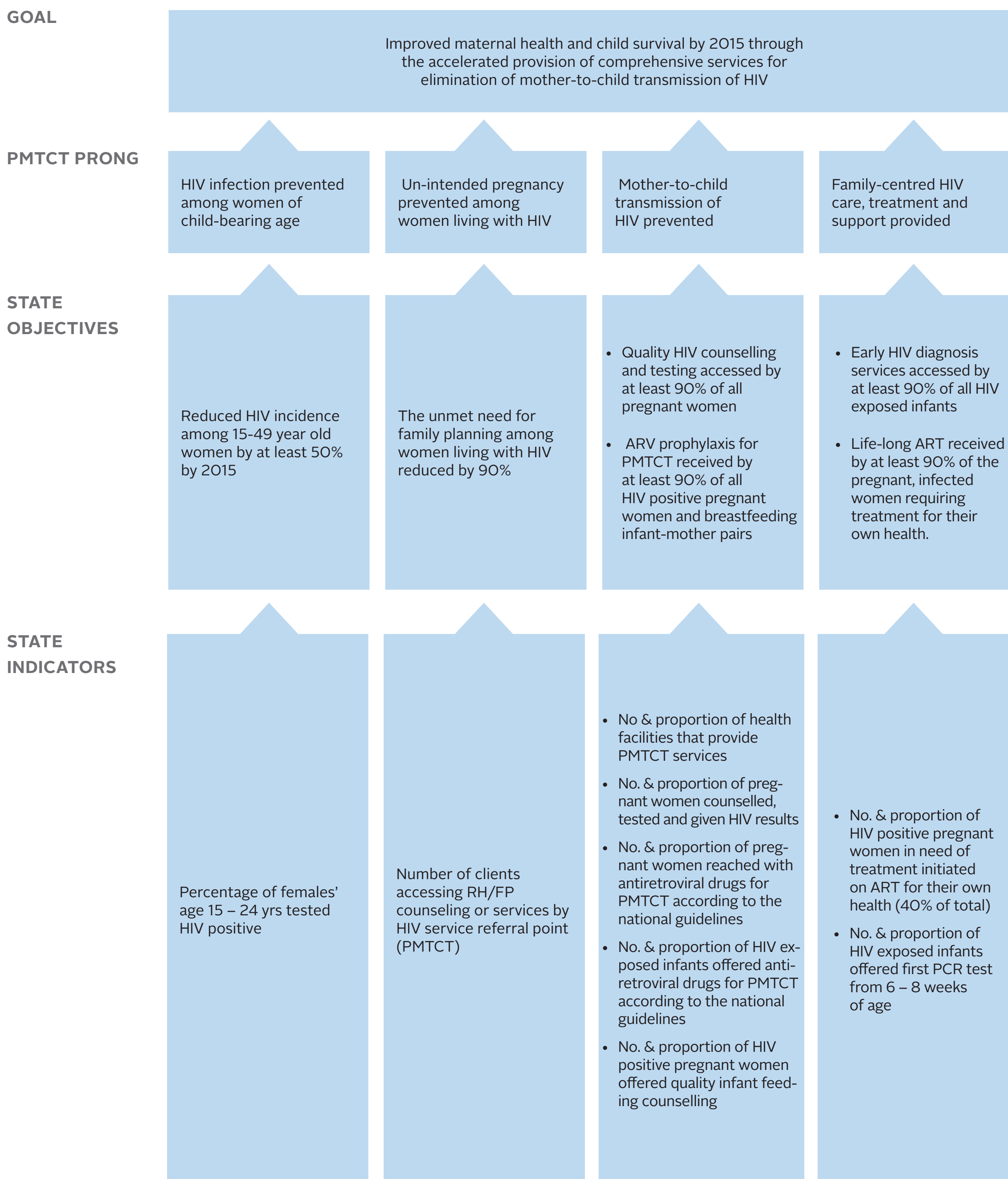
Monitoring and Evaluation Plan

The existing Information Management System will be utilized for routine collection of program data using the registers and reporting forms at implementing health facilities. The reporting will follow the established channels through the LGA to the state level where data will be compiled and shared for use in planning and policy decision making processes. The core indicators are summarized in Table 10 below.

Table 7: Targets for Core Indicators for Rivers State

Indicator	Baseline (2012)	2013	2014	2015
Number of health facilities that provide ANC plus PMTCT services	66	246	310	310
Number females age 15 – 49yrs newly tested HIV positive	7,025	6,021	4,958	3,832
Number of pregnant women counselled tested and given HIV results	24,160	99,733	240,645	319,951
Number of HIV infected women aged 15 – 49 years who accessed comprehensive family planning services	N/A	5,367	5,524	5,483
Number of pregnant women reached with antiretroviral drugs for PMTCT according to the national guidelines	778	5,984	14,439	19,197
Number of HIV exposed infants offered antiretroviral drugs for PMTCT according to the national guidelines	69	957	5,416	9,122
Number of HIV positive pregnant women offered quality infant feeding counseling	N/A	957	5,416	9,122
Number of HIV positive pregnant women in need of treatment initiated on ART for their own health (50% of total)	430	2,992	7,219	9,599
Number of HIV exposed infants offered first PCR test from 6 – 8 weeks of age	156	5,984	14,439	19,197

8.1 RIVERS STATE PMTCT SCALE-UP PLAN FRAMEWORK



SECTION

9 Summary Budget

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

Table 8: Rivers State Summary Budget by Focus Area

THEMATIC AREAS	Year 1 (NGN)	Year 2 (NGN)	Year 3 (NGN)	Total (NGN)	Total (USD)
PMTCT service supply systems	601,528,925	1,667,025,775	271,787,200	2,540,341,900	16,389,303
Health care commodities	1,430,937,672	2,971,348,362	2,860,394,657	7,262,680,692	46,856,004
PMTCT demand creation system	92,168,925	248,951,675	169,199,100	510,319,700	3,292,385
Monitoring & evaluation	398,525,100	119,933,500	63,577,250	582,035,850	3,755,070
Program management	1,047,034,455	1,562,664,380	87,797,450	2,697,496,285	17,403,202
Grand total	**3,570,195,077**	**6,569,923,692**	**3,452,755,657**	**13,592,874,427**	**87,695,964**

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%

Strategic intervention	Activities
THEMATIC AREA: PMTCT SERVICE SUPPLY SYSTEMS	
Training & capacity	Train HCWs and community volunteers (including retired HCWs, community pharmacists) for HTC (including male and female condom demonstration) from all (160 i.e. non-government and non-PMTCT) facilities- 11-day residential training. 2 trainees per facility = 320 persons in 9 cycles of 35
	Conduct 3-day training for HCW on syndromic management of STIs for 160 facilities. 2 persons per facility = 320persons in 9 cycles of training with 35 participants
Community Services	Provision of HTC and STI job-aids, SOPs, etc (505 facilities)
Mentoring & supervision	Conduct twice-monthly HTC outreach testing services from primary (250) and secondary facilities (30) giving total of 280 already existing public facilities
	Conduct quarterly visits to supervise and mentor sites and community services by SIT. Covering 280 sites - assuming 10 teams (2 persons per team) x 2 facilities per day x 5 days/month = 60 days per year x 2.5 years **Expand SIT to include representative from free medical care (group 1)
Condom promotion	Ensure placement of condom dispensing machines in strategic locations (hotels, hostels, community hall, youth centers, hot spots, etc.) and community pharmacies (link to logistics group)
PMTCT service supply systems sub-total	
THEMATIC AREA: HEALTH CARE COMMODITIES	
Procurement (quantification, forecasting)	***Drugs***
	Procure drugs for STI treatment: Amoxicillin, Ciprofloxacin, Ceftriazone
	Procure ARVs for post exposure prophylaxis (TDF, 3TC, AZT, EFV, LPV/r)
	Consumables
	Procure RTKs (Determine test kits) in line with national algorithm
	Procure RTKs (Unigold HIV test kits) in line with national algorithm
	Procure RTKs (Stat pack HIV test kits) in line with national algorithm
	Procure lab consumables for 308 new scale-up PMTCT sites
	Distribute HIV test kits and lab consumables in line with national algorithm (to be distributed alongside other commodities)
	Procure male condoms for HIV prevention
	Procure female condoms for HIV prevention
	Procure IPAC consumables (methylated spirit, cotton wool, gloves, lancet, work bench pad, jik, syringes, penile models, buffer, sharp boxes, bin liners) and ANC equipment

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)
30,469,050	91,407,150	-	121,876,200	786,298
10,614,650	31,843,950		42,458,600	273,926
2,525,000	7,575,000-	-	10,100,000	65,161
6,720,000	13,440,000	13,440,000	33,600,000	216,774
14,400,000	28,800,000	28,800,000	72,000,000	464,516
64,728,700	**173,066,100**	**42,240,000**	**280,034,800**	**1,806,676**
44,811,111	179,244,444	179,244,444	403,300,000	2,601,935
10,012,500	40,050,000	535,758,459	95,666,100	617,201
1,339,200	4,080,000	18,480,000	10,339,200	66,705
630,000	1,575,000	188,944,313	4,419,000	28,510
267,879,229	535,758,459	163,701,734	1,339,396,147	8,641,265
6,160,000	18,480,000	8,006,035	43,120,000	278,194
-	-	-	-	-
53,622,240	107,244,480	107,244,480	268,111,200	1,729,750

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% *(Continue)*

Strategic intervention	Activities
FOCUS AREA 2: HEALTH CARE COMMODITIES *(CONTINUE)*	
Procurement (quantification, forecasting)	***Equipment***
	Procure autoclaves and sterilization equipment (cost in IPAC commodities)
Distribution	Distribute male and female condoms for HIV prevention (to be distributed alongside other commodities)
Training & capacity	Conduct 2-day centralized training on logistics management of HIV/AIDS commodities (LMHC). Cost for 46 participants (TOT) from 23 LGA
	Conduct 2-day step down training on logistics management of HIV/AIDS commodities (LMHC) at LGA level. Cost for 2 participants per facility per LGA
	Conduct 5-day pharmaceutical care training for pharmacist/pharmacy technicians. Refer to service supply
	Conduct 6-day lab activation training for lab scientists/technician for ART sites (2 persons per facility X 12 facilities) Refer to service supply
	Conduct onsite 3-day sample handling training for HCW in PMTCT sites (10 persons - nurses, doctors, laboratory staff- per facility X 3) Refer to service supply group
	Conduct PCR training for laboratory scientists (2 persons facility X 10 days) Refer to service supply
Health care commodities sub-total	
FOCUS AREA 3: PMTCT DEMAND CREATION SYSTEMS	
Training on IPC	Conduct 2-day stakeholders' planning meeting on demand creation for PMTCT TWG, Prevention TWG, and NEPWHAN
	Conduct 3-day LGA level IPC Training for 30 health care workers per LGA
	Conduct 3-day message material & message adaption workshops for 20 persons
Community mobilization	***Sensitization***
	Hold state PMCTC launch /one-day state high level sensitization meeting with first lady & 60 women leaders and influential stakeholders
	Convene 1-day sensitization meeting with chairmen and head of personnel of the 23 LGAs at the state level
	Convene 1-day sensitization meeting for traditional leaders in 23 LGAs
	Convene 1-day state level sensitization meeting for religious leaders
	Conduct 2-day training for community mobilization skills on demand creation of integrated ANC/PMTCT demand for 50 (2 batches of 25 each)
	Conduct quarterly community sensitization on free medical care program and registration for free passport for free medical care in 319 wards

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)
4,417,400			4,417,400	28,499
373,000	1,865,000		2,238,000	14,439
389,244,680	**888,297,383**	**893,464,983**	**2,171,007,047**	**14,006,497**
2,516,000			2,516,000	16,232
5,724,325	17,172,975		22,897,300	147,725
2,902,500			2,902,500	18,726
342,000			342,000	2,206
253,200			253,200	1,634
977,500			977,500	6,306
408,000		2,516,000	2,924,000	18,865
5,523,000		3,920,000	9,443,000	60,923
11,484,000	45,936,000	45,936,000	103,356,000	666,813

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% *(Continue)*

Strategic intervention	Activities
FOCUS AREA 3: PMTCT DEMAND CREATION SYSTEMS *(continued)*	
Community mobilization	***Advocacy***
	Conduct 5-day advocacy and mobilization TOT for 25 Persons
	Conduct 3day LGA level advocacy and community mobilization training for 23 participants
	Conduct 1-day LGA level advocacy and sensitization meeting for LGA officials level (ward, community leaders)
Media engagement	Conduct 3-day training for 30 journalists on media coverage for PMTCT at state level
	Adapt and Produce PMTCT radio jingles
	Broadcast radio jingles
	Produce radio programs
	Broadcast radio programs
	Produce & broadcast TV spots
	Produce & broadcast TV programs
Mentoring & supervision	Hold 1-day quarterly roundtable (men, care forum) for male involvement in PMTCT demand creation in 23 LGAs for 30 persons
	Conduct 2-day training of 10 mother-mentor on home visits to mobilize on ANC/PMTCT services per 23 LGA
	Support mother - mentors to provide mentorship to pregnant women living with HIV through community based adherence counseling (stipends)
	Support quarterly PHCs - Frontline Health providers forum for active involvement in demand creation for 20 persons per 23 LGA
IEC materials	Provide 280 cameras for 280 PMTCT sites in the state
	Develop and produce posters, leaflets, cue cards, T-shirts & fez caps, billboards
Community services	Conduct quarterly community dialogue sessions in 319 wards
	Conduct community outreach (HTC and referrals) to enhance demand for PMTCT (kits needed, transport refreshments, canopy
	Conduct 2-day desk review/ mapping of social structures to determine resources and characteristics of beneficiaries for 46 persons
PMTCT demand creation systems	
Objective 1 sub-total	

Year 1 Budget (Naira)	Year 2 Budget less one-off activities (Naira)	Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)
5,546,000			5,546,000	35,781
20,102,000			20,102,000	129,690
8,294,000			8,294,000	53,510
3,889,000	-	3,889,000	25,090	25,090
300,000	-	300,000	1,935	1,935
1,500,000	1,500,000	3,000,000	19,355	19,355
2,400,000	-	2,400,000	15,484	15,484
3,600,000	3,600,000	7,200,000	46,452	46,452
9,300,000	-	9,300,000	60,000	60,000
6,150,000	6,150,000	12,300,000	79,355	79,355
699,200	2,796,800	2,796,800	6,292,800	40,599
-	5,436,600	-	5,436,600	35,075
-	12,420,000	12,420,000	24,840,000	160,258
2,357,500	9,430,000	9,430,000	21,217,500	136,887
12,600,000		-	12,600,000	81,290
	47,690,000		47,690,000	307,677
-	47,371,500	47,371,500	94,743,000	611,245
8,389,700	33,558,800	33,558,800	75,507,300	487,144
4,050,000	-	-	4,050,000	26,129
92,168,925	**248,951,675**	**169,199,100**	**510,319,700**	**3,292,385**
546,142,305	**1,310,315,158**	**1,104,904,083**	**2,961,361,547**	**19,105,558**

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

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

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

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

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

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

Strategic intervention	Activities
THEMATIC AREA: PMTCT SERVICE SUPPLY SYSTEMS	
Training & capacity	Train providers on FP (dual method) service delivery as appropriate for cadre * integrate into HTC training and extend by 1 day. No cost – integrated into HTC training to give 11 days
	Conduct advocacy visit to the Chairman of HMB to ensure the establishment of functional FP units within all secondary facilities (no cost attached)
	Conduct FP technology training for nurses in secondary facilities - 1 person per facility, 6 weeks training with 2 weeks residential component and 4 weeks field component/mentoring = 28 persons, 1 training cycle.
	Conduct mentoring for nurses trained on FP technology (above) - weekly mentoring (2 day) visits to secondary sites (23 sites) = x facilitators and 92 visits
	Conduct quarterly meeting of site and LGA RH focal persons - LGA based, 1 every quarter = 23 meetings per quarter x 280 HCW (1 per facility) = 92 meetings per annum x 2.5 years
Mentoring & supervision	Conduct monthly supportive supervision visits (linked to integrated supportive supervision)
Service delivery	Facilitate creation of community-based support groups in LGAs where there are no support groups
	PSensitize support group members on FP and dual method use. 1 sensitization per LGA (23) x 30 persons per LGA
Community services	Provide FP SOPs, guidelines, job aids, etc. All sites (280)
PMTCT service supply systems sub-total	
THEMATIC AREA: HEALTH CARE COMMODITIES	
Procurement (quantification, forecasting)	***Consumables***
	Procure FP commodities, (including condoms, oral pills, , Injectables, Implants, intrauterine contraceptive devices) No cost key into national program
	Equipment
	Procure Equipment for FP (clinic couches, angle lamp, sterilization units, intrauterine contraceptive devices insertion kits, weighing scale, BP apparatus, stethoscope, Jadelle insertion kits, sharps boxes, furniture etc.). No cost ; key into national program
Distribution	***Consumables***
	Transport & distribute family planning commodities from State stores to SDPs (to be distributed alongside other commodities)
Training & capacity	Conduct 5-day residential Contraceptive Logistics Management System (CLMS) training
	Conduct 5-day step down non - residential Contraceptive Logistics Management System (CLMS) training
PMTCT demand creation system sub-total	
Objective 2 sub-total	

Year 1 Budget (Naira)	Year 2 Budget less one-off activities (Naira)	Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)
2,804,100	8,412,300		11,216,400	72,364
1,012,000	3,036,000		4,048,000	26,116
51,520,000	103,040,000	103,040,000	257,600,000	1,661,935
			-	-
-	-	-	-	-
1,242,000	3,726,000		4,968,000	32,052
246,400	492,800	492,800	1,232,000	7,948
56,824,500	**118,707,100**	**103,532,800**	**279,064,400**	**1,800,415**
-	-	-	-	-
-	-	-	-	-
2,363,900	-	-	2,363,900	15,251
548,600	3,291,600	-	3,840,200	24,775
2,912,500	**3,291,600**	**-**	**6,204,100**	**40,026**
59,737,000	**121,998,700**	**103,532,800**	**285,268,500**	**1,840,442**

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 all pregnant women

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 trainings for HCWs in sites as appropriate (see section below for listing)
	Conduct 6-day integrated PMTCT training for all sites = 280 doctors (from all scale-up PMTCT and CC sites) in 8 cycles of training x 35 persons per cycle
	Conduct 5-day IMPAC PMTCT for nurses/CHEWS = 2 nurses + 2 CHEWs x 280 facilities= 1120 participants in 32 cycles of training with 35 participants per training
	Conduct laboratory training - 1 person per facility x 280 facilities. 8 cycles of training x 35 persons per cycle.6 days
	Conduct 5-day pharmacies training for pharmacists and community pharmacists - 28 hospital facilities (2 per GH + 3 in tertiary) and preceptors (1CP per 5 PHCs/PH = 50 CPs) = 109 trainees in 3 cycles of 37 persons. Residential
	Conduct 2-day ARV dispensing and documentation for pharmacy technicians, nurses CHO and CHEWs. 2 per site x 280 sites = 560 participants. Residential. 16 cycles of training x 35 persons per cycle
	Conduct training of trainers (TOT) for pharmacists (master trainers) to conduct on-site best practice training. 1 day orientation x 40 consultants/master trainers. 1 cycle x 1 day
	Conduct 5-day onsite pharmacy follow-up best-practice training including logistics (1 facilitator per site X 280). Facilitators (honorarium) x 5 days with travel (etc), tea break and participants materials. Assume 10 persons per site
	Conduct on-site adherence training in 280 sites. I day meeting involving 20 persons per site
	Conduct LMIS training for all facilities. 5 day training x 2 persons (nurses/CHEWs/pharm tech) per facility = 560 persons. 16 cycles of training x 35 persons per cycle
	Conduct sample handing training for HCW - 3 persons per facility x 280 facilities = 840 persons. 3 day training. 24 cycles
	Integrate HTC into ongoing HBC initiative for MCH and scale-up current system implemented by CHEWS to other (20) LGAs (currently in 3 LGAs) by conducting training for all (23) LGAs - linked to HTC training in prong 1
Mentoring & supervision	Support community-based support group monthly meetings for applicable facilities - 1 meeting per month per LGA (20 persons) = 23 meetings per month = 276 meetings per year x 2.5 years
	Support group volunteers to carry out tracking and adherence support through monthly phone calls and home visits - 2 persons (1 facility focal person + 1 support group volunteer) x 280 facilities x monthly communication + monthly transport
	Conduct quarterly visits to supervise and mentor sites and community services by SIT. Covering 280 sites - assuming 10 teams (2 persons per team) x 1 facilities per day x 10 days/month = 120 days per year x 2.5 years **Expand SIT (group 1)
Site activation	Facilitate pre-activation assessments for 280 sites
	Site activation meetings (PMTCT sites) - 1 day duration x 252 sites x 10 persons 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)
14,556,400	43,669,200	-	58,225,600	375,649
180,016,000	540,048,000	-	720,064,000	4,645,574
26,102,800	78,308,400	-	104,411,200	673,621
6,070,450	18,211,350	-	24,281,800	156,657
33,654,400	100,963,200	-	134,617,600	868,501
555,800			555,800	3,586
29,785,000	89,355,000	-	119,140,000	768,645
3,500,000	10,500,000	-	14,000,000	90,323
			-	-
83,607,600	250,822,800		334,430,400	2,157,615
-	-	-	-	-
14,904,000	29,808,000	29,808,000	74,520,000	480,774
18,480,000	36,960,000	36,960,000	92,400,000	596,129
28,800,000	57,600,000	57,600,000	144,000,000	929,032
-	-	-	-	-
1,814,400	5,443,200	-	7,257,600	46,823

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 all pregnant women *(continued)*

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

Strategic intervention	Activities
THEMATIC AREA: PMTCT SERVICE SUPPLY SYSTEMS *(CONTINUE)*	
Service delivery	Provide PMTCT SOPs, job aids, etc. in all (280) facilities x 3 copies/facility
	Support sample transfer for mothers - no cost, linked to logistics
	External quality assurance for lab - no cost, linked to logistics
Community services	Conduct community outreaches targeting strategic locations to reach pregnant women (integrated into community outreach in prong 1)
PMTCT service supply systems sub-total	
FOCUS AREA 2: HEALTH CARE COMMODITIES	
Procurement	***Drugs***
	Procure ARVs for triple prophylaxis (TDF + 3TC + EFV) for infected pregnant women 90%
	Procure ARVs for triple prophylaxis (other regimen like LPV/r)
	Procure ARVs (NVP suspension) for HIV exposed infants
	Procure cotrimoxazole for infected pregnant women
	Procure cotrimoxazole for HIV exposed infants
	Procure Haematinics for pregnant women
	Procure other drug commodities (antibiotics, antifungal, anti haematinics etc.)
	Procure DBS bundle kits
	Procure PCR reagents
	Procure pharmacy consumables (dispensing envelop, dispensing bags, dispensing trays, spatulas, etc.)
	Procure PCR machines and accessories (X 1)
Distribution	***Drugs***
	Distribute ARVs for HIV infected pregnant women & exposed infants (to be distributed alongside other commodities) Key into distribution plan
	Redistribute ARVs for infected pregnant women & HIV exposed infants
	Redistribute cotrimoxazole for infected women & HIV exposed infants
Others	Provide funds for DBS sample transfer to and from Uyo
Health care commodities sub-total	
Objective 3 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)
823,200	1,646,400	1,646,400	4,116,000	26,555
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
442,670,050	**1,263,335,550**	**126,014,400**	**1,832,020,000**	**11,819,484**
31,705,500	63,411,000	63,411,000	158,527,500	1,022,758
7,645,890	15,291,780	15,291,780	38,229,450	246,642
8,280,000	16,560,000	16,560,000	41,400,000	267,097
1,600,000	3,200,000	3,200,000	8,000,000	51,613
120,000	240,000	240,000	600,000	3,871
12,500,000	25,000,000	25,000,000	62,500,000	403,226
120,000	240,000	240,000	600,000	3,871
2,934,190	5,868,380	5,868,380	14,670,950	94,651
247,317	494,634	494,634	1,236,584	7,978
1,008,000	2,016,000	2,016,000	5,040,000	32,516
66,160,897	**132,321,794**	**132,321,794**	**330,804,484**	**2,134,222**
508,830,947	**1,395,657,344**	**258,336,194**	**2,162,824,484**	**13,953,706**

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	Training of 2 lab scientists on DNA PCR – 10-day training plus local transport for 4 trainees
	Conduct 5 day PHDP training (master training) for support group members. 5 persons per LGA x 23 LGAs = 115 persons in 3 cycles of 39 persons
	Conduct trainings (see section below for listing)
	Integrated ART training (adult, pediatric, OIs, etc) for 28 sites - 10 days x 5 per facility = 140 persons in 4 cycles of 35 persons
	TB/HIV training for 28 sites -5 persons per site x 5 days x 28 facilities in 4 training cycles
	Pharmacy training -5 days x 2 persons x 28 facilities = 56 persons in 2 cycles of 28
Site activation	Pre-activation assessments for 28 sites - link to program management
	Site activation meetings (ART sites) - 5 days duration x 28 sites x 10 persons per site
Mentoring & supervision	Support the provision of provider-initiated testing (and subsequent referral as appropriate) at immunization points for mothers coming for Pentavalent 1 - no cost
	Support group volunteers (including mentor mothers) to carry out tracking and adherence support through monthly phone calls and home visits (linked to prong 3 above) cost linked to prong 3
Linkages/referrals	Provision of DBS collection services in all facilities - linked to logistics
	Support referral of DBS samples - linked to logistics
	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	Laboratory training for ART -6 days x 28 facilities x 2 persons per facility = 56 persons in 2 cycles of 28
PMTCT service supply systems sub-total	
THEMATIC AREA: HEALTH CARE COMMODITIES	
Procurement (quantification, forecasting)	***Drugs***
	Procure ARVs for ART
	Consumables
	Procure nutritional support (plumpy nuts) for exposed infants. Refer to service supply
	Procure other rapid test kits (syphilis, Hepatitis B& C and pregnancy tests)

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)
-	-	3,660,000	-	-
6,094,375	18,283,125	29,280,000	24,377,500	157,274
-	-	-	-	-
9,708,200	29,124,600		38,832,800	250,534
8,151,000	24,453,000		32,604,000	210,348
2,475,800	7,427,400		9,903,200	63,892
360,000	1,080,000	7,104,000	1,440,000	9,290
7,563,500	22,690,500	-	30,254,000	195,187
2,952,800	8,858,400		11,811,200	76,201
37,305,675	**111,917,025**	**40,044,000**	**149,222,700**	**962,727**
169,484,079	338,968,158	338,968,158	847,420,395	5,467,228
722,863,680	1,445,727,360	1,445,727,360	3,614,318,400	23,318,183

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 (Continue)

Objective 6: Increase provision of lifelong ART to at least 90% of HIV infected pregnant women requiring treatment for their own health(Continue)

Strategic intervention	Activities
THEMATIC AREA: HEALTH CARE COMMODITIES (CONTINUE)	
Procurement (quantification, forecasting)	***Equipment***
	Procure air-conditioners & refrigerators for lab and pharmacy to maintain cold chain
	Procure 25 KVA generator for facility (18 secondary Health facilities in the State i.e. 1 per LGA)
	Procure laboratory reagents for 28 new comprehensive centers
	Procure lab equipment for 10 new HIV comprehensive centers + accessories
	Procure POC CD4 machine
	Consumables
	Print and disseminate registers and LMIS tools for management of HIV/AIDS commodities refer to M&E
	Equipment
	Procure vehicle for distribution & reverse logistics of health commodities
	Procure motor cycles/tricycles and engine boats for distribution & reverse logistics of health commodities too hard to reach and riverine areas in the state.
Supervision	Conduct bi-monthly DQA /SQA to ensure data/service quality in PMTCT sites refer to service supply
	Conduct bimonthly State Logistics TWG meetings
	Conduct supportive supervisory visit for logistics management of HIV/AIDS commodities
	Conduct bimonthly logistics peer review meetings
Infrastructure	Infrastructural upgrade of facilities' pharmacy & lab stores
	Infrastructural upgrade of LGAs' pharmacy stores
	Renovate facility labs to provide comprehensive ART services in 28 health facilities selected for HCC services. Refer to program management
	Conduct residential training (TOT) on warehousing, de junking & safe disposal of waste/expired commodities
	Conduct step down training on warehousing, de junking & safe disposal of waste/expired commodities
	Conduct 3-day planned preventive maintenance training for engineers and equipment operators
	Support sputum sample transfer to testing sites
Laboratory services	Set up TB DOT/AFB laboratory refer to program management
Stock management	Provide funds for CD4/hematology/chemistry sample transfer logistics from PHCs to secondary facilities
Health care commodities sub-total	
Objective 3 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)
20,448,181	40,896,362	40,896,362	102,240,906	659,619
39,231,580	96,049,730		135,281,310	872,783
6,516,475	6,516,475		13,032,950	84,084
156,000	936,000	936,000	2,028,000	13,084
220,000	1,320,000	1,320,000	2,860,000	18,452
60,000	360,000	360,000	780,000	5,032
7,165,700			7,165,700	46,230
1,747,400	8,737,000		10,484,400	67,641
1,526,500	1,526,500	-	3,053,000	19,697
-	-	-	-	-
3,200,000	6,400,000	6,400,000	16,000,000	103,226
972,619,595	**1,947,437,586**	**1,834,607,880**	**4,754,665,061**	**30,675,258**
1,009,925,270	**2,059,354,611**	**1,834,607,880**	**4,903,887,761**	**31,637,986**

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	USG Lead M&E IP in the state to organize capacity of the State IHDM team on data analysis and information dissemination
Strategic Information	Set up an inventory system for M&E tools in SMOH
	Set up IHDM team at the state level
	Set up IHDM team at the LGA level
Central Database	Design the template for the e-factsheet and service coverage report
	Produce 4 editions of e-factsheet and service coverage report
Routine Monitoring	Set up a system to update list on quarterly basis
	Conduct 5 days per month mentoring & supportive supervision to HFs in the 23 LGAs
	Organize quarterly mentoring & supportive supervision and DQA visits to LGAs & HFs in the state
Capacity Building	Hold 1-day meeting for all stakeholders in the state to harmonize facility list in the state
	Hold 2-day non-residential meeting for all stakeholders in the state to establish an IHDM team
	Hold a step down meeting for all stakeholders in the LGA level to establish an IHDM team
	Hold quarterly IHDM meeting at the state level
	Hold monthly IHDM meeting at the LGA levels
	Hold 6-day enhanced M&E & IHDM training for 45 state level officers.(2 persons per programme area)
	Hold 6-day enhanced M&E & IHDM training for 230 LGA level officers(10 per LGA)
	Conduct 4-day TOT training on all data collection & reporting tools for 46 LGA officers(2 per LGA)
	Conduct 3-day training on all data collection & reporting tools for 505 health facilities
	Conduct two OR studies related to PMTCT and IMNCH
Advocacy	Advocacy to relevant govt. agencies to support the funding, procurement & supply of M&E tools
Other	Mapping & revalidation of existing facilities
	Publish the finalized comprehensive list of facilities in SMOH website
	Set up a state level sub-committee (SACA, SMOH, PHCMB, development partners) to manage the forecasting, procurement & supply of M&E tools
	Procure 5 project vehicles (Toyota Hilux) for the IHDM Teams at the state level (each for SASCP, SHMB, SPHCMB, SACA and State DPRS)
	Procure & supply M&E tools to HFs
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)
5,000,000	-	5,000,000	32,258	
-	-		-	-
28,869,000	14,434,500	7,217,250	50,520,750	325,940
8,400,000	2,100,000	2,100,000	12,600,000	81,290
300,000	-	-	300,000	1,935
600,000	-		600,000	3,871
3,320,400	-		3,320,400	21,422
3,448,000	1,848,000	1,848,000	7,144,000	46,090
45,972,000	22,986,000	22,986,000	91,944,000	593,187
8,067,000	-	-	8,067,000	52,045
48,577,000	-	-	48,577,000	313,400
6,345,000	-	-	6,345,000	40,935
54,686,700	-	-	54,686,700	352,817
			-	-
5,310,000	-	-	5,310,000	34,258
37,500,000	-	-	37,500,000	241,935
147,130,000	73,565,000	29,426,000	250,121,000	1,613,684
1,009,925,270	**2,059,354,611**	**1,834,607,880**	**4,903,887,761**	**31,637,986**

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: PROGRAM MANAGEMENT	
Situation analysis	Implement recommendations of training needs assessment report
	Sign MOUs with private facilities on eMTCT services
	Review existing HIV/AIDS State Policy (including implementation) within the system affecting access to quality service delivery and make recommendations on gaps
Coordination & Resource mobilization	Conduct annual review of human resource gaps (resource availability and HR capacity development) - Done during annual review meetings
	Procure identified equipment (fridge, air conditioners, computers, furniture, pallets) for 210 SDPs
	Conduct CQI assessment across the facilities and develop capacity building plans
	Inaugurate CQI teams at the facilities
	Conduct monthly mentorship & supportive supervisory visit meetings
	Disseminate reviewed (approved) policies to relevant stakeholders
	Conduct quarterly review meeting with stakeholders of eMTCT scale-up program
	Adopt & domesticate the State eMTCT Plan at the 23 LGAs in partnership with the PHC Board
	Develop and harmonize costed work plan from various thematic areas/groups developed during the eMTCT workshop
	Disseminate costed eMTCT work plan to relevant stakeholders in the state
	Print and distribute the costed work plan for eMTCT scale-up
	Conduct flag off meeting of PPP initiative for eMTCT scale-up in the state
	Conduct quarterly SMT review & tracking meeting of Scale-up Plan and produce report
	Support quarterly eMTCT Technical Working Groups meetings
	Conduct monthly SIT meetings
	Conduct monthly LGA Technical Committee Meeting
	Conduct monthly HIV desk officers meeting at the state level for the 23 LGAs
	Conduct monthly cluster coordination meetings
	Conduct annual review meeting with all stakeholders
	Write proposals to prospective partners
	Publish Progress Score Card on eMTCT activities in the state media/ Recognition of Public & Private Partners in the Success Story
	Develop monthly, quarterly, financial resource need for eMTCT scale-up plan by sending fund requests to funding partners

Year 1 Budget (Naira)	Year 2 Budget less one-off activities (Naira)	Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)
-	-	-	-	-
-	-	-	-	-
130,000	-	-	130,000	839
6,632,000	6,632,000	-	13,264,000	85,574
6,632,000	6,632,000	-	13,264,000	85,574
-	-	-	-	-
1,150,000	-	-	1,150,000	7,419
4,070,000	4,070,000	4,070,000	12,210,000	78,774
-	43,550,000	-	43,550,000	280,968
-	-	-	-	-
130,000	-	-	130,000	839
57,500	-	-	57,500	371
235,000	940,000	940,000	2,115,000	13,645
323,600	1,294,400	1,294,400	2,912,400	18,790
781,800	3,127,200	3,127,200	7,036,200	45,395
5,604,000	22,416,000	22,416,000	50,436,000	325,394
590,875	2,363,500	2,363,500	5,317,875	34,309
9,360,000	32,760,000	32,760,000	74,880,000	483,097
9,983,850	9,983,850	9,983,850	29,951,550	193,236
257,500	257,500	257,500	772,500	4,984
170,000	170,000	170,000	510,000	3,290
10,000	10,000	10,000	30,000	194

Prong 4: Family centered care and support

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

Strategic intervention	Activities
THEMATIC AREA: PROGRAM MANAGEMENT *(continued)*	
Infrastructure	Develop BOQ for 308 SDPs for renovation based on current infrastructure assessment
	Carry out renovation of 308 health facilities
	Conduct yearly review of infrastructure
HR & staffing	Recruit required health care personnel (60 doctors, 100 nurses, 80 CHOs & CHEWs, 50 record officers, 40 lab scientist/technicians and 70 pharmacists/ pharmacy technician) over 2 years
Community mobilization	***Advocacy***
	Conduct advocacy for recruitment of required health care personnel by 15 SMT members.
	Conduct advocacy to Association of General & Private Medical Practitioners of Nigeria (AGPMPN) & Association of Pharmacist of Nigeria (APN) Rivers State & others on eMTCT scale-up plan
	Develop advocacy kit & conduct advocacy to relevant stakeholders on policy implementation
	Conduct advocacy to the Governor on eMTCT State Work plan on resource support required from the state
	Carry out advocacy to multi-nationals/private organizations to support eMTCT scale-up plan in the State
Capacity building	Capacity building for 96 staff of the private sector on work plan development and financial management in eMTCT
	Train 15 SMT, TWG and facility personnel on CQI
	Implement capacity building plans
	Train 15 SMT on grant or resource support proposal writing and resource mobilization
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)
1,596,000	3,932,000	-	5,528,000	35,665
200,000,000	500,000,000	-	700,000,000	4,516,129
	-	-	17,000	110
651,716,130	651,716,130		1,303,432,260	8,409,240
15,000			15,000	97
45,000	-	-	45,000	290
		-	-	-
-	-	-	-	-
75,000	75,000	75,000	225,000	1,452
7,701,900	15,403,800	-	23,105,700	149,069
10,965,000			10,965,000	70,742
-	-	-	-	-
1,840,800	-	-	1,840,800	11,876
1,047,034,455	**1,562,664,380**	**87,797,450**	**2,697,496,285**	**17,403,202**
1,445,559,555	**1,682,597,880**	**151,374,700**	**3,279,532,135**	**21,158,272**
3,570,195,077	**6,569,923,692**	**3,452,755,657**	**13,592,874,427**	**87,695,964**

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